Report of the Independent Inquiry Telford Child Sexual Exploitation

Chaired by Tom Crowther QC

VOLUME THREE
OF FOUR

12 July 2022

Commissioning Body: Eversheds Sutherland (Intl) LLP

EVERSHEDS SUTHERLAND

Chapter 4: Taxi Licensing and the Night-Time Economy

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4. Taxi Licensing and the Night-Time Economy

Introduction

4.1 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. This limb of the Inquiry's Terms of Reference seeks to investigate significant claims made during the consultation period, which relate to the alleged involvement in CSE of the taxi industry and the night-time economy, in particular nightclubs and fast food takeaway restaurants.

4.2 Whilst gathering evidence from CSE victim/survivors, the Inquiry heard numerous accounts of children being subjected to unwanted sexual attention in taxis,[1] which led in some cases to rape or other serious sexual assault by the driver.[2] 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,[3] as happened in the case of Lucy Lowe, a child who was murdered in 2000 by her 'boyfriend', a local taxi driver. I have also seen reference to the allegation that taxi drivers are believed to work together for the purpose of committing CSE, for example;

"*Asian men will pick up a girl in a taxi when drunk, stop at a shop, supposedly to buy a drink, and then drive off, leaving the girl abandoned. He will then call other men, one of whom will pick the girl up, thereby "rescuing" her, with the others driving to a pre-arranged location in readiness for the second taxi to bring the girl there in order that all the men can rape her.*"[4]

4.3 I have also seen evidence from a parent, whose daughter, a suspected CSE victim, now refuses to travel anywhere in a taxi, due to her past experiences.[5]

4.4 Also of serious concern to the Inquiry are the reports relayed by professionals, of taxi drivers harassing children and loitering outside schools, picking pupils up at lunchtimes. For example:[6]

"*It was usual practice for some girls… to leave the school grounds at lunchtime, with these men, in some cases not returning to school for afternoon lessons once the lunchtime period had ended. Due to the layout of the school it would have been obvious that the girls were leaving and returning in these cars.*"[7]

4.5 One head teacher told me that licensed taxis would drop children off at school in the morning and that:

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1 [redacted] pg 37 [redacted] pg 12 [redacted] pg 2
2 [redacted] pg 10, [redacted] pgs 3-4 [redacted] pg 5, [redacted] pgs 5-6
3 [redacted] pg 9
4 [redacted] pgs 56-57
5 [redacted] pg 31
6 [redacted] pg 2
7 [redacted] pg 2

"*… there were girls who said they'd been up the Wrekin before they'd come to school. And you know you have to ask yourself, you know despite the fact you didn't necessarily have concrete evidence, you had to ask yourself what was going on with a taxi driving a girl up the Wrekin before school, why would you go up the Wrekin if you know, you know, I mean there'll be people who don't know what the Wrekin is… but if you think about what the Wrekin is, how remote and how quiet it is up there, what on earth had you been up the Wrekin for*?".[8]

4.6 Furthermore, of the CSE victim/survivors who have come forward to the Inquiry, many 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.[9] The Inquiry has heard that the upstairs rooms of some of these establishments were used as premises for committing serious sexual assaults[10] and of several cases of children being raped by food delivery drivers when accompanying them on food delivery runs[11] or otherwise befriending them.[12] In addition, at least one local nightclub has been named as a venue where children were exploited.[13]

4.7 Finally, I have noted that Telford & Wrekin Council's (the "Council") own initial investigations into suspected CSE activity, in approximately 2000, were triggered in part by concerns about children going missing who were then:

"*… going to that takeaway, being befriended by Asian men that worked in that takeaway and they were also being trafficked through, by Asian men, through the taxi services."*[14]

4.8 In order to fully investigate these allegations, and the response or action taken by the Council to address them, I will consider:

4.8.1 The application of the taxi licensing regime in Telford & Wrekin, to include driver and vehicle licensing; the sources of information upon which the Council relies; the Council's relationship with the trade to 2008; enforcement since 2008 including cross-border licensing; and 'badge swapping', a practice allegedly used by the perpetrators of CSE.[15]

4.8.2 The 'night-time economy' to include nightclubs (especially 'under 18s' events) and other licensed premises, where these are relevant to the Inquiry's Terms of Reference; measures put in place by the Council to ensure the safety of those around licensed premises and the use of any information generated as a result; and West Mercia Police's ("WMP") approach to the night-time economy as a whole.

[8] [redacted] pg 38
[9] [redacted] pg 4
[10] [redacted] pg 5
[11] [redacted] pg 9
[12] [redacted] pg 2, [redacted] pg 11, [redacted] pg 3, [redacted] pg 13, [redacted] pg 17
[13] [redacted] pg 4, [redacted] pg 45, [redacted] pg 6, [redacted] pgs 6-7
[14] [redacted] pg 4
[15] [redacted] pg 8

Specific disclosure requests

4.9 In preparation for the examination of these areas, requests for specific disclosure were made to relevant organisations, as follows:

4.9.1 Telford Magistrates' Court – the Inquiry requested all relevant documentation, however no documents were forthcoming. This is perhaps unsurprising given the passage of time (the magistrates lost responsibility for liquor licensing in 2003) and likely retention period.

4.9.2 The Council – the Inquiry requested a list of all taxi licensees, including details of suspensions and the reason for those suspensions, from the date the Council assumed responsibility to the present day. The Council advised in response that information of this nature was only available dating back to 2002, which was then provided.

4.9.3 Shropshire Council – again, the Inquiry requested a list of all taxi licensees, from 1989 to the present day. As part of this list, details of all licence suspensions, revocations, written warnings, other interventions and the reason for those interventions were requested, as well as a complete list of taxi licences held by Shropshire Council and its previous iteration, Shropshire County Council. This level of detail was required due to the concerns raised about taxi licensing specifically and it being described as both a historic and live issue, as well as the need to examine the 'cross-border' issue.

4.10 As regards Shropshire Council, the first request was made in October 2020. As I have explained in Chapter 1: Background to the Inquiry, Shropshire Council recorded its concern about the request being disproportionate and about the legitimacy of this request as it was concerned about releasing personal data of all licensees where its records did not suggest, even at the lowest level of credibility, any indication of a connection to CSE. For this reason, Shropshire Council instead undertook preparation of a list of taxi, private hire drivers, vehicle proprietors and operators "*where we consider there is or may be a link to CSE/other exploitation*"[16] (the emphasis is mine). Irrespective of the level of confidence in this data, I expressed concern around this as there could be relevant information in the records even where there is no obvious link to CSE and/or exploitation generally. I therefore requested that Shropshire Council provide the Inquiry with a complete list of taxi licences held by Shropshire Council (and its predecessor, Shropshire County Council), dating as far back as 1989, where available. I 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.

4.11 Shropshire Council has provided the following information to the Inquiry:

4.11.1 The first tranche of disclosure involved a manual check of 600 taxi and private hire driver licenses going back to 2013 (which is the date its current licensing IT

[16] [redacted]

system was implemented) and the records related to matters that had been addressed by officers under delegated decision making powers.

4.11.2 The second tranche of disclosure related to drivers where matters were referred to its '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.

4.11.3 The third tranche of disclosure was a list of records relating to vehicle proprietors or private hire operators where the matters were referred to its '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.

4.11.4 The fourth tranche of disclosure, which was disclosed in March 2022 in response to the Maxwellisation process, was a list of records relating to the above matters, but for the time period from 2009 (the date at which Shropshire Council in its current form came into being) until 2013, when the current IT system was installed. These records had been sourced by carrying out searches of the system used prior to 2013.

4.11.5 In its response to the Maxwellisation process, Shropshire Council also informed the Inquiry that its Records Management Service had confirmed that there were no records in the Shropshire archives relating to licensing records prior to 2009.

4.12 In summary, Shropshire Council provided information only from the period of 2009 to present and only where it took the view that the record gave an indication of a connection to CSE or other exploitation. This was in sharp contrast to the initial disclosure request of records of all taxi licensees and related documentation from the period of 1989 to present, receipt of which would have allowed the Inquiry to make its own assessment of relevance.

Taxi Licensing

4.13 In order to understand the history of licensing of taxis in Telford, it is first necessary to explain what is meant by a 'taxi'. The term 'taxi' is used interchangeably in everyday life to represent vehicles which are in law known as Private Hire Vehicles and Hackney carriages. There are different licensing provisions for the different classes of vehicles and licences for the various classes confer different rights. In each case a local authority is responsible for granting a licence.

Private Hire Vehicles ("PHVs")

4.14 PHVs are regulated under the Local Government (Miscellaneous Provisions) Act 1976. Drivers, vehicles and operators must be licensed. The licensing authority must be satisfied that the applicant driver and operator pass the "*fit and proper person*" test under that legislation, before a licence is granted.

4.15 PHVs are not allowed to ply for hire - that is, to stop for customers who hail them or to wait at taxi ranks for custom. They must be pre-booked. Their fares are not controlled by the licensing authority and nor is there a requirement for a meter.

Hackney carriages

4.16 Hackney carriages are regulated under the Town Police Clauses Act 1847, the Local Government (Miscellaneous Provisions) Act 1976 and the Road Traffic Act 1991, amongst other legislation. Driver and vehicle licences are required, but not an operator licence. Again, for drivers, the "*fit and proper person*" test must be passed.

4.17 Hackney carriages are permitted to ply for hire. They are allowed to wait at designated taxi ranks. They operate a fare tariff set by the licensing authority and must run a meter.

4.18 There is an overlap, in that Hackney carriages are also able to undertake pre-booked work. Furthermore, that work can begin outside the Hackney carriage's licensed area. In this way, Hackney carriages can operate as PHVs in areas where the local authority has no enforcement powers over them.

Licensing in Telford & Wrekin

4.19 Legislation provides that in a local authority operating a Cabinet structure, such as exists in the Council, the Cabinet itself is not to exercise the licensing function with respect to Hackney carriages and PHVs.[17]

4.20 The Council therefore delegates this function to its Licensing Committee, which in turn delegates to the Principal Licensing Officer and, in certain circumstances, to a Licensing Sub-Committee. There is a right of appeal against an adverse decision to the magistrates' court and from there to the crown court.

4.21 To summarise, the Council's Principal Licensing Officer is the person (as the authorised officer of the Council[18]), in most cases, who is responsible for exercising licensing decisions in relation to PHVs and also for those Hackney carriages which have applied for a licence in its own area. The Council has no enforcement power, however, for those Hackney carriages or PHVs which may be operating legally within the area, but whose licence has been applied for and obtained from a different authority.

Issuing of a licence to drive a PHV or Hackney carriage

4.22 As previously noted, the drivers themselves of both PHVs and Hackney carriages (those which fall under the jurisdiction of the local authority), require licences to drive them, which includes satisfying the "*fit and proper person*" test.

[17] Local Government (Functions and Responsibilities) (England) Regulations 2000 Schedule 1(B)
[18] Local Government (Miscellaneous Provisions) Act 1976 s.48 (4)(a)

Determining suitability of an applicant – pre-2002

4.23 In terms of determining the suitability of applicants, the Council will follow the provisions laid out in its Suitability Policy, of which there have been various iterations over the timescale the Inquiry is tasked with examining. The first of these, I understand, was published in 2004.

4.24 At the time when the town was governed by Shropshire County Council, the Inquiry heard that *"there is no knowledge of systems or processes in place for the period 1989 – 1999",* but that:

> *"… there is **some** corporate knowledge of the situation post-1999 but this is limited. At that time, Senior Licensing Officers had regard to the Department for Transport's Circular 2/92 and Home Office Circular 13/92* [(the "Circulars")] *on the relevance of convictions when determining taxi driver applications."*[19]

4.25 The emphasis in the wording is original. I have seen the Circulars referred to; they are a combined document.[20] The Circulars themselves, as well as the related supplemental guidance (the "Guidance") were issued following the grant of the power in the Road Traffic Act 1991 for local authorities to obtain police national computer ("PNC") checks of applicant drivers.[21]

Use of disclosed information

4.26 The Circulars were largely procedural but did set out, firstly, that:

> *"In considering applications from potential licence holders authorities should be aware that applicants do not have to reveal, and licensing authorities must not take into account, offences which are spent under the Rehabilitation of Offenders Act 1974…".*[22]

4.27 Furthermore, the Circulars noted that the fact that a person has a criminal record or is known to the police does not necessarily preclude them from holding a driver's licence:

> *"The authority concerned should make a balanced judgement about a person's suitability taking into account only those offences which are considered relevant to the person's suitability to hold a licence. A person's suitability should be looked at as a whole in the light of all the information available.*
>
> *In deciding the relevance of convictions, authorities will want to bear in mind that offences which took place many years in the past may often have less relevance than recent offences. Similarly, a series of offences over a period of time is more likely to give cause*

[19] [redacted] pg 67
[20] [redacted]
[21] Section 47 Road Traffic Act 1991
[22] [redacted] pg 4

for concern than an isolated minor conviction. In any event the importance of rehabilitation must be weighed against the need to protect the public."[23]

4.28 However, a specific draft policy in respect of sexual offending was also provided in the Circulars, due to the fact that drivers of PHVs and Hackney carriages often carry unaccompanied passengers. This draft policy set out conditions noting that applicants with convictions for serious sexual offences should be refused until they can show a substantial period (of at least three to five years) free of such offences, and that more than one conviction of this kind should preclude consideration for at least five years. It further stated that:

"In either case, if a licence is granted a strict warning as to future conduct should be issued."[24]

4.29 The obligation of the police to report acquisition of a conviction was dealt with, but the need for information sharing in both directions underlined that:

"If a police force is able to identify that the holder of a driver licence has acquired a relevant conviction, it will give details to the local nominated officer. This will occur only where the police are aware that a person is licensed under the Act and so will not mean that the nominated officer will automatically get information about all relevant convictions."[25]

Frequency of assessing suitability

4.30 As to frequency of checks of this information, the Circulars provided that:

"Checks should not normally be made on persons other than in connection with an application for grant or renewal of a licence. If, however, serious allegations are made against a driver, or previously unrevealed information comes to light and the nominated officer is satisfied that the information cannot be verified in any other way, a police check may be requested."[26]

4.31 It follows, then, that frequency of checks would depend on frequency of renewal, which, for the Council, was (at that time) on a three yearly basis.

Determining suitability of an applicant – 2002 to date

2002 to 2004

4.32 In terms of frequency of licence renewal, the Council changed its policy to a single year licence validity in 2002, remarking that:

"There were many problems with three year driver licences where drivers moved address and failed to inform the Council, or drivers' medicals and police national computer checks

[23] [redacted] pg 6
[24] pg 11
[25] pg 7
[26] pg 5

expired during the course of the three year licence and although reminder letters were sent to drivers, in many cases they failed to respond."[27]

4.33 There was also a change in the law in 2002[28] that removed taxi drivers (in the widest sense) from the effects of the Rehabilitation of Offenders Act 1974, meaning that otherwise spent convictions could now legitimately be required and taken into account by a licensing authority, in deciding whether an applicant was a "*fit and proper person"*.

4.34 This is reflected in the Council's '*Guidance relating to the Relevance of Convictions and Cautions: Supplemental to the Home Office guidance on the Relevance of Convictions*'[29] which provided (the emphasis is original):

"…***all*** *convictions must be disclosed, including spent convictions… In addition, applicants must disclose any recent simple cautions they have received or any pending matters… all convictions, spent or live, will be assessed.*"

4.35 I have not seen any evidence that the Council updated its working practices, as opposed to merely its guidance, at that time, as a result of this change in the law. However, the Inquiry understands from the Council that it introduced criminal records checks for all new and renewal applicants from the point that the law changed.[30]

2004 to 2009

4.36 The first suitability policy I have seen from the Council, titled '*Criteria to be used when determining whether or not to grant, renew, suspend or revoke a private hire driver's licence or a hackney carriage driver's licence*' was said to be introduced in 2004.[31]

4.37 As to the substance of the policy, it declares, in respect of drivers with sexual offence convictions, that:

"*An application will not be considered until a period of 3 years free of conviction is shown and any application with a conviction within this category will be put before the Appeals Panel for determination*."

4.38 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[32] for rape and the release regimes operating in the 1990s[33] and 2000s[34] combine to mean that a person convicted of a rape offence could be eligible to apply for a licence immediately, or very soon

[27] [redacted] pg 2
[28] The Rehabilitation of Offenders Act 1974 (Exceptions) (Amendment) Order 2002 para 5(3)(a)
[29] [redacted] pg 4
[30] [redacted]
[31] [redacted] pg 67
[32] R v Billam [1986] 1 WLR 349
[33] Criminal Justice Act 1991, section 33
[34] Criminal Justice Act 2003, section 244

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.

4.39 In response to the Maxwellisation process, the Council was keen to stress that the three year period is a proposed minimum term guideline only and that the decision is dependent wholly upon the circumstances of the offending. Further, that it would be impossible for any council to set out a policy dealing with every criminal offence. It reiterated the overriding test in determining whether to grant or renew a licence, which is whether the applicant is "*fit and proper*".[35]

4.40 On 4 October 2005, the Council's General Purposes Board considered a response to the draft '*Best Practice Guidance for Taxi and PHVs'*, produced by the Department of Transport. This draft guidance suggested that three-year licences were not only the legal maximum period but the "*best approach*", as annual re-licensing can "*impose an undue burden on drivers and licensing authorities alike*".[36]

4.41 So far as criminal records checks were concerned, the draft guidance noted:

"*A criminal record check is an important safety measure and is widely required. Taxi and PHV drivers can be subject to an Enhanced Disclosure through the Criminal Records Bureau; this level of disclosure includes details of spent convictions and police cautions. In considering an individual's criminal record, local licensing authorities will want to consider each case on its merits, but they will doubtless take a particularly cautious view of any offences involving violence, and especially sexual attack.*"[37]

4.42 The draft went on to note that PHV operators were not exceptions to the Rehabilitation of Offenders Act 1974, meaning that standard or enhanced disclosures could not be required as a condition of the granting of an operator's licence. A basic disclosure, in which spent convictions were not considered, would be appropriate. However this did not currently exist under the then Criminal Records Bureau ("CRB") scheme, a national scheme whereby checks could be made on the PNC about an individual's criminal history, later replaced by the Disclosure and Barring Service ("DBS").[38]

4.43 The Council's conditions of licence for PHVs, for 2002[39] and 2006[40], are essentially identical. Notably, they oblige a driver to "*notify the council of any conviction recorded against him or her by any court within 7 days of such a conviction being imposed,*" but not to notify of pending proceedings or formal cautions. The 2008 iteration[41] maintains the same formula.

4.44 I understand from the Council that, as well as drivers being obliged to notify of pending proceedings, other safety mechanisms are triggered at the time of review of the licence, for example complaints being made against the driver by a third party. A driver charged (both instances of underlining are mine) with a sexual offence, for example, would not be

35 [redacted]
36 [redacted] pg 10
37 [redacted] pg 10
38 [redacted] pgs 12-13
39 [redacted] pg 4
40 [redacted] pg 5
41 [redacted] pg 4

deemed fit and proper to hold a licence and would therefore have their licence revoked. The Council continues to adopt this approach, which I understand is standard practice across licensing authorities.[42]

2009 to 2011

4.45 The Council's policy was redrafted, retitled and expanded in 2009 as '*Policy for Determining the Grant, Renewal, Suspension, or Revocation of a Private Hire Operator Licence, a Private Hire, Dual or Hackney Carriage Driver/Vehicle Licence with Relevance to Convictions'*.[43] It included a list of new sexual offences under the Sexual Offences Act 2003. The direction for consideration of sexual offences was also changed: "*Any application with a conviction within this category will automatically be put before the Council's Licensing Committee for determination*", with the reference to a conviction-free period now being the more generic:

"*Each case will be judged on its merits. A person with a current conviction for serious crime need not be permanently barred from obtaining a licence but should be expected to remain free of conviction for 3 to 5 years, according to the circumstances, before an application is entertained."*

4.46 In 2010, the Local Authority Coordinators of Regulatory Services ("LACORS") published a template convictions policy[44] and the Council responded with a policy based upon it titled '*Taxi and PHV Licensing Criminal Convictions Policy*'[45]; there was for the first time specific guidance as to spent convictions and the approach to outstanding matters.

4.47 It noted that The Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975, allowed the Council to take into account all convictions recorded, whether spent or not and that:

"… the Licensing Authority will have regard to all relevant convictions, particularly where there is a long history of offending or a recent pattern of repeat offending…".

4.47.1 Furthermore that:

"*If the individual is the subject of an outstanding charge or summons their application can continue to be processed, but the application will need to be reviewed at the conclusion of proceedings. If the outstanding charge or summons involves a serious offence and the individual's conviction history (including 'spent' convictions) indicates a possible pattern of unlawful behaviour or character trait, then in the interests of public safety the application may be put on hold until proceedings are concluded or the application may be refused.*

If an applicant has, on more than one occasion, been arrested or charged, but not convicted, for a serious offence which suggests he could be a danger to the public, consideration should be given to refusing the application. Such offences would include violent offences and sex offences."

42 [redacted]
43 [redacted]
44 [redacted]
45 [redacted]

4.48 This policy made clear that the Council conducted enhanced CRB checks for any driver applicant. An enhanced check details spent convictions and non-conviction resolutions, such as cautions. The foundation for this level of check was the Council's contention that all drivers could potentially be asked to undertake regulated activities (such as transporting schoolchildren); there was no contrary view expressed by drivers.[46] I understand that these enhanced CRB checks were used by the Council to ascertain information which may be relevant in cases which had fallen short of a conviction.[47]

4.49 As to the expectation of a conviction-free period, this was part of a generic introduction again, but framed in this way:

"*A person with a conviction for a serious offence need not be automatically barred from obtaining a licence, but would normally be expected to:*

(a) *Remain free of conviction for an appropriate period; and*

(b) *Show adequate evidence that he or she is a fit and proper person to hold a licence (the onus is on the applicant to produce such evidence). (Simply remaining free of conviction will not generally be regarded as adequate evidence that a person is a fit and proper person to hold a licence).*"[48]

4.50 In terms of serious sexual offences, the policy provided:

"*Unless there are exceptional circumstances, an application will normally be refused where the applicant has a conviction for an offence such as rape, assault by penetration, offences involving children or vulnerable adults or any similar offences (including attempted or conspiracy to commit) offences which replace the above.*

In addition to the above the licensing authority will not normally grant a licence to any applicant who is currently on the Sex Offenders Register."[49]

4.51 As to other sexual offences, the text of the Circulars' proforma – recommending a three to five year conviction-free period - was now incorporated as part of the body of the document as policy, rather than as a quote. It read:

"… as hackney carriage and private hire vehicle drivers often carry unaccompanied passengers including schoolchildren and adults with learning disabilities, application with convictions for indecent exposure, indecent assault, importuning, or any of the more serious sexual offences, should be refused until they can show a substantial period (at least 3 to 5 years, free of such offences. More than one conviction of this kind should preclude consideration for at least 5 years. In either case if a licence is granted a strict warning as to future conduct should be issued."[50]

46 [redacted]
47 [redacted]
48 [redacted] pg 2
49 pg 9
50 [redacted]

4.52 The Council therefore did not adopt the more detailed suggestion and longer quarantine period set out by LACORS, which essentially stated that an applicant should have been free of conviction for at least ten years (or at least three years must have passed since the completion of the sentence, whichever was longer) for a number of sexual offences, which included sexual assault, exploitation of prostitution and trafficking for sexual exploitation. There was also a lesser period of time, at least three years since conviction (or completion of the sentence, whichever was longer), for offences including, but not limited to, indecent exposure and soliciting ('kerb crawling').[51]

4.53 The Council informed the Inquiry in its response to Maxwellisation that:

"*… unless there are exceptional circumstances, an application will normally be refused where the applicant has a conviction for an offence such as rape, assault by penetration, offences involving children or vulnerable adults or any similar offences*…"[52]

2011 to 2016

4.54 In 2011, there were changes relating to criminal conviction checks.

4.55 First, following a submission made by a number of local taxi firms, together known as the Telford Private Hire Association, that an operator was not exempted from the operation of the Rehabilitation of Offenders Act 1975 and a review of the national position in light of this,[53] the Council accepted it would no longer require CRB checks[54] (this had been foreshadowed in 2005; "*basic*" checks were still not available).

4.56 Second, the CRB ended the practice of providing enhanced CRB checks for taxi drivers, this now only being required for drivers who transported children on a regular basis. The Council – after some disquiet[55] - reviewed its policy (published only the previous year) in December 2011, which now dropped the use of the word "*enhanced*" in relation to criminal records checking, substituted "*DBS*" for "*CRB*"[56] and relied on applicants to volunteer the detail that would otherwise have been provided by the enhanced check.

4.57 The DBS reversed its predecessor's position on driver checks in short order; and Disclosure Scotland began to offer basic checks under a delegation from the DBS. A version of the policy, titled '*Licensing Policy: Hackney Carriage and Private Hire*', dated August 2012[57] stated:

"*… criminal record disclosures will be required at the maximum level set by legislation... This is currently a basic disclosure for Private Hire Operators and an enhanced disclosure for Private Hire and Hackney Carriage Drivers.*"

51 [redacted] pg 7
52 [redacted]
53 [redacted]
54 [redacted] pg 1
55 [redacted]
56 [redacted]
57 [redacted]

4.58 The version of the Council's '*Criminal Convictions Policy*' issued in October 2013[58] obliged drivers to notify the Council in writing of any conviction, caution or charge recorded against them, within seven days of its imposition. This was despite the fact that a change in law in 2013 meant that some previous offending history could now be filtered out, specifically protected cautions (for some offences) which were spent (more than six years since they were received).[59]

2016 to 2020

4.59 In 2016, the Council's draft Criminal Convictions Policy was circulated with proposed changes – in particular, to increase the conviction-free period for sexual offences. A comment on the document says:[60]

"*The policies adopted by English councils tend to be similar to each other because they were all based on the Home Office Circular issued in 1992. There is widespread recognition now that the Circular's references to sexual misconduct are excessively lenient. It is therefore proposed to increase the period free of conviction from 3 to 5 years to 5 to 10 years."*

4.60 Presumably some English councils had chosen to adopt the LACORS wording – which provided for a longer conviction-free period and a more offence-sensitive approach than this draft – when the Council had chosen not to in 2010.

4.61 It was further recommended in the policy that the wording relating to an applicant who had previous convictions for rape or serious sexual offences, or is on the sex offenders' register, be amended so as to change the "*would not normally*" formulation to a discretion to license in "*exceptional circumstances*".[61]

4.62 The policy, when published in April 2017,[62] showed significant differences from the draft. The effect was to make the policy more stringent. The conviction-free period expected in sexual offences was significantly increased (to ten years) and, while the discretion to licence rape-convicted applicants was retained, the discretion to license sex offender registrants in exceptional circumstances was not included: the formulation "*the licensing authority will not grant a licence to any applicant who is currently on the Sex Offenders Register*" was adopted. The obligation on drivers to report potentially adverse matters[63] was comprehensive:

"*The Licence holder shall notify the Council in writing of any conviction, caution, warning or charge recorded against him/her by any Authority within 7 days of such a conviction, caution or charge being imposed."*[64]

58 [redacted]
59 [redacted]
60 [redacted] pg 15
61 [redacted]
62 [redacted]
63 [redacted]
64 [redacted] pg 6

2020 to date

4.63 The policy dated 1 January 2020, titled '*Taxi (Hackney Carriage) and Private Hire Licensing Policy for Determining the Suitability of a Person to hold a Licence*'[65] reflected guidance published by the Institute of Licensing and made a number of changes:

4.63.1 First, it prefaced the guidance with the following: "*Whilst officers and the licensing committee will have regard to the policy and in some cases this policy says "never", each case will be considered on its individual merits".*

4.63.2 Second, notwithstanding that it declared that convictions that would prevent a licence being issued, it included:

"*Exploitation*

Where an applicant or licensee has been convicted of a crime involving, related to, or has any connection with abuse, exploitation, use or treatment of another individual, irrespective of whether the victim or victims were adults or children, they will not be licensed. This includes slavery, child sexual exploitation, criminal exploitation, grooming, psychological, emotional or financial abuse, but this is not an exhaustive list.

Sex and indecency offences

Where an applicant has a conviction for any offence involving or connected with illegal sexual activity or any form of indecency, a licence will not be granted. This will apply to any applicant who is currently on the Sex Offenders Register or on any 'barred' list."

4.64 In July 2020, the Department for Transport published '*Statutory Standards for Taxi and Private Hire Vehicles*'.[66] It said:

"*The past failings of licensing regimes must never be repeated. The Department has carefully considered the measures contained in the Statutory Taxi and Private Hire Vehicle Standards and recommend that these should be put in to practice and administered appropriately to mitigate the risk posed to the public. The purpose of setting standards is to protect children and vulnerable adults, and by extension the wider public, when using taxis and private hire vehicles.*"

4.65 It also set out a number of principles and recommendations to which a licensing authority must have regard in exercising their functions, specifically drawing on the Institute of Licensing report. The recommendations matched the formulations adopted by the Council in its most recent policy – which had itself been based on the Institute of Licensing

[65] [redacted]

[66] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/928583/statutory-taxi-and-private-hire-vehicle-standards-english.pdf

recommendations. The Council's most recent policy reflected changes made to immigration offences and an updated section on in-car CCTV.[67]

4.66 I have focused this analysis on the Council's approach to character thus far; but in its assessment of what is a "*fit and proper person*" it is open to a licensing authority to impose conditions. These very commonly include:

4.66.1 A topographic knowledge examination;

4.66.2 A medical check; and

4.66.3 A driving standards check.

Training for taxi drivers

4.67 In 2015, the Council introduced compulsory CSE awareness training for all new and renewing drivers as part of a system of training that had been in place on general matters since 2011.[68] Initially the CSE training was delivered by a member of the Licensing Team and, later, by amending the pre-existing PowerPoint presentation.[69] The training slides read:

"*Child Sexual Exploitation (CSE)*

Signs to look out for and what to do

- *Taking/collecting young people (girls and boys) from hotels/B&B's/house parties*
- *Picking up young people from other cars*
- *Young people who look distressed or intimidated*
- *Observing suspicious activity in hot-spot areas*
- *Young people under the influence of drugs and/or alcohol*
- *Attempts by young women to avoid paying fares in return for sexual favours*
- *Regular males requesting taxi rides to and from locations - taking young people with them*
- *Taking young people to A&E* [(Accident & Emergency)]*, who are not in the presence of parents*
- *Young people with injuries such as bruising or blood stains*

67 [redacted]
68
69

What to do:

- *Make notes about the information you know*
- *Call the police non-emergency number 101 to report your concerns about possible sexual exploitation*

Information to share:

- *Names*
- *Locations and addresses of concerns*
- *Descriptions of people*
- *Car registration plates, makes and models of vehicles*
- *Description of concerning activity.*"

4.68 Subsequent versions of the training gave prominence to signs that a child may be involved in drug crime[70] and the 2019 version strongly encouraged drivers to "*seek advice from your Operator's Safeguarding Officer,*" as an alternative to dialling 101.[71]

4.69 The statutory standards of July 2020,[72] to which I have referred with regard to the Convictions Policy, also dealt with training of drivers, noting at paragraphs 6.5 and 6.6:

"*Licensing authorities should consider the role that those in the taxi and private hire vehicle industry can play in spotting and reporting the abuse, exploitation or neglect of children and vulnerable adults. As with any group of people, it is overwhelmingly the case that those within the industry can be an asset in the detection and prevention of abuse or neglect of children and vulnerable adults. However, this is only the case if they are aware of and alert to the signs of potential abuse and know where to turn to if they suspect that a child or vulnerable adult is at risk of harm or is in immediate danger.*

All licensing authorities should provide safeguarding advice and guidance to the trade and should require taxi and private hire vehicle drivers to undertake safeguarding training. This is often produced in conjunction with the police and other agencies. These programmes have been developed to help drivers and operators:

- *provide a safe and suitable service to vulnerable passengers of all ages;*
- *recognise what makes a person vulnerable; and*

[70] [redacted] pgs 26-27
[71] [redacted] pg 28
[72] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/928583/statutory-taxi-and-private-hire-vehicle-standards-english.pdf

- *understand how to respond, including how to report safeguarding concerns and where to get advice.*"

4.70 It seems to me that the Council's training programme had covered these issues since 2015: whilst this is to be commended, there was clearly scope for such training to be introduced earlier than 2015, given Telford's history of CSE and concerns about children in taxis. Further, training is only required of those who actually apply for licences, and this does not address the issue of unlicensed drivers and in particular 'badge swapping', which I will address later in this chapter.[73]

Power to attach conditions to the licence

4.71 As noted initially, as well as licensing drivers and operators, the Council has an obligation to ensure suitability of vehicles. So far as Hackney carriages and PHVs are concerned, the Council has the power to attach to the grant of a licence any condition it requires reasonably necessary.[74]

4.72 The Inquiry asked the Council of any changes it had made to licensing requirements as a result of safeguarding and CSE; and the Council replied by referring to the "*tinted windows policy*".[75]

Tinted windows policy

4.73 The potential danger to an occupant arising from a window being tinted to the extent that an outsider is unable to see into the car, is an obvious one. The Inquiry understands that in 2002, conditions were applied by the Council to applicants for vehicle licences, which required that:

"*… the Council shall refuse any vehicle submitted for licensing which has been equipped with production line manufactured or retro-fitted blacked out windscreens and/or windows. Standard tinted windscreens and windows are acceptable providing all occupants in the vehicle can be clearly seen from the outside with the doors closed and the windows up."*

4.74 It is not clear what concerns led to the adoption of this condition although general witness and victim/survivor accounts speak of children being carried in taxis by perpetrators in the early 2000s[76]; the condition was varied between 2002 and 2006 to provide that:

"*The Council shall refuse any vehicle submitted for licence which is fitted with windows to the rear of the driver and which allow less than 60% of light to be transmitted through them.*"

4.75 Presumably, this was a stricter requirement than previously because the allowance was made that:

[73] [redacted] pg 11, [redacted] pg 19
[74] Ss.47, 48 Local Government (Miscellaneous Provisions) Act 1976
[75] [redacted] pg 71
[76] [redacted] pg 14, [redacted] pg 75, [redacted] pg 4

"*Vehicles which are currently licensed and fitted with windows to the rear of the driver which allow more than 45% of light to be transmitted through them, will remain licensed for a maximum period of 12 months from the date of the introduction of this condition.*"

4.76 Despite the allowance, this was not uncontroversial. The Council states in its evidence that:

"*This condition was proactively enforced by the Principal Licensing Officer at that time. The enforcement of this condition became an issue with the trade and was a factor leading to allegations of racism against the Licensing Team made by the local taxi trade.*"[77]

4.77 In 2008, the requirement was modified:

"*The Council shall refuse any vehicle submitted for licence which is fitted with tinted windows to the rear of the driver which are not factory fitted options at the time of the manufacture of the vehicle.*"[78]

4.78 In 2016, however, the Council reported that:[79]

"*… it became apparent that factory fitted tinted windows were becoming darker and more common in vehicles. As a result of a) an incident reported by the Street Pastors and b) licensing officers noticing that vehicles submitted for inspection had rear windows which did not allow officers to see passengers inside the vehicle but which were compliant, the Principal Licensing Officer and the Public Protection Manager initiated a review of the condition as it was no longer considered fit for purpose. Research on levels of tint was carried out and the trade was consulted with. A report was submitted to the Licensing Committee with the following draft condition which was approved by Members and introduced on 1st July 2017:*

'*Any vehicle submitted for licence which is fitted with tinted windows must have windows which are factory fitted options at the time of the manufacture of the vehicle; and*

The vehicle shall be constructed and/or designed so as to enable passengers to be seen in the vehicle from any direction when observed from outside of the vehicle; and

Glass shall have a minimum light transmittance of 75% for the front windscreen, 70% for the front side windows and 34% for all other vehicle window glass'."

4.79 The new standard was more onerous than that which had caused controversy in the mid-2000s (34% transmittance as opposed to "*windows which allow less than 60% of light to be transmitted*" or 40% transmittance) though, various sources suggest, lighter than much manufacturer-fitted "*privacy glass*". While I have no evidence to compare the Council's approach to tinted window conditions to that of other local authorities, it certainly seems to me to have been proactive at a time of concern about children in taxis notwithstanding

[77] [redacted] pg 76
[78]
[79] [redacted] pg 77

the difficulties the stance caused with the trade. It is also right to note that the Council remained resolute over the years in its commitment to the tinted window condition.

CCTV scheme

4.80 Another measure, which has been mentioned as a potentially useful tool in helping to address the CSE situation locally,[80] is the implementation of CCTV in taxis.

4.81 In 2010, the Council published a policy on CCTV in taxis.[81] I have read evidence that this related to an emerging scheme by the Council to supply CCTV equipment to operators and drivers. Operators and drivers would own the systems, but the Council would retain rights to the recordings.

4.82 A witness told the Inquiry that the CCTV scheme failed, noting that:

"*… they had a scheme where they put CCTV cameras in private hire vehicles… that caused a lot of a problem because when they were going* [to] *download the information from the hard drive inside the car, then they were reviewing it back at the office. They were having the drivers for every little infraction, so the drivers then got really pee'd off because they were, like, they felt that that information was being used to spy on them rather than to protect them. So they ripped it all out, and they haven't had it since."*[82]

4.83 Nevertheless, they were positive about a revival:

"*I know it's something that* [*a member of the team*] *has been looking into about encouraging, and I know* [*a provider*] *has been quite supportive on getting CCTV back in vehicles. My only input is that the data is used correctly, not as a stick to beat the drivers…, I mean I think we'd have to be the data controller, but only use the data in serious incidences where there are serious allegations, either to prove the driver innocent or to convict a driver. We shouldn't be looking at it and, yes, if I catch a driver smoking in his cab I'm gonna tell him off. If I catch him, you know, but not use the CCTV as a stick. Use it correctly. That's, you know, the way it's meant to be and have a little bit of respect for the drivers, and not use it in the way that it was used before, 'cause I think it was incorrectly used before. I think it's, they were a little bit overenthusiastic about having the drivers for doing things wrong, which wasn't what it was all about. It was about protecting the drivers as well as protecting the public..."*[83]

4.84 Perhaps reflecting this renewed enthusiasm by the Council and an operator, the policy was updated in April 2021.[84] CCTV would not be mandatory under the new scheme, and ownership of images would remain with the Council as before.

4.85 In response to the Maxwellisation process, the Council stated that:[85]

80 [redacted] pg 11, [redacted] pg 13
81 [redacted]
82 [redacted] pg 114
83 [redacted] pg 114
84 [redacted]
85 [redacted]

4.85.1 It is very supportive of mandatory CCTV usage in taxis (in the widest sense). It is of the view, however, that due to cross-border licensing and the lack of legislation to mandate the use of CCTV, the mandating of CCTV in a particular authority area would simply serve to drive applicants to those authorities who do not have such a requirement whilst still being able to operate within the borough.

4.85.2 It considers a voluntary scheme of CCTV is more appropriate and that, by working with the taxi trade, it can encourage drivers to see that CCTV serves a dual purpose by protecting both passengers and drivers.

4.85.3 It considers there are real issues around the practicalities and legalities of CTTV operating in taxis, noting that if the equipment is provided and used by the Council, the Council would be the data controller for the purpose of data protection legislation.

4.85.4 The Local Government Association has published a document 'Developing an approach to mandatory CCTV in taxis and PHVs', which states "… the code is clear that a mandatory policy around CCTV systems in taxis will require strong justification…".

4.85.5 That the Department for Transport's 2010 guidance suggested that local authorities encourage rather than mandate CCTV use.

4.86 I understand from the Council that the Local Government Association is undertaking a consultation on CCTV use in taxis and the Council will be providing a response to that consultation; I have not seen a copy of the proposed response or of a draft, however. I do consider the early adoption of a Council-run taxi CCTV scheme was a positive step and it is a matter of regret that the apparent dispute between licensing and the trade over the use to which the product should be put was not overcome.

Sources of Information

4.87 In terms of where the Council sources the information which is used to determine the outcome of licence applications, in its Corporate Submission to the Inquiry the Council stated that it:

"*… will also undertake checks on its Personal Safety Precautions Register, a register that is used to inform risk assessments when officers are engaging with/visiting individuals with individuals' details being added to the register based upon intelligence provided by officers (through their dealings with members of the public) and other agencies such as West Mercia Police.*" [86]

[86] [redacted]

Personal Safety Precautions Register

4.88 Asked for further detail about the Personal Safety Precautions Register, or "PSP Register", the Council replied:[87]

"The PSP Register was originally introduced in 2003 and was updated for an electronic version in 2006. This is primarily used as a risk management tool to help keep Council officers and Members safe in their work. The owner of the PSP Register is the Health & Safety team.

Information can be added to the PSP Register by any officers within the Council, provided that the information is of a nature that meets the criteria for inclusion. Where an officer feels that a person behaves in a way which could pose a significant threat of physical or mental harm, then they can make a request to the Health & Safety team for an entry to be made on the register. The Health & Safety team then assess the information and decide whether or not it is appropriate for an entry to be made on the register. Nominated officers throughout the Council have access to the Register to enable it to be searched for relevant information. This includes members of the Licensing Team. If any adverse information is identified which would mean that granting a licence was contrary to the Council's Licensing Policy, then this would be processed in the usual way; this could mean that it would be referred to the Licensing Sub-Committee for consideration or decided under delegated powers by officers, dependent upon the circumstances.

The information obtained through PSP Register check would be added to information obtained from other sources, so that a view could be formed as to the suitability, or otherwise, of the individual applying for a licence.

The members of the Licensing Team who have access to the PSP Register include Licensing Technical Officers, Licensing Enforcement/Night-time economy officers, Principal Licensing Officer and those who interact with members of the public, applicants and businesses."

4.89 A curiosity, given the existence of the PSP Register since 2003, was the Council's offering that: *"The* [Licensing] *team has been undertaking checks of the PSP register since 2017."*

4.90 When asked for further information regarding this last statement, the Council clarified that it was decided, following the review by the Council's Children & Young People Scrutiny Committee in 2016, (the "Scrutiny Review"), and the resultant internal review of practices, "*that the PSP Register was a source of information that may inform the decision-making process for taxi applications and has been used since*".[88]

4.91 The Council further acknowledged that "*the PSP Register has limitations …* [and] *… it does not, and cannot, capture intelligence based upon all people living and working within the Borough*"[89]. It also noted that:

87 [redacted] pg 71
88
88
89

"*… taken on its own, the information contained in the Register would not be sufficient to enable the licensing authority to make decisions concerning the fitness and propriety of applicants. It's* [sic] *value comes in enabling the authority to consider the weight of other evidence that might be provided to it*".[90]

4.92 While I understand and accept that PSP information would not be the only information needed for a licensing decision, I fail to understand why the resource was not used in licensing decisions for over a decade after its inception.

Safeguarding services

4.93 An obvious further source of relevant information is the Council's Safeguarding service. The Council told the Inquiry:[91]

"*Corporate knowledge indicates that, from at least 2009, the Principal Licensing Officer has been invited to attend LADO meetings where they have involved a Telford and Wrekin licensed driver with any appropriate action identified by the LADO being implemented by the Licensing Team as required. Even where the LADO meeting results in no further action being required, the Licensing Team will take steps they consider appropriate to ensure the suitability of a driver.*"

4.94 It offered this example of how the system worked and what actions would ensue:

"*… following a report to the Safeguarding team of injury to a child, the Safeguarding investigation concluded that there was no wrongdoing on the part of the driver and so no action was required. However, a comment was also made that the driver was related to a CSE perpetrator. The enhanced DBS check in respect of the driver came back clear of any convictions or other relevant information disclosed at the discretion of the Chief Police Officer's discretion. Further proactive enquiries were made by the Licensing Team with West Mercia Police to ask if there were any known links, concerns or intelligence which indicated that the applicant was connected to CSE. West Mercia Police confirmed that there was no indication of additional risks and no links to CSE.*"

4.95 The Council's original Corporate Submission also noted:

"*The Council has also more recently developed a process by which checks are made of records held by the Council's Independent Safeguarding team on the Council's Protocol system for details relevant to any applicants and, in the event of any investigation of concerns, in respect of existing drivers.*"[92]

4.96 As to what "*more recently*" meant, the answer came:

"*The Licensing Team originally made enquiries to see if* [it] *was possible to access information that may be relevant to new driver applications in or around 2012/13 but, due to concerns about whether or not it was possible to share such information for such*

[90] [redacted] pg 73
[90] pg 64
[92] pgs 72-73

purposes, this did not come to fruition. From 2015, information sharing took place between Safeguarding and the Principal Licensing Officer where there were specific incidents or information disclosed to Safeguarding. Checks in respect of new/renewal applications, it is believed that this commenced in or around 2018/19."[93]

4.97 Documents have shown that there was licensing/public protection membership of the Local Safeguarding Children's Board ("LSCB") in the mid-2000s,[94] when there was discussion about CRB checks for taxi drivers, and from 2015,[95] where there were regular updates about delivering training for taxi drivers and PHV operators.

4.98 In response to the Maxwellisation process and, in particular, my finding that concerns about data protection legislation hampered essential information sharing, the Council accepted that there was some concern around data sharing, but stated that this was due to constraints around the legislative provisions relating to data collection and data use.[96]

4.99 To me, this tended to suggest that nervousness about non-Safeguarding access to Protocol and data sharing in general was not confined to the activities of the Children Abused Through Exploitation ("CATE") team. I have been assured in this regard that these checks would instead be made with the Safeguarding team and that information sharing practices have improved since this time, as evidenced in changes made by the Council following the Scrutiny Review.[97]

4.100 It seems to me, though, that there should be a routine request for relevant information held by Safeguarding in every new application and renewal, and that the request should be according to a published protocol. Furthermore, all involved – Safeguarding/CATE practitioners and licensing officers – should be trained to understand not just the 'constraints' of data sharing but the circumstances in which the legislative provisions allow data sharing, so that when it is right to share data, the sharing is done confidently and without delay.

Other authorities

4.101 The Council has indicated that where an applicant discloses a previous licensing history with another authority, it will routinely make checks with that authority. Additionally, in 2015 a specific information sharing agreement was put in place between the Council and Shropshire Council.[98] It provides that information will be shared to "*safeguard the public, particularly children and vulnerable adults*", and will include:

"*All relevant evidence, information and intelligence to assess the fitness of an applicant to hold a hackney carriage/Private Hire drivers licence including:*

93 [redacted] pgs 72-73
94 [redacted] pgs 6-8
95 [redacted]
96 [redacted]
97 [redacted]
98 [redacted]

The applicant/driver's history (e.g. complaints and positive comments from the public, compliance with licence conditions and willingness to co-operate with licensing officers) whilst holding a licence from the Council or any other authority.

Patterns of behaviour, irrespective of time-scale over which they have occurred, in terms of proven offences and other behaviour/conduct that may indicate the safety and welfare of the public may be at risk from the applicant/driver."

4.102 The information sharing will take place when new applications and renewals are being considered and when new information is received which may be relevant to the review of an existing licence.

4.103 In 2018, the Local Government Association launched a national register of taxi and PHV refusals and revocations known as "*NR3*".[99] The register is open to local authorities who are members of the National Anti-Fraud Network at no cost; it is a subscription service for others. The register does not provide full details but allows local authorities to contact the previously licensing (or refusing) authority to find out further details of an applicant. The Council signed up to NR3 on 23 September 2019.[100]

Relationship with the trade

4.104 In considering the taxi business generally I have considered the information I have seen as to the relations between the Council and the trade.

4.105 The Inquiry understands from evidence relating to the Licensing Team in the 2000s that a team member left the team because of threats from taxi operators and damage to his personal property.[101] Furthermore, evidence has been given to the Inquiry that the then Chief Executive was openly unimpressed by the taxi trade in Telford and gave instructions that they should be "*brought into line*".[102] As a result, licensing enforcement involving random stops for vehicle condition checks began on Friday and Saturday nights, at increased frequency,[103] in association with WMP. Many construction and use infractions could have resulted in WMP issuing fixed penalty notices, but the team chose simply to warn drivers - an approach which, in itself, I do not criticise - so as to maintain a cordial relationship.

4.106 I have seen a memo dated 13 April 2005,[104] which relays information being received from a licensed operator that a body called the "*Ethnic Minorities Drivers Association*" had been created on the instructions of two licensed operators and a driver. The informant indicated that the group was "*out to get*" a member of the Council's Licensing Team.

[99] https://www.local.gov.uk/topics/licences-regulations-and-trading-standards/national-register-taxi-and-private-hire-licence
[100] [redacted]
[101] [redacted] pg 18
[102] [redacted] pg 19
[103] [redacted] pg 9
[104] [redacted]

4.107 On 8 November 2005 the General Purposes Board considered[105] a complaint made against an operator that a driver had abandoned three "*young females*" in an unlit layby at night, following a dispute about payment of a deposit. The operators were issued a severe warning as to their procedures in relation to communication of deposit payments and complaints handling. It was noted that on 6 March 2006 the General Purposes Board's concerns had not been rectified, and the operator appeared before the General Purposes Board again in April 2006 in respect of a separate complaint.[106]

4.108 On 12 May 2006 the Council received, through the Chief Executive and others, an email headed "*Asian private hire drivers meeting*".[107] I have seen information that certain operators' drivers had rallied others to attend the meeting.[108] The email said:

"*As you are probably aware, Asian Private Hire drivers met with council representatives on Tuesday evening to discuss growing concerns and policy changes made by the licensing dept. over the last couple of years, and how they impacted, in particular on Asian Drivers.*[109]

The meeting went very well and drivers went away in positive frame of mind, believing real action was going to be taking place through a series of meeting which were to be setup (the next meeting being in two weeks time) …

Yesterday evening, the licensing dept. carried out one of their stop and search checks of privet [sic] *hire drivers. The result of this was constant phone calls to me; these are some of the comments (I began to write them down after I received the first few):*

'Who is controlling who, obviously [a member of the Licensing Team] *makes the decisions, the meeting was a waste of time, because the very next day we have licensing doing exactly all those things we want sorting out, what a waste of time'*

'I was disappointed, we went to the council with good faith, and I thought things were going to get done, but nothing, same old council making promises they can't keep'

'It's your fault [name] *getting us to go to the council meeting, when you knew, that we would be targeted the very next for speaking our minds, thank you very much'*

'What's going on, surely licensing should have waited for the next meeting, not try to make a point the next day and intimidate us, I think they are trying to stop us attending any further meetings'

'As I said at the meeting, [a Licensing Team member] *is in control, he makes the rules, and he is a* [racist]*'*

I was amazed and gob-smacked, that after all that was said and done at the meeting, that Licensing could not wait to be out there the very next day, showing private hire drivers who

105 [redacted]
106 [redacted]
107 [redacted]
108 [redacted]
109 [redacted] pgs 1-2

was in charge and thus nothing had changed in this regard. They knew when the meeting was happening and could have at least waited until the next meeting before carrying out such an exercise. We have once again lost driver trust, and the good work that went into bringing people together, allowing them to express their view; this has now been destroyed. [Name] *at the meeting pointed out very clearly, that drivers had come to the meeting in good faith and that we need to make sure that there was no backlash from licensing.*

The Council, I am sorry to say, is getting accused of being racist towards Asian drivers, words I hate hearing and saying for that matter, especially when I have personally spent several years working to build peoples confidence in T&W Council. I also feel that I have wasted my time and effort in bringing people together; which now makes the next phase of this process even harder.

The bottom line is, you have one single concern (expressed over and over again), and this was expressed quite openly at the meeting, [a member of the Licensing Team]. *This name keeps coming up again and again; private hire drivers are not happy, particularly Asian drivers, they see him as loose cannon. The negative impact of this one individual on T&W is beginning to be a tremendous one.*

I don't know where we will be taking this now; but certainly, T&W needs to start doing some joint [sic] *up thinking; whilst* [others] *work tirelessly to tackle race, equality and diversity issues and bring communities together, you have other dept's within the council destroying it."*

4.109 At 06:42 the next morning a Cabinet Member wrote to the then Corporate Director thus (the emphasis is original):[110]

*"**I firmly believe that we should now instruct* [the Licensing Team] *to suspend further operations until the meeting you and I have agreed has taken place.***

This meeting needs to take place next week involving as many as the key players as possible."

4.110 The Chief Executive replied formally to the original complaint later that day:[111]

"I have had the opportunity to read your email and having spoken to [an elected member], *we have decided that the most appropriate way to deal with the issues you have raised is to hold an independent investigation.*

Both [they] *and I take the allegations in your email very seriously and given the sensitivity of the issues believe that all the parties concerned should agree who the 'independent investigator' should be. It is essential that the investigation commences as soon as possible and I will be giving some thought to the remit of the investigation as well as who could be appointed to conduct it.*

110 [redacted] pg 1
111 [redacted]

Whilst agreement on who will lead this investigation is being finalised, there will be no further discussion about the allegations until everyone can be interviewed by the independent investigator."

4.111 In May 2006,[112] members of the Licensing Team received an internal communication from a colleague, expressing their concern that the matters dealt with against the particular operator in November 2005 and April 2006 had not been resolved; they said:

"Since dealing with [the operator] *it is obvious that there are a number of dangers to staff. This has become even more apparent in the past week. Besides the threat to the property and personal safety of Licensing staff, there is now the added worry of being accused of acting in a racist manner."*

4.112 Within the hour, a member of the Council's Legal Services team[113] was contacted for advice in relation to this matter:

"*With reference to* [name]*'s email, I am very conscious that a week has passed since* [we were told]… *there was going to be an independent enquiry into complaints of racism being made against the Licensing Team. To date we have received no detailed information about the complaints that have been made or about any independent enquiry.*

I suspect that [the Operator] *may well be orchestrating the complaints and have to decide what action, if any, we need to take in relation to the issues raised by* [the email].

I take the view that we should check that the proper systems are now in place at [the Operator]. *In other words that we carry with our enforcement role.*

I would be grateful if I could have some written guidance as to what the complaints against the Team consist of, whether an investigation of some kind is going to take place and if so what it's terms of reference are. I would also like some written guidance on what we do as far as the issues raised… in relation to [the operator] *are concerned."*

4.113 Later that day an unlinked email to the Chief Executive[114] set out this query received:

"I have just been contacted by [an elected member] *asking if the next planned taxi stop and check event on 13th June is to go ahead. One of his staffed* [sic] *has asked the question of him because of the police producing a critical incident plan following the issues that have been raised by the community."*

4.114 And offered this solution:

"I would suggest we halt any proposed action but don't publicise this."

112 [redacted] pg 1
113 [redacted]
114 [redacted]

4.115 This suggestion – which seems to me to have been the worst of all worlds – happily did not cut any ice; the Chief Executive wrote to the original complainant the same day:[115]

"You have made some very serious, possibly criminal allegations against Council staff. The Leader and I are taking this very seriously. In the circumstances the Leader and I decided on Friday to arrange for these matters to be independently investigated. We want this investigation conducted both thoroughly and quickly and in a way that is focused on the allegations as referenced in your letter. It is not our intention that the investigation is broadened, It will be a matter for the independent investigator to decide (within the framework of the terms of reference) how to conduct the investigation and who needs to be spoken to.

In order to assist the investigation and to avoid the risk of subsequent misrepresentation I have asked all Council staff and Members to suspend any current or planned activities or meetings in relation to these matters until the investigation is completed."

4.116 Enforcement was shut down completely, pending the report of an independent inquiry.[116] This quickly caused concern among the Licensing Team[117] and Legal Services[118]; an example was given of an enforcement officer being unwilling to proceed, without direct management advice, against a PHV driver who had refused to accept a written warning for an obvious driving infraction on 11 May 2006. In another example, when a taxi driver was charged with battery against his partner, Licensing again sought advice from the Council's Legal Services:

"I would normally speak to [the driver] *and based on his account of what happened and any charges, etc decide whether or not his licence should be suspended. What should I do now?"*[119]

4.117 In June 2006 an elected member of the Council expressed concern that complaints were not being acted upon;[120] in July a member of the Licensing Team sought permission to deal with 11 outstanding enforcement cases, including suggestions of inappropriate behaviour with children.[121] It is not apparent whether permission was given.

4.118 The external investigation report was published in September 2006.[122] It recognised that:

"… on a number of occasions the impact of enforcement activity has disproportionately affected Asian drivers… several reasons have been put forward to explain the disproportionate impact. Although we believe there is merit in these reasons the absence of full and comprehensive information relating to these enforcement activities leaves the

115 [redacted]
116 [redacted]
117 [redacted]
118 [redacted]
119 [redacted] pg 1
120 [redacted]
121 [redacted]
122 [redacted] pg 4

Council vulnerable to such allegations and the perception that Asian drivers are being victimised."

4.119 The report bemoaned the lack of a collaborative working relationship between the Council and the trade; it made particular reference to the tinted window policy, which it suggested failed to strike a proper balance between risk to public safety and the cost to the trade. There was, according to the report, "*an unhelpful prevailing culture within the Licensing Team which is more concerned with enforcement than developing a positive and mutually beneficial relationship*".[123]

4.120 The newly formed Telford Private Hire Association called immediately for members of the Licensing Team to be dismissed.[124] An email I have seen suggested that a large number of Hackney carriage drivers had met to draw up a petition expressing their support for the work of the Licensing Team.[125] I pause to reflect that Hackney carriage and PHV drivers' interests do not necessarily run together.

4.121 It is not part of my Terms of Reference to review the independent investigation into the allegations made against the Licensing Team. I do not know enough about the history of enforcement in order to be able to comment on the findings of this investigation. But I consider I have plentiful evidence to allow me to set out what happened and to determine the effect of this incident upon taxi licensing in Telford.

4.122 I have already noted a moratorium on enforcement during the investigation period. On 5 December 2006, communication between the Licensing Team and WMP included the following:[126]

"*… has any decision been made as to whether you are coming out this weekend?"*

"I have made further enquiries and the decision has gone up to the Chief Executive for a decision, no less. I am led to believe that the feeling at Director level was NO!"

4.123 As a result there was the following exchange within ranks in WMP:

"*For your information, the licensing enforcement team are not coming to play."*

"Taxis?"

"No its looking at pubs and clubs. Wouldn't even consider taxis at the moment but it looks like they can't play at anything."

"Who do I need to speak to at BTW to persuade them that this is an essential part of partnership working?"

123 [redacted] pg 4
124 [redacted] pg 2
125 [redacted]
126 [redacted]

4.124 That last question – from a Chief Inspector who had carefully resisted indulgence in the juvenile (but, I consider, harmless) language of "*coming out to play*" - made its way to director level within the Council. The reply came:

"*… still think that we shouldn't take part at the moment because although this is a separate subject area there is scope for the trade to see our enforcement officers in police cars and it is possible that some PHV drivers will be stopped by the police if they see something wrong with a vehicle. This will place our officers in a difficult position. I hope that* [a senior police officer] *might understand that we are at a sensitive point in our relationship with the trade and would be willing to support a partner's difficult choice. Incidentally I'm not sure that the reference to "coming out to play" is professional for a serious operation*."[127]

4.125 It is plain that the "*difficult choice*" that had been made was not to run taxi enforcement for some time lest the trade was put out. I am not convinced that this choice was difficult; rather, it seems to have been the path of least resistance.

4.126 In December 2006 the General Purposes Board wrote to the operator who was the subject of the complaint in November 2005 (and a signatory to the Telford Private Hire Association letter[128]) to note that he had taken none of the steps required to rectify systems after the complaint.

4.127 The Inquiry understands that, during the investigation, a sign had been put on the footbridge near the Licensing Team's office reading "*RIP* [a specified member of the Licensing Team]"[129]; WMP advised the team to "*watch their step*"[130] and the Council itself inspected enforcement officers' homes, moved letter boxes out of front doors and fitted CCTV. It was thought that the member of the Licensing Team, to whom the sign referred, had been ousted and this affected the Licensing Team's morale. The Inquiry further heard that all subsequent enforcement operations had to be approved by senior management; the team became a "*shadow of its former self*"[131], though I accept that this was only the assessment of one individual and did not necessarily reflect the view of the whole Licensing Team.

4.128 A member of the Licensing Team gave an account of how the team had been affected by the racism allegations. They said:

"*I think morale was affected but we continued working as normal, the effect of enforcement was that we stopped the regular vehicle enforcement exercises as in we no longer did them monthly. We carried on doing enforcement but it was introduced slowly in the night-time economy, not nearly as pro-active as we had been or reactive I should say to intelligence, like plying for hire etc.*"[132]

127 [redacted] pg 1
128 [redacted]
129 [redacted] pg 23
130 [redacted] pg 23
131 [redacted] pg 25
132 [redacted] pgs 11-12

4.129 I understand that there was an instruction not to refuse or revoke any licences under delegated authority, only to grant licences.

4.130 In so far as any licence applications which were not clear cut, these were to be sent to the Licensing Committee. I heard evidence that there was fear within the Licensing Team that any actions might be perceived as being racist.[133]

4.131 These licence applications were taking place at a time when the evidence shows the importance of a properly rigorous licensing and enforcement regime. First of all, of course, this was the time of the Operation Chalice intelligence-gathering phase, when it was clear CSE perpetrators were active in Telford. The Inquiry has heard the following evidence from victim/survivors:

"*There was a ring of different people, some were taxi drivers, and they used to supply drink and these different girls, nothing happened to me straight away but eventually it did.*"[134]

"*There was an incident when I was 12 where I had a taxi from my friend's house, that he'd arranged and this taxi driver tried to assault me kind of thing, but I got home and I told me mum, my mum called the police… there was about six or seven Asian men who came to my house. They threatened my mum saying that they'll petrol bomb my house if we don't drop the charges.*"[135]

"[Name] *was forced into the back of this taxi and raped*."[136]

4.132 The parent of a victim/survivor told the Inquiry about seeing "*a load of taxis outside a restaurant or you see young girls going in, that kind of filtered out to the smaller areas*".[137]I also read evidence that:

"*… there was a huge problem there with taxis and girls being picked up … I mean I witnessed taxis coming and going, but it was who to turn to… and who to talk to, who to report to… then we did start reporting it to our local Councillor to be honest who we felt would pick it up… and all that would come back was, well* [a local women's refuge] *is being manned, when we knew damn well it wasn't being manned.*"[138]

4.133 Second, I have seen, within licensing material, the following detail in respect of concerning cases that:

4.133.1 The Council's Children's Services team had become aware of taxi drivers offering children free rides in return for sexual activity.[139]

133 [redacted] pg 12
134 [redacted] pg 3
135 [redacted] pg 3
136 [redacted] pg 10
137 [redacted] pg 14
138 [redacted] pg 15
139 [redacted] pg 11

4.133.2 It was noted on a Council case file that one child had been seen performing oral sex on taxi drivers.[140]

4.133.3 A driver who had offered to waive a fare in exchange for oral sex in December 2006 had apparently faced no enforcement activity[141] - despite being very quickly identified by the Licensing Team - until February 2008; despite having been arrested in September 2007 as the suspected perpetrator of a sexual assault, with a similar request for oral sex, in respect of a vulnerable woman in March 2007. When he was contacted by the Licensing Operations Manager, he was informed that his renewal would be processed subject to the investigation. Happily, the result of the investigation appears to have been that the driver's licence was revoked.[142]

Enforcement since 2008

4.134 The Inquiry understands from the evidence it has heard that enforcement was slow to recover after this period:

"*… there wasn't much enforcement happening at all… it was around about end of sort of 2011 that* [the Licensing Team] *started doing enforcement again… I think their* [the Licensing Team's] *fingers had been burnt a little bit. They were a bit sore about it so there was kind of like a relaxation on enforcement and then when* [the Licensing Team] *started to do it again, it all got a bit personal. I know* [a team member] *had to… put CCTV up at* [their] *house to protect* [them]. *So I think there was a little bit of trepidation in the earlier days about doing enforcement."*[143]

4.135 As to the experience of a member of the Licensing enforcement team, I heard:

"*Any enforcement operation I have been involved in or since organised, it never puts me off. I've been shouted at, I've had people in my face, I've had people follow me around Asda threatening me, it doesn't bother me. I'm made of sterner stuff. It's something that, with the guy that followed me around Asda, I just reported it to the police, police spoke to him, he's never been in contact since. The other guy that verbally attacked me and followed me, in a plying for hire operation, I nicked him, he wasn't happy, he waited for us, he followed me back to the police station, he waited for me outside, he got really verbally abusive. All I did was complete a statement and send it to Shropshire and they just revoked his badge, so he didn't win. He can shout and scream as much as he likes, he's never going to win and thankfully, touch wood, I've never been physically touched.*

…

Certainly on enforcement, plying for hire operations, it's never stopped me, we've now got body cameras as well ourselves so we wear body cams with our stab vests. Anything on

140 [redacted] pg 5
141 [redacted]
142 [redacted] pg 22
143 [redacted] pgs 82-84

them that can get downloaded and used in evidence should they contest the plying for hire or what I said or how I behaved."[144]

4.136 In the period when enforcement was lax, the regulatory landscape changed. In November 2008, judgment was given in the case of *R (on the application of Newcastle City Council) v Berwick-upon-Tweed Borough Council and Others.*[145] The administrative court held that PHV operators licensed in one local authority area can properly use Hackney carriages to fulfil pre-booked hire in another local authority area. Further, PHV journeys do not have to take place within the licensing local authority area and (since 2015[146]) an operator licensed in one area can take a booking and subcontract it to an operator in another licensed area.

4.137 The twin ramifications of the decision were explained in evidence to the Inquiry, the first being that an operator can choose their licensor and the second being that the choice that the operator makes has a direct effect on the resources – through fees income - of the local authority. Local authorities are, in effect, in competition with each other, with those authorities who require a less rigorous process being able to offer a cheaper licensing fee. The Council's conditions remained relatively stringent with driver awareness training and a test, as well as other disparities with neighbouring authorities, including as to vehicle requirements. This had an enormous impact on the size of the fleet licensed by the Council: a witness told me: *"we went down from 540 to about 150 drivers literally overnight".* [147]

4.138 Not only were Shropshire's fees lower than the Council's – Shropshire Council's own licensing department certainly took the view that they were "*too cheap*"[148] – standards were materially different, as follows:[149]

Telford	**Shropshire**
Applicants must have held full driving licence for at least three years	Applicants must have held full driving licence for at least one year
All applicants to have medical assessment every three years	Applicants to be screened for fitness before licence first issued and at five-yearly intervals over age 45
Doctor must see applicant's medical history	No requirement for doctor to see medical history
Licensing send medical forms to nominated doctor with a photo of the applicant	Medical forms downloaded from website; no requirement for doctor to have seen photo

144 [redacted] pg 84
145 [2008] EWHC 2369 (Admin)
146 Section 11 Deregulation Act 2015
147 [redacted] pg 18
148 [redacted]
149 [redacted]

4.139 Shropshire Council had droves of applicants: the minutes of a regional licensing workshop held in Birmingham in October 2011[150] show that an officer of Shropshire's licensing authority reported that:

"… licensing consultants and some licensing solicitors have promoted Shropshire to the trade generally resulting in a 400%[151] increase in drivers and vehicles being licensed by Shropshire."

4.140 Further, while the officer said "*it was not entirely clear why Shropshire had been chosen*", they nevertheless "*concede*[d] *that the knowledge test and licensing conditions in Shropshire were perhaps less onerous than in some other authorities*."

4.141 The combination of lower standards and lower cost rather removes any confusion as to Shropshire Council's popularity; though it should be noted that Shropshire successfully defended a condition that Hackney carriage licences should only be granted to drivers operating within its area.[152]

4.142 Attempts to agree on a regional standard also failed. A Council witness told me that they regarded the Suitability Guidance, published by the Institute of Licensing in 2008, (the "Suitability Guidance") as a useful starting point for building common standards with neighbouring licensing authorities. That was a false hope. When Shropshire Council was contacted by the Council and asked if they would be adopting the Suitability Guidance, they were told that Shropshire did not see any need to change its policy. Shropshire Council was still adopting the Department of Health circular, which the witness noted was "*quite ancient*".[153]

4.143 This situation had a number of consequences:

4.143.1 First, licensing income crashed with a resulting effect upon the size of the team. I was told:

"*Licensing is self-sufficient in that income is from the licensing fees which are set at cost recovery, we're obviously not allowed to make a profit. Not all licensing functions we can recover at cost, an example of that would be the Licensing Act where the fees are set in statute so we as a Council don't work those out to cover costs, we can't.*"[154]

4.143.2 In this way, the income of the Licensing Team depends on the number of licences granted.[155] As a concrete example of the consequence, another member of the

150 [redacted]
151 [redacted] pg 2
152 [redacted]
153 [redacted] pg 22
154 [redacted] pg 8
155 [redacted]

team noted that "*they had a team of about ten when I first started… the Licensing Team is four people".*[156]

4.143.3 Second, drivers and operators licensed in other authorities could work in Telford without satisfying the "*fit and proper person*" or vehicle standards upon which the Council insisted. The Inquiry was told:

"*As soon as 2011 our concerns started to rise about drivers that were being issued with licences by Shropshire Council, and were coming back and driving in Telford & Wrekin, driving our residents and our visitors around, and some of these drivers we had either refused applications or the licences had been reviewed and we had revoked them, and they were appearing licensed by Shropshire Council...*"[157]

4.143.4 Third, the Council's Licensing Team has limited regulatory powers in respect of drivers licensed by other authorities. In broad terms while they can deal with certain on-street infractions, such as plying for hire by PHVs[158], they cannot deal with complaints about drivers other than by referring to the relevant licensing authority. One member of the team said of such complaints:

"[The] *Licensing Team, have to identify, if we can, from the information given us… which of those Councils licensed the driver and vehicle, and then we pass the complaint on to them. The amount of times myself and my colleague* [name of colleague and position]*, have asked for feedback as to the outcome of any investigation they've led, the amount of times that that just disappears into the ether and we don't actually hear back is frustrating.*"[159]

4.143.5 Fourth, though, and most seriously, the Council's decision to adopt the Cabinet member's suggestion to suspend licensing enforcement was a disastrous one.[160]

4.144 In relation to Shropshire Council's apparent refusal to consider changing its policy, upon being asked whether it would be adopting the Suitability Guidance by the Council, the Inquiry understands from Shropshire Council that this guidance was in fact "*fully considered*"[161] when drafting its most recent licensing policy, which covers the time period of 2019 to 2023.

Lobbying for reform

4.145 There were, and are, no compulsory minimum regional or national standards in relation to taxi licensing beyond the "*fit and proper person*" test, despite repeated calls for implementation. In terms of national lobbying, in 2011, David Wright, the then MP for

156 [redacted] pg 77
157 [redacted] pg 19
158 [redacted]
159 [redacted] pg 24
160 [redacted]
161 [redacted]

Telford, wrote to the Department for Housing and Local Government, about cross-border hiring. David Wright received this reply from the minister at the Department for Transport:

"*I note what you say about licensed taxis carrying out pre-booked journeys in districts other than their own licensing area, and about drivers who are not deemed 'fit and proper' by Telford and Wrekin who then acquire driver licences elsewhere.*

Whilst I recognise that you want to see early action to change the law governing cross-border hiring and driver licensing, these are not issues which can easily be dealt with in isolation or in advance of the wider Law Commission review."[162]

4.146 The Law Commission considered the issue and in May 2014 published its report, recommending national standards, and a draft bill. No parliamentary time has been found for that bill, however.

4.147 In 2017, Richard Overton, deputy leader of the Council, wrote to the Department for Transport to raise cross-border hiring and the effect of the Deregulation Act. He received this reply:[163]

"*As you are aware, legislation allows all taxis and PHVs to undertake pre-booked journeys outside the area in which they are licensed, and PHV operators to sub-contract bookings to PHV operators based in other licensing areas. These measures have enabled the taxi and PHV trade to work more flexibly to meet the needs of passengers, increasing the availability of licensed operators, drivers and vehicles and mitigate the risk of passengers being turned away when a booking cannot be directly fulfilled. This benefits passengers as they do not have to try to find another operator, a particular concern for those travelling on their own or late at night. We believe that where local operators cannot meet demand, the sub-contacting of bookings, both within and across licensing borders, is preferable to the risk of the public resorting to the use of illegal, unlicensed, uninsured and unvetted drivers and vehicles…*

John Hayes [a minister at the Department for Transport] *has recently set up a working group to consider current issues concerns relating to taxi and private hire vehicle licensing, and produce focussed recommendations for action. The first meeting of the working group took place on 26 September and it will be considering the regulation of the trade as one of its key areas for discussion. We are inviting a range of interested parties to provide some written input to the group, to make sure they have full range of views to consider. We would welcome your input to this; we are asking for summaries of about 500 words…*"

4.148 Richard Overton, deputy leader of the Council, wrote to the Secretary of State for Transport on 27 February 2018 to make the point that the absence of national standards meant that the Council's requirement for CSE training and awareness for drivers was not required by surrounding authorities, whose drivers could continue to operate within the borough with impunity. Richard Overton asked for a swift response he could put before a full Council meeting; I have seen no reply at all.

162 [redacted] pg 3
163 pgs 9-10

4.149 The next month, Richard Overton and the Council Leader, Shaun Davies, wrote to a Minister of State at the Department of Transport setting out what seems to me to be a fair summary of the situation:[164]

"*At the moment, standards vary widely across licensing authorities, so what may be acceptable in one area is not acceptable in another. This seems nonsensical, as we can refuse to grant a licence in Telford & Wrekin, and that person can apply to a neighbouring (or other) authority and obtain one there, but still work within our area. In fact, a number of operators that have been established in Telford & Wrekin for some time have openly admitted to advising private hire drivers to apply for drivers and vehicle licences in neighbouring authorities whose licensing conditions are not as robust as Telford & Wrekin's. These drivers returned to drive for hire and reward in Telford & Wrekin. What is most worrying is that public safety is at the forefront of any decisions we make and if we refuse to grant a licence, it will be for legitimate reasons in order to protect the travelling public. For that licence to be granted in another authority just because they have lower standards than in Telford & Wrekin is simply not acceptable.*"

4.150 The Department for Transport minister replied in May 2018 indicating that they had passed correspondence to the "*Task and Finish Group*".[165]

4.151 This group – presumably also the working group referred to in 2017 - was commissioned by the Department for Transport under Professor Mohammed Abdel-Haq[166], and reported in 2019. It recommended national minimum standards, national enforcement powers, and a national licensing database.

4.152 The Government's response accepted the recommendations[167], with a promise to "*take forward legislation when time allows*"[168]; though its actual response has been the 2020 Statutory and Best Practice Guidance (to which I have already made reference) which made clear (at paragraph 2.8) "*licensing authorities must reach their own decisions, both on overall policies and on individual licensing matters in light of the relevant law*" – which is, of course, a reinforcement of localism rather than an endorsement of national standards.

Information sharing

4.153 As to information sharing between authorities, there was initially no agreed protocol. The Council would write to neighbouring authorities requesting or sending information – three examples from 2011 as follows:

"*Telford & Wrekin Licensing Service is in receipt of several complaints with regards to the above Shropshire plated Hackney Carriage Vehicle operating in Madeley. I have now investigated the matter and spent a large part of today watching the vehicle standing and*

[164] [redacted] pg 13
[165] pg 17
[166] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/954327/taxi-and-phv-working-group-report-document.pdf
[167] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/923695/taxi-task-and-finish-gov-response.pdf
[168] Government Response to the report of the Task and Finish Group para 2.4, pg 8

plying for hire in Madeley. I was not able to ascertain owner/driver details but would like to invite the driver in for an interview under caution to discuss possible offences under S45 of the Town Police Clauses Act 1847."[169]

"*I recently interviewed the above driver, who was suspended by this Council from driving licensed vehicles on 22nd March 2011, regarding a conviction at Telford Magistrates Court on 13th May 2011.* [The driver], *who is a licensed driver with Shropshire Council, indicated to me during his interview that Shropshire Council were unaware of this conviction. I advised* [the driver] *that he should inform you. I have, today, written to* [the driver] *revoking his Telford & Wrekin Private Hire Driver Licence."* [170]

"*… in relation to the 14 licences granted by Licensing Committee with special conditions attached, once the licences are issued please can you let us have the plate numbers and vehicle details of these and other licences granted with special conditions so that we can identify the vehicles if we see them in Telford's borough.*"[171]

4.154 This information sharing was not always effective. On 3 August 2012, Shropshire Council's Licensing Team declined to issue address details of a licensed driver to Telford without a formal request, noting "*I'm not sure whether there is an information sharing protocol between our respective councils?".*[172]

4.155 With regard to ex-Telford drivers licensed by Shropshire Council, the Inquiry was told:[173]

"I collated a list of about 16 drivers that we'd either refused or revoked that Shropshire Council had licensed…. Some of those that were on that list were safeguarding reasons why they'd had their licences refused and revoked."

4.156 In respect of the 16 drivers, Shropshire Council has indicated to the Inquiry that reviews were undertaken between September 2014 and April 2015, with "*relevant action*" taken in each case. Where there were safeguarding concerns that related to any driver who was licensed by Shropshire Council, these were addressed individually, with input from WMP, and where there was sufficient and relevant evidence of inappropriate behaviour that could be satisfactorily attributed to a licensed driver, action was taken to ensure that these drivers were no longer licensed with Shropshire Council. It is not clear how many of the 16, if any, continued to hold a licence and for how long.

4.157 Shropshire Council has further indicated that, from 2015 onwards, "*proactive checks*" have been made with Licensing Teams in other local authorities where an applicant's address is outside Shropshire, as well as with those other authorities' safeguarding leads.[174]

4.158 I have seen a document which must have been produced after January 2013, which suggests that the Council had not received any request from Shropshire Council regarding the history of a driver previously licensed by the Council; and that Shropshire Council had

169 [redacted]
170 [redacted]
171 [redacted]
172 [redacted] pg 1
173 [redacted] pg 19
174 [redacted] pg 22

licensed drivers refused or revoked by the Council for conduct including dishonesty offences, sexual misconduct, complaints of inappropriate behaviour, physical abuse of a member of the Licensing Team, sexual remarks made to a Council official and violent disorder.[175] Shropshire Council complained that it was under extreme pressure in performing licensing enquiries, but its request for help from the Council was rebuffed: which, given the way the Council's Licensing Team was funded, seems entirely understandable.[176]

4.159 An information sharing agreement was drafted between the Council and Shropshire Council in 2012, but was not signed until July 2015.[177] I have seen no evidence it was used prior to this date. I was told that, by that stage, the Council's licensed fleet had:

"… *slowly built* [back] *up but then Wolverhampton City Council started licensing our vehicles too and drivers, so although we had built up, we suddenly lost an enormous amount of income in the form of taxi licence fees literally overnight.*"[178]

4.160 They estimated the number of licensed PHVs to have fallen in 2015 to approximately 80, from 150 at the Shropshire trough and over 450 at the 2010 peak.[179]

4.161 Opinions as to how well information sharing worked at this stage vary. One Licensing Team member told the Inquiry:

"*I've got a really good relationship with Shropshire, absolutely brilliant relationship with Shropshire. We share information, we look at each other's, we help each other out all the time and I know, I am 100% sure that if I pass on anything to Shropshire about any of their drivers, what they've done here in Telford, they will deal with it. Completely confident because they always get back to me, always emailing with others backwards and forwards so I know for a fact that they do deal with it and quite often I have provided them with evidence where they've revoked a driver's badge or whatever.*

On the other hand, if they're licensed by Wolverhampton City Council, I am not that confident.

…

[About Wolverhampton] *it's a one way street. So, I would send them information and I would get nothing in return. Not always an acknowledgement that they've received this. What I tend to do I will then refer it into the police and say, "Look, he's not licensed by us, he's licensed by Wolverhampton so you'll need to contact West Mids Police" and then hopefully West Mids Police, because they police Wolverhampton, would have more results from dealing with Wolverhampton taxi licensing than we do … I can't put my hand on my heart and say to a member of the public when they've reported something to me about a Wolverhampton driver that it's going to be dealt with because I can't because we don't get*

175 [redacted]
176
177
178 [redacted] pg 8
179 pg 8

any feedback. So I don't know whether it's dealt with or not and they are, their standards are lower than ours."[180]

4.162 Another member of the team gave the opposite view:

[Witness:] *"Since* [the data sharing agreement with Shropshire] *was implemented, every new application or renewal application, and we still do it to this day, or a Telford licence through the information protocol, we send names, addresses, and dates of birth to Shropshire and ask for any relevant information they might hold on that driver before we determine the application. It doesn't happen the other way round.*

[About Wolverhampton]*… they're better, we don't have an information sharing protocol with Wolverhampton but what Wolverhampton do, is they will send us a data protection request for anybody who applies to them, who says they've been licensed with us*.[181]

"We have a lot of communication with Wolverhampton both ways."

[Inquiry:] *"But not so much with Shropshire?"*

[Witness:] *"Not so much with Shropshire, no."*[182]

"I had regular meetings with [a Licensing Team member] *in Shropshire but unfortunately, because* in [their] *words I always used to complain to* [them] *when I went because I always used to take* [their] *bad news stories of examples of complaints we were getting about their licensed drivers and vehicles,* [they] *stopped the meetings and they stopped and that was it. We didn't have any more, so I don't think* [they] *liked me telling* [them] *what was wrong with* [their] *drivers and vehicles."*[183]

4.163 A WMP representative who gave evidence to the Inquiry appears to agree with this latter view, stating that:

"… the national taxi-licencing protocol is fatally flawed, as it is entirely possible for a taxi to operate in an area but be licensed by a completely different local authority."[184]

4.164 Shropshire Council's view was stark:

"*The situation whereby a taxi/private hire vehicle can operate in an area but be licensed by a completely different authority, is, fundamentally, a result of historic legislation, which is not fit for purpose in the 21st century and has left local licensing authorities and the DfT* [(Department for Transport)] *with an outdated regime and the use of 'sticking plasters'*."[185]

4.165 While individual information sharing agreements with neighbouring authorities plainly have value, it seems to me that the Council should seek to persuade its neighbours of the value

180 [redacted] pgs 36-39
181 [redacted] pgs 26-27
182 [redacted] pg 46
183 [redacted] pgs 23-24
184 [redacted] pg 17
185 [redacted] pg 25

of a regional, common information sharing agreement; it is no answer simply to wait for a national solution.

Badge swapping

4.166 I have read in various witness accounts concerns being raised about taxis being driven by people other than the licensed driver,[186] a practice known as 'badge swapping', with a typical example being:[187]

"[the perpetrator] *gave false details, his cousin's name, and was told to bring his driving licence to the police station the next day. … I later learned that* [the perpetrator] *did not have a driving licence and his cousin took his own documents into the police station the next day and the matter was dropped … this kind of thing happened a lot*."

4.167 The Inquiry was also told:

"… there are many unregistered taxi drivers, who use the driving licences of brothers or other family members, often then using the taxis for trafficking young victims of CSE".[188]

4.168 Also that:

"… well what have they done previously under another name and taxi drivers, there is a loophole and especially with the Asians because [name] *shouldn't have been driving a taxi… my husband asked one of the taxi guys that waited at Telford Train Station, the black cabs, and apparently they can do it under another name because they don't get checked."*[189]

4.169 The Council told the Inquiry that it aims to carry out enforcement exercises several times a year, including in Wolverhampton and Shropshire Councils' territories if invited. Both Wolverhampton and Shropshire Councils are invited to all exercises of this nature run by the Council, in order to enable all licensed vehicles to be inspected, regardless of their licensing authority.[190]

4.170 The Inquiry asked a Council officer whether badge swapping was an issue that the Licensing Team had encountered during enforcement and/or compliance exercises and was told:

"*No. All those exercises that I mentioned that we carried out as enforcement exercises over the year with taxis, whether it's plying for hire or joint VOSA exercises. The first thing that any Licensing Officer does… is you ask the driver for his badge, because it's an offence not to wear a badge. We always ask for the driver's badge to identify the driver. Because even before we became CSE aware, back in the days before Operation Chalice, one of the things that it's our duty to ensure is that there aren't any unlicensed taxis out there, or unlicensed drivers, and it is something that any Licensing Officer or Licensing Enforcement Officer will always ask for and look at the driver's badge. If they haven't got the driver's badge you*

186 [redacted] pg 11
187 pg 8
188 pg 19
189 pg 4
190 [redacted] pg 89

send them home to get the driver's badge and come back immediately. When you see the driver's badge of course you always check the badge against the person behind the wheel, and I can say that I have never ever… been aware of any Licensing Officer, including myself, coming across an imposter during any enforcement exercises we've done."[191]

4.171 As to a specific allegation of badge swapping which had received national press attention, the Inquiry heard that:

"[the Council] *found absolutely no evidence or hint of anything that said that that driver had allowed his vehicle to be used by somebody else."*[192]

4.172 The Council told the Inquiry that:

"*… the fact that no incidents of 'badge-swapping' have been detected during Council or multi-agency exercises or in general day to day contact with the taxi trade would suggest that it is improbably* [sic] *that any instances of "badge swapping" would be identified through such activity."*[193]

4.173 I confess I do not find it easy to understand what the Council is saying in this response: whether it is suggesting that badge swapping does not occur, or it is suggesting that enforcement is an imperfect tool for detecting it; the latter makes little sense, as the member of the Licensing Team made clear it is simply an exercise in comparing the person presenting the licence to the photograph on it.

4.174 In response to the Maxwellisation process, the Council suggested that, if badge swapping does occur, it does not occur on a scale large enough for licensing enforcement to be able to detect it during enforcement operations.[194] I confess that my view of this suggestion is that it is an extremely defensive and unhelpful response. If badge-swapping risks going undetected by the Council's enforcement operations, it should engage the public as sources of information, by raising public awareness of both the requirement for a licensed driver to display a badge, and of ways to complain about non-compliance.

Disruption tactics

4.175 In response to a query about any enforcement action or disruption activity completed by the Licensing Team and the Council's Public Protection team as a result of suspected CSE, the Council referred to mapping work which was taking place, trying to link suspects with cases of CSE. As part of this work, a Council employee was tasked to undertake licensing checks in respect of CSE. I have seen a one page document which refers to some of the victim/survivors of CSE and sets out the connections between them and the schools they attended.[195] I have also seen minutes from a Senior Officers' Co-Ordination meeting dated 3 October 2007[196] where it states that a Council employee is to *"undertake licensing checks*

191 [redacted] pg 15
192 [redacted] pg 16
193 [redacted] pg 77
194 [redacted]
195 [redacted]
196 [redacted] pg 2

regarding taxi drivers". However, I have not seen any further evidence of these checks or evidence of the impact it had on tackling CSE.

Statistical analysis

4.176 The Council and Shropshire Council have provided the Inquiry with four spreadsheets that contain taxi licensing information regarding taxi drivers licensed within the councils, where enforcement action has been taken. As I have noted above, it is important to note that the disclosure is incomplete, in part due to the time that has elapsed, and the Inquiry has not been provided with a complete list of all licences issued to taxi drivers during the time period of the Inquiry's Terms of Reference.

4.177 Notwithstanding this, I have analysed the data available which provides information about enforcement action taken against individual drivers. My analysis suggests that perpetrators or associates known to WMP may have been issued with taxi licences by both the Council and Shropshire Council.

4.178 The analysis conducted by the Inquiry was as follows:

4.178.1 The Inquiry cross referenced the names against a list of perpetrators and/or associates known to the Inquiry for their involvement/links with CSE (collated from documents provided to the Inquiry by WMP).

4.178.2 The result of this cross-check suggests that there were indeed some perpetrators/associates who held taxi licences.

4.178.3 A degree of caution must be exercised here as the taxi licensing data does not always provide the dates of birth of the taxi drivers. It is therefore possible that a perpetrator and taxi driver share the same name, but are in fact two different individuals. It is also possible that at the time the taxi licence was issued that the driver had no known association with CSE and it would therefore have been impossible for either the Council or Shropshire Council to identify concerns at the application stage.

4.178.4 It should also be noted that in the majority of cases, enforcement action had been taken against the taxi driver, for example, the licence had been revoked, or the badge returned or the licence refused, which suggests that an effective system is in place when concerns are raised.

4.178.5 The Inquiry also reviewed the spreadsheets to identify any particular drivers that could be of interest by searching the spreadsheets for terms that could be associated with CSE. For example, if there was information that a driver had spoken inappropriately to a female passenger, or had been accused of sexual activity with a female under the age of 16.

4.178.6 From the list of names collated, searches were conducted against the material disclosed to the Inquiry by the Council and WMP and it was found that some further taxi drivers currently or previously licensed by the Council or by

Shropshire Council were potentially known by other agencies to have involvement or links with CSE. Again, I must exercise a degree of caution here given that the spreadsheets do not provide the dates of birth of the taxi drivers.

4.178.7 It is also important to note that where serious allegations had been raised against a taxi driver, the information disclosed that enforcement action was taken.

Conclusions – Taxi Licensing

Character of Applicants

4.179 In so far as licensing policy for applicants was concerned, the Council adopted a policy (though termed "*draft*") early in respect of previous sexual offending by applicants. Although on a contemporary view a period of at least three to five years' free of offending appears minimal, this was the national guidance contained within the Home Office Circulars at the time.

4.180 I note that the Council held concerns early on about the effectiveness of the licensing regime under a three year licence validity, and in 2002 moved to a single year validity. At the same time changes in the law allowed the Council to take into account otherwise "*spent*" convictions.

4.181 In its first formal policy the Council noted that any applicant with a sexual offence conviction would go before the Appeals Panel for determination; but it chose to adopt an eligibility period of at least three years conviction-free, which was the lowest end of the scale suggested in national guidance.

4.182 In some respects the Council's scrutiny was rigorous – for example pre-2012 it continued to insist upon enhanced CRB checks for driver applicants, although the legal basis for the stance was thin.

4.183 However, by 2012, the Council retained its guidance of at least three to five years sexual offence conviction-free before application would be considered, notwithstanding the 2010 LACORS guidance suggested ten years post-conviction. The LACORS period was finally adopted in 2017, which seems to me to be a very significant gap since publication and likely indicative of oversight rather than a deliberate policy.

4.184 It is plain that the Licensing Team was keen to see material held by the Safeguarding service as early as 2012, but that information sharing did not begin until 2015, and then at the discretion of Safeguarding, and that it was not until 2018 or later that routine checks began.

4.185 It is still not clear to me why the Council did not make use of the PSP Register prior to 2017, given it had been in existence by then for 14 years; it would seem to be an essential resource.

4.186 So far as information sharing is concerned, I have heard varying accounts of cooperation between the Council and neighbouring local authorities. I cannot choose between accounts which suggest that one neighbour was more cooperative than the other, but I can conclude that it is regrettable that there is not a regional or national protocol on mandated information sharing between licensing authorities. I therefore include a recommendation to this effect in the Recommendations section at the beginning of this Report.

Other conditions

4.187 The Council developed a tinted windows policy as early as 2002. The dangers of heavily tinted windows are obvious: if the back seat is not visible, enforcement authorities and others cannot see who is being carried or what is happening in the vehicle. The initial requirements of the policy excluded some factory fitted tinted windows and as a result – and after complaints – were changed in 2008. Following consultations with the trade, they were changed again in 2016 with specific light transmissibility requirements. As I have noted above, the Council seems to me to have been proactive in imposing this condition at a time of concern about children in taxis. The Council remained committed to the condition despite the difficulties it caused with the trade.

4.188 The Council's CCTV scheme was published in 2010. This was a potentially useful innovation, but the evidence I have seen tends to suggest it failed because of a somewhat overenthusiastic and even petty approach to enforcement; that every infraction became an issue, rather than the cameras being used to protect passengers and drivers. It seems that as a result the scheme fell into disuse, though I understand from the Council that it is keen to revive it and that plans to do so are in train.[197] The reasons for the failure of the previous pilot scheme must be remembered and not repeated.

4.189 The Council introduced compulsory CSE training for taxi drivers in 2015; this was in my judgment a positive, if belated, move, as was the requirement for operators to designate a safeguarding officer. In the Recommendations section, I consider whether such training can be rolled out more widely.

Regulation in practice

4.190 Quite clearly, other authorities have operated less rigorous licensing schemes than the Council and have benefitted from custom and income, while the Council has been deprived of both. As a result, I confess that I regard a system that encourages drivers to choose lighter touch, non-local regulators and in doing so to starve the local regulator of funds as utterly bizarre and quite unjustifiable. This is a matter for central government, and out of my remit; but I can say that I regard the lobbying attempts of Telford politicians on the point as measured and persistent and the response of central government as disappointing in the extreme.

4.191 Whatever the standards required by the Council, they are only meaningful if they are enforced. In this regard, the 2006 dispute with taxi drivers showed both sides in a poor light. First, some of the drivers were personally hostile to members of the Licensing Team

197 [redacted]

and members of the team felt threatened as a result. Second, there appears to have been no real engagement between the parties: it may be that the dispute might have been avoided if there was the sort of negotiation over contested terms as there was in 2016 over (again) tinted windows. Third, it is a great shame that after a public meeting between the Council and the newly formed Telford Private Hire Association, enforcement resumed the following day; a move that seems to me to have been designed to show who was (still) boss. Fourth, though, and most seriously, the decision by senior officers in the Council and by an elected member to suspend licensing enforcement was a disastrous one. On the material I have seen it was borne entirely in 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 the Chalice offending, when concerns reported about the exploitative behaviour of taxi drivers and misuse of badges by those purporting to be taxi drivers, were at their height.

4.192 Finally, the statistical analysis that the Inquiry has undertaken, though necessarily couched with caution about duplicated names, tends to suggest that there were suspected CSE perpetrators in Telford who have previously held a taxi licence issued either by the Council or Shropshire Council.

4.193 That is in my view a significant result and one which is more likely to be attributable to some feature of the job which is attractive to perpetrators, rather than to chance. The obvious feature that a CSE perpetrator would find attractive is that taxi drivers hold a position of responsibility to the public; people tend to trust them. It also shows why an effective system of licensing and enforcement is vital, and why the public must know about the standards they are entitled to expect: they must know how to complain, and must to be able to make a complaint easily and quickly.

4.194 I take the view that on the evidence I have seen the Council does now operate an effective system of licensing, but remains hampered by inconsistent standards on regional regulatory requirements and information sharing. It is difficult to see what more the Council and its officers could have done to lobby central government on this point, and indeed the battle was seemingly won by the concession in 2019 that the Government would introduce statutory standards "*when time allows*". For my part I cannot see legislation that addresses this shocking difference in standards as anything other than an unalloyed good, and fail to understand the lack of priority. People should be able to feel safe in taxis. This is something I have also sought to address via my recommendations.

The Night-Time Economy

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

Legislative provisions

4.196 In its Corporate Submission[198], the Council provided detailed information about licensing legislation. It explained to the Inquiry that the licensing and regulatory requirements that premises must comply with are dictated by the activities carried out by the premises. There are various requirements that each premises may need to comply with. For example:

4.196.1 Premises licence (to enable it to carry out licensable activities);

4.196.2 Personal licence (to enable it to sell alcohol);

4.196.3 Sex Establishment licence (if it operates as a sexual entertainment venue);

4.196.4 Gambling licence (required if it provides gambling activities);

4.196.5 Food business registration (if it is also a premises that prepares, cooks stores, handles, distributes, supplies or sells food); and

4.196.6 Food standards requirements (such as in relation to food hygiene).

4.197 Licensable activities are:

4.197.1 The sale by retail of alcohol;

4.197.2 The supply of alcohol by or on behalf of a club to, or to the order of, a member of the club;

4.197.3 The provision of regulated entertainment; and

4.197.4 The provision of late night refreshment.[199]

4.198 The Council has, since the Licensing Act 2003, been the licensing authority in respect of licensable activities. 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.

4.199 Under the Local Authorities (Functions and Responsibilities) (England) Regulations 2000, licensing is a function which must not be the responsibility of the Council's Cabinet. The licensing authority is therefore required to set up a licensing committee which is responsible for discharging its licensing functions.

4.200 The Council explained that the Licensing Act 2003 requires licensing authorities to have regard to four licensing objectives: protection of children from harm; prevention of crime and disorder; public safety; and prevention of public nuisance.

4.201 The protection of children from harm is clearly relevant to my Terms of Reference and the Council has explained that the statutory guidance makes it clear that the protection of

198 [redacted]
199 Section 1 Licensing Act 2003

children from harm includes moral, psychological and physical harm, which not only includes harm associated directly with alcohol consumption, but also wider harm such as exposure to strong language, for example. I understand that, from March 2015, the statutory guidance issued under section 182 of the Licensing Act 2003 (the "Section 182 Guidance") has included that licensing authorities "*must also consider the need to protect children from sexual exploitation when undertaking licensing functions*".[200]

4.202 The Council told me that typical conditions that can be imposed on licences to protect children from harm include:

4.202.1 Restrictions on hours when children may be present;

4.202.2 Restrictions or exclusion on the presence of children under certain ages when particular specified activities are taking place;

4.202.3 Restrictions on the part of the premises to which children may have access;

4.202.4 Age restrictions;

4.202.5 Restrictions or exclusions when certain activities are taking place;

4.202.6 Requirements for an accompanying adult/children under a specified age to be accompanied by adult; and

4.202.7 Exclusion of under 18 year olds from the premises when licensable activities are taking place.

4.203 A licensing authority is required to set out which responsible authority (as defined in section 13(4) of the Licensing Act 2003, but including the Chief Officer of police, the fire and rescue authority and the local health board) it considers to be a competent body to advise on the protection of children from harm.[201] The Council has nominated the LSCB as the most appropriate body to consider and comment upon all relevant applications under the Licensing Act 2003.

4.204 In relation to the objective to prevent crime and disorder, the statutory guidance acknowledges that:

"*… licensing authorities do not have the power to judge the criminality or otherwise of any issues. This is a matter for the courts. The licensing authority's role when determining such a review is not therefore to establish the guilt or innocence of any individual but to ensure the promotion of the crime prevention objective.*"[202]

[200] [redacted] pg 87
[201] [redacted] pg 81
[202] Revised Guidance issued under section 182 of the Licensing Act 2003 (publishing.service.gov.uk)

4.205 I propose to consider the licensing of nightclubs, the measures put in place and any steps taken to make nightclubs and their environs safe, and briefly to consider other licensed premises.

Venues

4.206 In recent years, there have been three main nightclubs in the Telford area, these being: Club A; Club B; and Club C.[203]

4.207 Of these, it is Club A about which the Inquiry has heard most witness evidence, in terms of social workers having concerns that children were frequenting the nightclub[204]; that children were taking drugs or being drugged[205]; and that children were leaving the nightclub in a potentially vulnerable state.[206] I note that various initiatives have been trialled, in an attempt to address these issues. These are detailed below.

4.208 In terms of disclosure from the Council, the Inquiry compiled a list of premises of interest, using information gleaned from evidence, which formed the basis of the disclosure request. These included: Club A, Club C, Club D, Club E, Venue F and Venue G.

4.209 In response to the Inquiry's request for information, the Council's Public Protection team reviewed the information held on file and compiled this into a spreadsheet which was disclosed to the Inquiry.

4.210 The spreadsheet revealed:[207]

4.210.1 Club A had a record of one complaint from a parent in 2020 that their 15 year old child had been served alcohol at the premises. There had been complaints regarding the premises licence but this was said not to be related to child protection;

4.210.2 The Council held no information in relation to Club C given that it closed within the last 20 years;

4.210.3 There had been one complaint about Club D in 2008 and in 2014, but this did not relate to the protection of children. The premises closed in 2011;

4.210.4 Club E closed during the last five years; there had been complaints regarding underage sales;

4.210.5 There were no concerns regarding Venue F which closed over 10 years ago; and

4.210.6 Venue G had a complaint against it dated 2013 about a 'girls drink free' promotion. WMP and a Council officer advised that the event could not go ahead

203 [redacted] pg 15 and [redacted] pg 14
204 [redacted] pg 7
205 [redacted] pg 10
206 [redacted] pg 3
207 [redacted]

as it was considered irresponsible drinks promotion and breached licensing conditions.

4.211 Although Club C and Club E were closed premises, the Inquiry made a further request for information from the Council about these premises. Further documents were received in relation to Club E, but none of the information was relevant to the Inquiry's Terms of Reference. The Council informed the Inquiry that it had no information regarding Club C, given that it closed before the enactment of the Licensing Act 2003.

4.212 Given the overwhelming evidence the Inquiry has heard from victims/survivors and professionals about their concerns around nightclubs, I find it difficult to understand that the Council does not hold further information of relevance to this Inquiry, particularly given its obligation to have regard to the protection of children from harm in respect of licensed premises.

4.213 The Inquiry has also heard evidence about a new night-time economy venue which, according to one witness, is already proving to be the subject of concerns raised with the local MP by one constituent who complained that, "*the environment felt nothing short of predatory",*[208] with no CCTV in the immediate vicinity and no Police Community Support Officers ("PCSOs") or Street Pastors present or patrolling the area. The Inquiry heard that this type of behaviour had been witnessed (at a different local venue) five years ago and, given that it was now known about, the witness was surprised that it was being allowed to continue.[209] Although I have not heard any further evidence about this particular nightclub, this example does highlight the risks that nightclubs can pose and the important role the Licensing Team and others have to play in managing this risk.

Early response

4.214 The Inquiry has heard that during the Christmas period of 2008 there was violence and disorder in a certain area of Telford and in particular around Club A; as a result WMP "*flooded*" the area with officers as part of a targeted operation.[210]

4.215 At the same time a volunteer group began operating to provide a safe place for clubbers at the end of the night. This was based in a Methodist church in the local vicinity and operated on Saturdays as a night-time café giving out hot drinks, water and footwear to anyone in need. Additionally, its volunteers would direct children to taxis.[211]

Taxi Marshals

4.216 A formal Taxi Marshal scheme was introduced in 2009/10. The Inquiry heard that;

"*… it arose out of the need for enforcement… outside* [Club A] *in* [a named area of Telford]*, whenever we did plying for hire exercises, we always had drivers that picked up un-booked fares outside, and in the vicinity of* [Club A]*. We also knew from working with the police*

208 [redacted] pg 2
209 pg 1
210 pgs 3-4
211 pg 4

that it was just mayhem when everybody comes out of the night club at night… and there needed to be some safety controls in place for the separation of pedestrians, vehicles and to make sure that people got in the taxis they had booked. Because we can't be out doing plying for hire exercises every Friday and Saturday night, we needed to put some control measures in place. I think the better way to put it than enforcement, was some control measures, so we looked at introducing a Taxi Marshal."[212]

4.217 The Taxi Marshal scheme was initially partially funded by Wellington Town Council[213] and the Council; there was a similar marshal scheme created as a joint venture between the Council and the town centre's owners. Subsequently, the Police and Crime Commissioner ("PCC") has funded the Taxi Marshals scheme, to the extent of £107,000 between 2013 and 2020.[214] The Taxi Marshals are externally contracted[215] and individuals regulated by the Security Industry Authority.[216] The Taxi Marshals have been provided with the taxi driver CSE training for their information.[217]

4.218 One witness described the scheme:

"*The Taxi Marshals' purpose was to find out which private hire vehicles had bookings for which customers coming out of the night clubs and, as you say, matching them up. It also helps the private hire vehicle drivers because those that work according to the law and the rules, were having their own fares taken by other drivers plying for hire, so it helped them not lose their fares to those that were unlawfully plying for hire. Also the Marshals were there to assist the drivers if there were any disputes or if too many people tried to get in a licensed vehicle, you know, they're there generally to make sure that everybody is safe."*[218]

4.219 A report to the Community Safety Partnership in March 2019[219] noted:

"*The Taxi Marshal scheme is an essential part of keeping people safer within the night-time economy. The Taxi Marshals play a vital role in supporting the wider night-time economy partnership working model. To work closely with police and Street Pastors within the night-time economy in keeping people safe when leaving the area. The new supplier took up the contract for 10 months from 1st June 2018. The Service level agreement maintained the previous arrangements for 3 Marshals each working 5 hours giving a maximum of 15 hours per week to this scheme plus bank holidays and extra hours where required. From 1st April 2018 to 31st January 2019, the project outcomes have been delivered, with a total of 5940 passengers and 4503 licensed vehicles using the service*."

4.220 In order to ensure cooperation, the Council made it a condition of the driver awareness training that drivers cooperate with Taxi Marshals and:

212 [redacted] pg 28
213 [redacted] pg 29
214 [redacted]
215 [redacted]
216 [redacted] pg 31
217 [redacted]
218 [redacted] pg 30
219 [redacted]

"... *if any driver refused to show a Taxi Marshal who the booking was for… or if they're abusive to Taxi Marshals, or insisted on picking up somebody that hadn't booked them, then the Taxi Marshals' instructions were to take the information of the vehicles and report that to us. We have a report weekly from Taxi Marshals.*"[220]

4.221 I have seen an example of Taxi Marshals' information sharing in their report of a persistently uncooperative driver leading to a joint meeting between the Council and Shropshire Council's licensing representatives and consideration of police action in respect of the driver.[221]

Street Pastors

4.222 The Street Pastors scheme began in Brixton in 2003. It is now run across the country by the Ascension Trust. A founder member in Telford was a former employee of WMP.

4.223 An attempt to establish a Street Pastors group in Telford in 2007 was met with little enthusiasm. A witness told the Inquiry that neither the Council nor WMP were interested, seeing Shropshire generally (including Telford) as "*sleepy*".[222]

4.224 I heard from a senior officer at the Council, who recalled:

"*I thought it was a great initiative in terms of having those eyes and ears out on the ground and it worked well so… the idea was that we knew of a number of licensed premises where potentially people who are trying to get a taxi at night, there is an issue, somebody needs somebody to talk to while they're waiting for a taxi and they're vulnerable you know,* [Club A] *became a nightclub in Telford that became a centre of activity for this… where basically at closing time the Street Pastors are on help to support people and trying and helping people get home, not to accompany Police Officers, but if they spotted something they could report it.*"[223]

4.225 Funding for the Street Pastors initiative was secured by a grant from the PCC; a senior police officer at the time in Telford was a supporter. The first patrol took place on 1 July 2011.

4.226 The Street Pastors worked with the Council's Licensing Team, one of whom was invited to join its board.[224] The Inquiry understands from a source close to the Street Pastors that:

"They were very good at calming volatile situations, they would just kind of like go in between it all and split them all up and talk to people and hand out lollipops and flip-flops, stuff like that. So their actual role in the night-time economy when they started was very good. I mean I was very cynical about it. I didn't think it would be something that Telford would want but actually it worked really well. I think [when] [Club A] *closed and…* [Club H] *and* [Club E] [opened] *in the town centre, and there used to be quite a lot of disorder there*

220 [redacted] pg 30
221 [redacted]
222 [redacted] pg 3
223 [redacted] pg 56
224 [redacted] pg 33

and they actually calmed a lot of that down. They stopped a lot of that disorder just by being there really, just getting in amongst people, talking to people. Handing out lollipops because people won't shout at each other when they're sucking a lollipop."[225]

4.227 There was, though, a divergence of opinion over 'under 18s' events. Evidence I have seen suggests that these began in 2012 or thereabouts and, whilst they were held in nightclubs, the proprietors took care to ensure that alcohol was not supplied. Nevertheless, children found a way to consume alcohol and the Street Pastors found hidden bottles and empty ones. It was felt that children going out without adult supervision put them at risk, with one Street Pastor describing himself as a "*thorn in the flesh*" of WMP and the Licensing Team on this issue.[226]

4.228 This recollection is described similarly by a Licensing Team member, who told the Inquiry, of that Street Pastor: "*he did not like the under 18s events at all… he did everything he possibly could do to sabotage them*".[227]

4.229 That witness took a more relaxed view of the events, this being:

"*I think it was really safe, because inside the club they were safe. When they were outside the club we would make… nobody was allowed to just come out and wander off. You know, we would ask them where they were going, how they were getting home, and they'd be like, "Oh, my mum's here," or the street pastors or one of us would walk them round to where their mum's car was. I actually thought the only real issue was when we'd get this dozen or so kids that wanted to hang around afterwards, when it finished at ten and have food from* [a named local takeaway] *and things like that, but then they weren't left alone. The PCSOs would stay with them until they had dispersed or gone home or got in taxis or been picked up or whatever. I think they were, the kids liked them. The kids had fun, and I think they were actually safe events.*"[228]

4.230 It is important to note that this acceptance of the principle of 'under 18s' events was not uncritical, and that certain venues were effectively vetoed by the Licensing Team as unsuitable to hold such events, for a variety of reasons.[229] A senior officer at the Council recalled that there was no licensing power in respect of such venues that did not serve alcohol; instead this was done by a "*real*[ly] *strict conversation with the organisers*".[230] On certain occasions members of the Licensing Team and youth workers were managing the events themselves.[231]

4.231 I have also been provided with minutes of Night-Time Economy meetings between 2015 and 2018. These were multi-agency meetings hosted by the Council but including representatives of WMP, local businesses, the Street Pastors and others. The view of WMP, expressed in the minutes of a Night-Time Economy meeting dated 28 September 2015, was that the 'under 18s' events were becoming more regular as alternative provision for children

225 [redacted] pg 31
226 [redacted] pg 7
227 [redacted] pg 28
228 [redacted] pgs 28-29
229 [redacted] pgs 65-66
230 [redacted] pg 57
231 [redacted] pg 27

– youth clubs and the like – were closed.[232] WMP did not support the 'under 18s' events in night clubs,[233] although earlier documents, for example a 2012 local engagement strategy document for one particular police operation, suggest WMP had approved 'under 18s' discos as providing a "*safer environment*" which made "*recruitment* [by perpetrators of CSE] *more difficult*".[234]

4.232 At the same meeting it was suggested that Street Pastors had witnessed "*vulnerable teenage girls who are made up and dressed inappropriately to look older than they actually are*" and the view stated that the 'under 18s' events should be stopped for this reason; the risks of children being out in Telford without supervision could, it was suggested, be seen clearly.[235]

4.233 The Inquiry heard evidence from a WMP officer who also felt that 'under 18s' events created problems in the surrounding areas:

"I would always have a car out… on the kiddie discos… And you would get the patrolling Asian car trying to get them into the cars or talk with them… it was trying to disrupt that."[236]

4.234 The Inquiry understands that after a particular venue was closed in 2016, the 'under 18s' events stopped. As to any risk they had perceived, the Inquiry heard from a police witness:

"I can't remember us having any investigations or reports of serious sexual offending on the back of those and actually they were managed by the local authority."[237]

4.235 In a similar way, a Council witness told the Inquiry:

"I had no concerns whatsoever [about CSE] *because they were really well looked after and we used to get quite a lot of feedback from parents that they knew their child was safe, otherwise they wouldn't let them come…"*

4.236 They continued:

"I think that had a big impact on our young people when they scrapped the youth team… I had youth workers right up until the last event but what I did notice a difference without the youth workers, with young people, sort of being out and about more when I was out and about late at night. You'd see more young people out and then you'd see more issues being reported by PCSOs and police officers, young people getting alcohol and drinking alcohol in the parks."[238]

4.237 I asked the Council for further information about its Youth Team, including when it was disbanded and the reason for this. The response was that:

232 [redacted] pg 1
233 [redacted] pg 1
234 [redacted] pg 6
235 [redacted] pg 7
236 [redacted] pg 46
237 [redacted] pg 39
238 [redacted] pgs 32-33

"*… in 2016, the Council was faced with significant budget pressures, following years of reductions in funding from central government. As a result,* it *was required to identify an additional £30,000,000 savings on an ongoing basis, on top of the £80,000,000 already identified. As part of the budget setting process, each Directorate was required to identify ways in which such a savings target could be met. There was a need to ensure that statutory services were still operational at a sustainable level. The Youth Service was a discretionary service. Additionally, following commencement of the Localism Act 2011, and in line with the Council's Co-operative Values, steps had already been taken for some services to be transferred to Town/Parish Councils and local community groups. In February 2016, Cabinet approved a number of savings proposals which were then approved by full Council. These proposals included the cessation of the Youth Service with the Council working with local community groups to identify alternative operating models at a local level".*[239]

4.238 The minutes of the Night-Time Economy 'under 18s' events meetings[240] that I have seen essentially illustrate a difference of view between those responsible for monitoring and running the events themselves – the Licensing Team – and those concerned with what happened outside – the Street Pastors and WMP.

4.239 I relate these views and differences of opinion not in order to choose between them – it is not part of my function to do so – but to explain why it was that the Street Pastors began to record registration numbers of vehicles they regarded as suspicious. This practice extended beyond their patrol of 'under 18s' events.

4.240 A weekly Street Pastors report - the product of an extraordinary amount of work - would follow with a circulation of about 70 people, including WMP and the Licensing Team. As well as detailing the number of lollipops distributed, vomit bags used, and bottles cleared away, the following sort of detail was included:

"*There were a significant number of vehicles that aroused suspicion during the course of all these patrols and details are being forwarded to the SNT* [Safer Neighbourhood Team] *at Wellington.*

On Sunday night/Monday morning with no hackney carriages around, the private hire vehicles had a field day and the taxi marshals were overwhelmed by the numbers of private hire vehicles blatantly flouting the regulations. Details of some private hire vehicles were also noted which appeared to be in breach of the licensing regulations as follows:-

Monday morning –

1. VW VRM – XX00XXX *Licence plate* xxxx [Operator named] – *continually picking up unbooked passengers, hiding away on the car park and then driving quickly to people looking for lifts and whisking them away before the taxi marshals could intervene. Taxi marshal described this one in particular as 'high risk'.*

239 [redacted]
240 [redacted]

2. Honda VRM – XX00XXX – *Licence plate* xxxx– [Operator named] – *picking up without being prebooked.*

3. Ford VRM – XX00XXX – *Licence plate* xxxx - *picking up without being prebooked".*[241]

4.241 The Inquiry understands from the evidence that one Street Pastor was disappointed not to receive feedback on the use of this information from WMP or the Council. As a result, he "*didn't pull any punches*"[242] when he gave evidence to the Council's Scrutiny Review; he told the Scrutiny Committee that in some areas the activity of people involved in CSE was "*blatant*". The phrase was adopted in the Scrutiny Review with the following report:

"*The Street Pastors provided particularly compelling eyewitness accounts of predatory behaviour going on in the night-time economy and expressed some forthright views that a new generation of post-Chalice perpetrators is growing up and that open acknowledgement of the problem is needed for the issues to be tackled.*"[243]

4.242 One example of the material passed on by the Street Pastors was recorded at an 'under 18s' meeting as follows:

"[an attendee] *informed the meeting of an incident which was seen by the Streets Pastors recently. A 17 year old girl was seen getting into a car which was driven by a Asian man, the man was in his mid 40's and was believed to be not known by the girl though one of the Streets Pastors did recognize the man.* [A representative of Cohesion] *added that any incidents like this need to be passed onto the Council so they can support the Streets Pastors in dealing with these incidents, this is important as these incidents could lead to grooming and/or sexual exploitation."*[244]

4.243 As to cooperation between the Street Pastors and other bodies, I have seen minutes of meetings between the Street Pastors, WMP and the Council which suggest that the Street Pastors' weekly reports were being reviewed by the Council's Assistant Directors for Safeguarding, and that information had been passed to the Safeguarding team for action.[245] I have not however seen any evidence of how, if at all, this was acted upon.

4.244 Another set of minutes suggests there were initially difficulties with the WMP control room responding to the Street Pastors as they wished, with a reluctance to give OIS (police control room recording code) numbers.[246]

4.245 An Inquiry witness from WMP directly addressed the question of police use of the material gathered by the Street Pastors:

"… *the street pastors reports… come in normally… on a Monday morning and I worked with* [them] *to try and professionalise them because, let's be blunt, some of the comments could be verging on inappropriate. Some of what you may think were, so "Asian male stopped*

241 [redacted] pg 3
242 [redacted] pg 11
243 [redacted] pgs 27-28
244 [redacted] pg 2
245 [redacted] pg 4
246 [redacted] pg 2

and spoke to white girls", and that's what you'd get. You'd get a registration, we were suffering from racial profiling and that then being a perception, or that being portrayed that that was actually intelligence and it was rubbish…

You've got a diverse community in Telford and often when we did any digging into these that could be a 17, 18 year old Asian lad who's at college who was stopping and speaking with girls he's at college with…Unfortunately there was very little useful intelligence coming through those reports.

[A senior local police officer] *who knew the community inside and out tried to manage those street pastors… when information did come in* [they were] *all over it and I was assured that that which needed to be turned into intelligence was turned into intelligence and put onto the system, but to be blunt very little of it, if you go through the reports, if you genuinely look and think what could you put on a police system as intelligence was very little."*[247]

4.246 The Street Pastors still exist and have been funded continuously by the PCC ever since, receiving a total of approximately £50,000 to the end of 2020.[248] In addition, the scheme received several lump sums from the Primary Care Trust upon the latter's dissolution as well as various charitable donations.

Restaurants and Takeaways

4.247 There are many references, within the evidence I have seen, to perpetrators being linked with takeaways and restaurants, and to associated residential premises being used for exploitation. I have detailed some of those repeat locations and the nature of such perpetration in Chapter 2: Nature, Patterns and Prevalence of CSE in Telford. I have also noted above evidence from victim/survivors of CSE who met the perpetrators when working at these establishments in weekend employment, while still at school, or as a result of befriending delivery drivers through other friends and accompanying them on deliveries:[249]

"*I thought… well we weren't going to take any Chinese to an industrial estate where everything's shut… he... just parked up and I thought what's going on here. But I wasn't scared initially… then he undone his belt and pulled his trousers down….*"[250]

"*I remember that* [name] *took me to the pizza place where he worked, telling me I was to have sex with two men above the shop, to pay off a debt.*"[251]

"*It was arranged that* [name (aged 14)] *would lose her virginity to* [name], [an] *Asian man* [in his thirties] *who worked as a food delivery driver….*"[252]

4.248 One witness recalls being taken to a tandoori takeaway:

247 [redacted] pgs 37-38
248 [redacted] pg 6
249 [redacted] pg 15, [redacted] pg 9
250 [redacted] pg 9
251 [redacted] pg 15
252 [redacted] pg 2

"There were bedsits above the takeaway... In each bedsit… there would be around six to eight men and three or four girls... you were not just raped by one man but you were raped by loads of them."[253]

4.249 Some witnesses believed that the establishments are used as fronts for money-laundering[254] or drug-related activities as well as CSE and that those involved have regularly changed the names and identities of their businesses to avoid scrutiny by the authorities.[255]

4.250 As I have noted, the licensing role of the Council is limited to those premises serving late night refreshment, including alcohol or hot food. I understand from the Council that only 20 of the approximately 107 takeaways in the borough currently have a premises licence and it accepts that its role is therefore necessarily limited by this.[256] That said, the Council retains a general duty to protect children and, in this regard, members of the Licensing Team undertake alcohol test-purchase exercises, primarily based on intelligence received about infractions in both on and off licensed premises. This mechanism of regulation is unlikely to be useful in detection or prevention of CSE; and the detection and prevention of CSE is primarily, after all, a police function.

4.251 In light of the evidence, I also made a request for specific disclosure for information relevant to restaurants and takeaways. I provided the Council and WMP with a list of premises which were of interest (the "Identified Premises"): Food Premises 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11.

4.252 The Council disclosed a list that had been prepared by the Public Protection team which revealed:

4.252.1 Food Premises 1 was not known to the Licensing Team; and

4.252.2 Food Premises 2 was not known to the Licensing Team.

4.253 A condition for the 'Protection of Children from Harm' was placed on the licences of Food Premises 3, 5, 7, 8 and 10.

4.254 A condition of the 'Protection of Children from Harm' relates to the serving of alcohol and was not imposed by the Council, but rather was requested by each of the establishments above. They were therefore not imposed in response to concerns by the Council. Furthermore:

4.254.1 Food Premises 4 was not known to the Licensing Team and there were no records on the file, which was closed in 2010;

4.254.2 Food Premises 6 was not known to the Licensing Team;

253 [redacted] pgs 5-6
254 [redacted] pg 6
255 [redacted] pg 32
256 [redacted]

4.254.3 There were no concerns in relation to Food Premises 9; and

4.254.4 Food Premises 11 was not known to the Licensing Team and no records were found after the file was closed in 2018.

4.255 I requested further information from the Council in relation to the closed premises, namely Food Premises 1, 2, 4 and 5.

4.256 I received some information in relation to Food Premises 5, but none of the information was of relevance to my Terms of Reference. I was informed by the Council that Food Premises 1, 2 and 4 were not known to Licensing or Environmental Health and that there was no information to disclose.

4.257 I am particularly concerned, given accounts from victim/survivor witnesses, that certain restaurants have no documented concerns relating to them on the part of the authorities, despite being identified as known CSE locations within the local population. It is not apparent to me that there was routine information sharing by CATE and WMP with Licensing.

4.258 Plainly it is incumbent on me to investigate these allegations. Unfortunately the Council was unable to supply me with even basic information as to historic ownership or management.

4.259 I note in particular the evidence of one witness who stated that there are *"very few, if any, takeaways locally in Telford which are not involved with gang grooming to some degree"*[257] and that it is believed that *"much of the night-time economy is monopolised by a few major players. These are the same people who are behind the organised CSE"*.[258] Whilst I do not have sufficient evidence to corroborate that witness's view, I have been disappointed and surprised by the general lack of information the Council has been able to provide to the Inquiry with regard to nightclubs, takeaways and restaurants.

4.260 Allegations of establishments being used as a front for other illegal business enterprises cannot be ignored either. Whilst of course the Council is governed by data protection legislation and the information it stores is subject to statutory retention periods,[259] it is concerning that the Council appears not to retain this sort of information, given the clear concerns (some of them recent) about nightclubs and restaurants and the role they play in CSE. I consider that the Council could adopt a stronger role in the monitoring and licensing of these premises, particularly having regard to the mandatory licensing objective to protect children from harm. Equally, it is essential that any such information is shared with WMP, not only in order to ensure a multi-agency response, but also to ensure that any suspected criminal activity is appropriately investigated.

257 [redacted] pg 6
258 [redacted] pg 32
259 [redacted]

Information sharing

4.261 The Section 182 Guidance expressly provides that "*licensing authorities should give considerable weight to representations about child protection matters*".[260] The guidance expects the licensing authority to work closely with the police, young offenders' team and trading standards officers to tackle and address the sale and supply of alcohol to children and to take action where it is deemed necessary. To ensure that all relevant responsible authorities are aware of the history of any premises, the guidance states that:

"*… where, as a matter of policy, warnings are given to retailers prior to any decision to prosecute in respect of an offence, it is important that each of the enforcement arms should be aware of the warnings each of them has given*".[261]

4.262 The Inquiry asked for further information as to how this information sharing happens in practice. It was told that:

"[the] *Licensing Team is part of the core Public Protection team within the Council so both Trading Standards and Environmental Health form part of the same service and share the same database. All information received by the Council is therefore shared as a matter of course. Information on Licensing decisions such as a removal of a Designated Premises Supervisor is also communicated to the Police both through formal means required by the Licensing Act and to our Problem Solving Hub so there is an operational knowledge. Likewise, information obtained by the police about licensed premises is shared with the Licensing Team both through the Problem Solving Hub and also through licensing updates which the police send to the Licensing Team and the Licensing Team then return to the police with any information. The Police have dedicated Licensing Officers for the locality and they work very closely with the Council's Licensing Officer to ensure a collaborative approach is taken to any licensing matters. Furthermore, there is a statutory process to follow for the sharing of details regarding applications for a premises licence or review of a licence with all responsible authorities and the Licensing Team follows this process upon receipt of an application*".[262]

4.263 The Council told the Inquiry that the Licensing Team has worked closely with WMP in investigating any concerns that have been raised in respect of activity occurring on licensed premises or involving individuals that have designated positions in licensed premises under the Licensing Act 2003.

4.264 The Council further explained that this enabled the two agencies to share intelligence to support any action under the licensing regime, instigate licensing reviews and/or prosecution for breach of licensing conditions under the Licensing Act 2003 and any other prosecution that can be brought by the police. I comment further below on the role of WMP in responding to licensing information and intelligence about licensed premises in Telford.

4.265 In 2017, the Council's Public Protection team became a partner in the Multi-Agency Team Enforcement Strategy ("MATES") which brought together a number of enforcement

[260] Revised Guidance issued under section 182 of the Licensing Act 2003 (publishing.service.gov.uk)
[261] [redacted] pg 13
[262] pgs 91-92

partners led by WMP's Harm Reduction Unit ("HRU") to tackle problem premises and individuals.[263]

CSE Training

4.266 The Council explained to the Inquiry that, in October 2015, in response to concerns regarding the role played by licensed premises in the exploitation of children and young people, 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. The Council stated that 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 a premises to limit the risk of children and young people being exploited.[264]

4.267 Witnesses have provided evidence about a joint initiative between the WMP CSE team and the CATE team known as "*We Don't Buy Crime*". I understand that it was funded by the PCC.[265] The initiative was delivered to large local organisations, including hotels, designed to help frontline facing workers in the community to identify CSE signs and report concerns to the WMP. The Inquiry understands that the initiative has had significant success locally, with reports being made to WMP of children in hotels with inappropriate adults, and action subsequently being taken. I understand that, as a result of this initiative, more information has also been forthcoming to WMP about issues related to CSE.[266]

CATE and Licensing

4.268 The Inquiry has seen material which shows that members of the Licensing Team attended CATE strategy review meetings.[267] An example of action taken as a result relates to concern that a child, then 17, had repeatedly attempted to enter nightclubs in Telford; as a result one member of the Licensing Team had visited all licensed nightclubs to make staff aware of the identity of the child.[268] The Inquiry heard:

> "*… if any CATE worker was working with someone who would then admit that they'd been in a certain nightclub or they'd been into certain licensed premises as part of their CSE travel, I would then get called in and then I would go back to the licensed premises. There was one occasion where she was getting into* [a named nightclub] *and I had a meeting with her mum and her and they gave me permission to use her photograph. So I went back and I showed the club her photograph and said "Look, you mustn't let this person in, she's underage, she's been coming in here on a regular basis" and the doorman actually said, "Yes, I recognise her". I said, "Well you haven't been doing your age check right because she's under age."*[269]

263 [redacted] pgs 89-90
264 [redacted] pg 89
265 [redacted]
266 [redacted]
267 [redacted]
268 [redacted] pg 21
269 [redacted] pg 21

4.269 This would be effective to the extent that it prevented the child entering clubs in Telford, though an individual to whom this happened also explained:

"*So when CATE got involved the club that I was going to they told them that I was underage so it got me banned. So I decided to get out of* [Telford] *to go and party in Birmingham… This made everything ten times worse.*"[270]

4.270 I have seen another, much earlier, account of doormen and a club owner being receptive to information about children attempting to enter their clubs, accepting photographs, and turning them away thereafter - with like result[271]: equally I have read a victim/survivor account of being admitted to clubs as young as 11 years old because "*they knew me*".[272]

4.271 Overall, though, the accounts that I have heard and the material that I have read do not suggest that nightclubs were a primary venue for recruitment of children into exploitation or for sexually exploitative acts.

The Night-Time Economy and WMP

4.272 I have made reference to police action at various points during the course of this chapter – for example, an operation in 2008 apparently targeted violence around Club A.

4.273 I have considered other material to determine WMP's approach to the night-time economy and the challenges it brings to the police. Of course, many would consider that ensuring the streets are safe in town centres at night to be a core part of the police's everyday responsibilities.

4.274 I have outlined earlier in this chapter the licensing objectives contained within the Licencing Act 2003. In relation to the licencing objective of the prevention of crime and disorder, Home Office guidance issued under the Section 182 Guidance[273] makes clear that "*Licencing authorities should look to the police as the main source of advice"* on this objective.

4.275 While applications for a premises licence are issued by the licensing authority, section 13 of the Licencing Act 2003 defines the Chief Officer of Police as a responsible authority. As a responsible authority, the Section 182 Guidance indicates the police:

"… must be fully notified of applications and are entitled to make representations to the licensing authority in relation to the application for the grant, variation or review of a premises licence".[274]

4.276 Following the grant of a premises licence, the police as a responsible authority can ask that the licensing authority review the licence should there be any concerns that the licensing objectives are not being adhered to. On determining a review, the licensing authority can

[270] [redacted] pg 24
[271] pg 12
[272] pgs 7-8
[273] Revised Guidance issued under section 182 of the Licensing Act 2003 (publishing.service.gov.uk), pg 6
[274] Section 182 Guidance page, pg 49

take a number of steps, including modifying licence conditions or suspending or revoking the licence.

4.277 The Section 182 Guidance explains that:

"*… the police should take appropriate steps where the basis for the review is concerned about crime and disorder or the sexual exploitation of children*."[275]

4.278 This reference to the sexual exploitation of children appears in the most recent Section 182 Guidance, but was first introduced in revised guidance dated March 2015.

4.279 The police also have the power to apply to the licensing authority for summary review of a premises licence[276], where there are concerns of serious crime or serious disorder associated with the premises. The consequences of a summary review are that it allows for the imposition of interim measures (including licence revocation) and an expedited review process or hearing.

4.280 The Inquiry has seen evidence that WMP was alive to the need to ensure a police presence in areas that I have heard were relevant to CSE. In 2008, a Strategic Assessment noted that "*problematic streets*"[277] in named areas of Telford included a named street – which, as I note in Chapter 9: Attitudes and Impact, had for many years prior been regarded by some within WMP as a "*no-go area*"[278] for the police. Wellington centre was also noted as a priority, with the remark being made that "*the night time economy acts as a crime generator*".[279]

4.281 Later documents show that WMP was aware of the problem of under-18 year olds drinking in these establishments; in 2010, uniformed officers were tasked with visiting licensed premises to address the problem of under 18 year olds buying drink. The local policing teams were to monitor the resources allocated to the task, which I understand to mean ensuring a visible presence was maintained on the streets.[280]

4.282 I have also seen material from 2015 which shows that targeted patrols were still being made in Wellington centre on a Saturday night, largely driven by concerns about licensed premises and antisocial behaviour. Significantly though, these reports note car registration details and cross reference intelligence for briefings for subsequent patrols: I have seen such a briefing in which the association of a suspected CSE perpetrator with a particular vehicle is underlined.[281]

4.283 The minutes of the Night-Time Economy meetings, referred to earlier in this chapter, which were attended by representatives of WMP, local businesses, the Street Pastors and others, show, for example: police concern about criminal child exploitation at a particular

[275] Section 182 Guidance, pg 89
[276] Sections 53A-53D of the Licencing Act 2003
[277] [redacted] pg 49
[278] [redacted] pg 8
[279] [redacted] pg 49
[280] [redacted]
[281] [redacted]

restaurant[282]; sharing of information by the Council about forthcoming events that may require WMP presence[283]; WMP work with local businesses and town centre security around vulnerability and exploitation[284]; and WMP reporting of its monitoring of "*vehicles linked to CSE*".[285]

4.284 I have made reference in this chapter to the MATES scheme, which existed from 2017. I have seen material that showed this scheme turned its attention towards human trafficking in 2018,[286] recognising that trafficked people and potential CSE victims were often lured to the same businesses that sold illicit goods, and that accommodation linked with those businesses should be monitored. I have seen specific reference to a MATES operation where there was WMP CSE team involvement in enforcement relating to a business, as there had been, "*sporadic, low grade information around the accommodation and the potential that young females are being attracted to the premises*".[287]

4.285 Although the evidence I have seen shows a consistent approach to policing the night-time economy and problem areas in Telford, there was a change to a new shift model in 2019 which removed the "*tailored approach*" and I understand that this was not well-liked (albeit for unrelated reasons). It appears, though, that the new approach was quickly abandoned.[288] The Inquiry understands that this was to ensure that the teams could be adequately resourced and briefed.[289]

4.286 The Inquiry has heard that the current situation as to joint working between WMP and the Council, in particular, is that:

> *"The Local authority operate a day time and night time economy meeting where information and concerns are picked up, shared and problems addressed by partners including licensing professionals, pub watch's* [sic] *and local authority neighbourhood services representatives. In order that the received information can be progressed within the relevant policing departments, the HRU Sergeant and SNT Inspector attend in order to receive the information first hand.*
>
> …
>
> *Telford LPA* [Local Policing Area] *provides a weekly snapshot of all licensing visits across the Borough. Sometimes as many as 50 visits a week are conducted. This information is shared on a Monday morning and any follow up work is recorded by each department or partner agency. Joint operations are conducted with the support of the Special Constabulary. The LPA through the HRU has a rolling programme of engagement and targeted operations through the M.A.T.E.S format or their licensing stream. Hotels, Pubs,*

282 [redacted]
283 [redacted]
284 [redacted]
285 [redacted] pg 1
286 [redacted]
287 [redacted]
288 [redacted]
289 [redacted]

Clubs, Cinemas, Shopping Centres, Refuse Collectors, Street Pastors, Taxi Marshals are all partners that have been trained in identifying and reporting vulnerability including CSE."[290]

4.287 As part of the Inquiry's approach to evaluating WMP's response to the CSE threat posed by the night-time economy and the tracking of connected CSE intelligence, WMP was asked how intelligence was tracked and/or flagged on police systems. WMP told the Inquiry that no automatic flagging of addresses or individuals exists, and that the process of intelligence input and flagging is *"officer generated, based on professional judgement and usually when there is an ongoing investigation or risk of significant harm is identified".*[291] I have further examined how police intelligence is processed in Chapter 5: The Policing of CSE in Telford.

4.288 WMP explained that 'warning markers' can be manually placed on individuals through local intelligence systems, and there is also a capability to place markers on specified addresses via a different system.**[292]** It was explained that this latter system *"highlights to attending officers information of note connected to an address".*[293] I understand this system to be used in the main, to protect vulnerable people, vulnerable premises and for safety of police personnel.

4.289 A further request for disclosure was made to WMP, asking for information on how this system worked in practice and whether it had been used to place markers on the Identified Premises set out above, as well as premises known as Premises A, which I discuss in more detail in Chapter 5: The Policing of CSE in Telford. The request also covered the following bars/nightclubs which have, within the evidence, been referred to as locations used for CSE (together referred to as "Bars/Nightclubs"):

1. Club A
2. Club C
3. Club D
4. Club E
5. Venue F
6. Venue G

4.290 WMP explained how the current system of placing intelligence markers on specified addresses currently works in practice. The previous marker system was replaced by a new system in November 2020 using a "*Location Marker Application*". This new system relies on a WMP officer or staff member using the application to submit a request for the marker to be placed on a premises. A team within WMP receives the request, ensures the accuracy of the data provided and inputs it into a Location Marker Tool which links to WMP's Command and Control system. This results in a marker being shown on a WMP call handler's screen

290 [redacted] pgs 6-8
291 [redacted] pg 45
292 [redacted] pg 46
293 [redacted] pg 46

when calls come through from (or about) the premises in question (or any property within a 200m radius of it). WMP explained that:

"… if a call is received, then information will be immediately viewable on the Command and Control system, alerting officers to key risk information associated to the relevant address".[294]

4.291 WMP informed the Inquiry that the vast majority of WMP officers and staff (with the exception of administrative departments) are then able to view the incident on police systems. The Location Marker Application can also be used by officers to search for markers attached to particular premises.

4.292 WMP explained that the old system, pre-2020, relied on WMP officers or staff emailing requests for markers to be placed on premises, which was then added to the Location Marker Tool by a team within WMP in a similar way. The evidence provided to the Inquiry indicates that the OIS control room browser that managed the old system was decommissioned, after the new system using the Location Marker Application was introduced.

4.293 The Inquiry has examined WMP procedure documents that relate to both the old and new systems. In both documents, criteria are set for the consideration of markers prior to entry onto police systems. The criteria relate to the presence of intelligence or credible information/evidence of harm.[295]

4.294 In relation to the request for identification of previous intelligence markers connected to the Identified Premises, Premises A and Bars/Nightclubs, WMP told the Inquiry:

"Unfortunately we are very limited on the time period we can get the information from as OIS was decommissioned in July 2020 we are not able to get into the archive to review historic…Warnings. 7 years' worth of OIS incidents are viewable on the web browser, but the browser will only show those… Warnings that were active at the time of decommission."[296]

4.295 WMP reviewed the existing historic documentation which consisted of, first, emails requesting markers (on the old system) that could only date back to 2019 due to a two year retention policy for historic emails; and secondly, a spreadsheet that had been retained recording historic markers dating back to 2016. This spreadsheet revealed no evidence of previous relevant intelligence markers in relation to the Identified Premises, Premises A and the Bars/Nightclubs.

4.296 WMP provided a document summarising its findings, using available evidence of intelligence markers concerning the Identified Premises, Premises A and the Bars/Nightclubs from 2019 to present.[297] In relation to the Identified Premises, WMP disclosed that one premises had one relevant intelligence marker that was attached to a flat. While no date of entry was

294 [redacted] pg 3
295 [redacted]
296 [redacted] pg 1
297 [redacted]

provided, WMP confirmed that this marker would have been present on the old system prior to May 2020, when a request was made to remove it. The marker related to a female and the request to remove the marker stated:

"[Female] *is a Victim of Child Exploitation. Attending officers to be mindful of Risk Management Plan & Intelligence Opportunities if they come into contact. Female to be spoken to alone".*[298]

4.297 WMP disclosed that there are no recorded markers relevant to CSE in relation to any of the Bars/Nightclubs or Premises A.

4.298 WMP was also asked (in respect of all the same premises) whether warrants had been executed that related to CSE or linked offending. In summary, the Inquiry was told that there was no process within WMP force systems that could collect this information in a way that could provide an accurate record, as the police intelligence system used does not allow searching against warrants executed at a specific address.[299] Notwithstanding this, other criteria were used[300] which, whilst limited in accuracy, revealed that several warrants had been executed. The information did not confirm whether the warrants related to CSE, but at least one warrant was confirmed to have been executed on Premises A as part of Operation Chalice in 2009.[301]

4.299 Due to the limitations of records held by WMP, it is not possible for me to make any accurate conclusions as to whether intelligence marker systems and/or police powers to enter/search premises were being properly utilised by WMP in respect of night-time economy premises.

Conclusions – The Night-Time Economy

4.300 Those at the Council responsible for monitoring the night-time economy appear to be highly committed and diligent in their work, using pester power when the regulatory regime does not support them. To their credit, I can see that the Licensing Team and CATE cooperated to protect named children in clubs.

4.301 The evidence I have heard about 'under 18s' events tends to suggest that these were well managed and I have not heard of exploitation at such an event. Nevertheless they were regarded with suspicion in certain quarters, particularly by the Street Pastors, and in any event did not survive the culling of the Youth Service in 2016. I accept the evidence that the involvement of the Youth Service in these events and in other, perhaps less controversial, activities was a positive response and that it is regrettable that there is now no equivalent provision, leading to an increase in unsupervised gatherings of young people and public drinking. Those who wish to exploit children will certainly be drawn to such informal, unsupervised gatherings.

[298] [redacted] pg 3
[299] [redacted] pg 1
[300] Individuals linked to the address, recorded crimes against the address, intelligence reports linked to the address and organisations linked to the address.
[301] [redacted] pgs 2-4

4.302 That, of course, makes police response more important.

4.303 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. Tasking material – i.e. documentation and meetings used by WMP to allocate resource or focus to a particular issue - shows that there were efforts to address children buying alcohol. By 2015, WMP's approach was not only designed to disrupt by presence, but also to gather intelligence, and I have seen material which shows that officers were briefed as to current CSE suspects and their vehicles.[302]

4.304 The Taxi Marshal and Street Pastors schemes were both, in my view, exceedingly valuable; the latter and its members deserve particular credit as a voluntary organisation. Having considered the evidence, however, I do not consider that WMP was either dismissive of, or careless with, information generated by the Street Pastors, as has been suggested, and I accept the evidence that WMP worked to filter the mass of information it received for useful intelligence. Although Street Pastors material was also passed to the Council, I have seen no evidence as to what use, if any, it was put.

4.305 I have seen evidence of children being exploited having attended adult events in nightclubs, and although I have also read that historically children were allowed into clubs without challenge, it is reassuring that door staff appear now to heed warnings from the Council's Licensing Team about vulnerable children. The cooperation between Licensing and CATE that makes door staff aware of high risk individuals is plainly useful and should not be discounted simply because it has in the past led to children going further afield.

4.306 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, given the requirement for a premises to be undertaking a licensable activity before the Council can take an enforcement role. Nonetheless, where a premises is undertaking a licensable activity, the Council must have regard to its mandatory licensing objective; the protection of children from harm.

4.307 The Inquiry made targeted requests for information about the Identified Premises given that it had seen evidence that such locations had been associated with CSE. Although some of the premises were not known to the Council, the Council did hold some information about six of the premises, suggesting therefore that they were undertaking a licensable activity. As a result, I am surprised, given the number of these reports and the extent to which the names of certain establishments feature in papers relating to victim/survivors of CSE, that the Council does not hold files on them and the police evidence does not suggest (as far as it was able to do so) that they were targeted areas of concern. In light of the protection of children from harm licensing objective, I regard this as evidence of a failure in scrutiny and potentially in information sharing within and by each organisation.

4.308 More positively, I have seen evidence of longstanding cooperation between WMP and the Council on licensing matters; this appears to have been reinforced with the MATES scheme

302 [redacted]

and I welcome the widened focus of enforcement operations since: for example, the recognition that when a shop is the target of enforcement, associated accommodation should routinely be investigated given the potential for use in human trafficking or CSE, and specialist CSE team officers involved.

4.309 Further, 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 that training – however delivered - must be an ongoing process and not a 'one off' event.

4.310 The recommendations I seek to make in the Recommendations section at the beginning of this Report seek to enhance further the improvements that I have referred to above; to continue initiatives that I believe have shown some success; and to encourage authorities to continue to work together to ensure that CSE remains on the radar of those involved in the Telford night-time economy.

Victim/Survivor Voice

"There'd be girls going into the bedrooms having sex, whether they were forced I don't know, but I know mine was. Food, everything you'd expect at a house party. Started off in the front room laughing, joking, girls dancing, alcohol flowing, so it's that whole get the girls guard down, or the lads because this could happen to lads… get their guard down, get them drunk so they don't know what they're doing, what they're saying then they'd go off into the bedroom.

…

And it's not just big rings of people, it can be little groups. It doesn't have to be this whole sexual circle of more than one person or it's got to be six people. It can be one or it could be any other number of people. And it can happen, in flats, houses, restaurants… if they get them early enough, the victims, if they can get them early enough and get their, really into their heads and have a strong pull then that victim is probably lost forever."[1]

1 [redacted] pg 12, pg 25

Chapter 5: The Policing of CSE in Telford

Contents

5. The Policing of CSE in Telford

Introduction

5.1 Telford is policed by West Mercia Police ("WMP"), which came into being in October 1967 upon the merger of Worcestershire, Worcester City, Herefordshire and Shropshire constabularies.

5.2 This chapter is lengthy. I have already set out a distilled version within the Executive Summary, which does not need repeating here, and the contents should also assist readers in navigating this chapter. As can be seen, I seek to address in this chapter the policing of CSE in Telford, as led by WMP, throughout the key periods of my Terms of Reference. There is a dedicated section, as one would expect, to Operation Chalice ("Chalice"), however I also deal with what I believe to be a crucial phase of early intelligence gathering around CSE, during the late 1990s and early 2000s, as well as how certain CSE investigations were handled post-Chalice.

5.3 As with Chapter 3: The Council Response to CSE in Telford, there are also a number of scene-setting sections, which are included so that readers may understand the background to, and the context within which WMP has operated over the years, as one of 43 national police forces. For example, I have set out the relevant guidance, legislation and offences relating to child sexual offences over the years at the beginning of this chapter, and I have also sought to explain the national, regional and local approaches to intelligence gathering, insofar as I have considered this to be relevant to the collation of intelligence around the issue of CSE. Against this background, I have been able to assess WMP's own policies, procedures and training, insofar as these relate to child sexual offences and exploitation, and I have also considered relevant independent inspections and reviews of WMP's performance in this regard.

5.4 I also deal with what I consider to be standalone issues relating to missing persons; the use of civil orders in respect of perpetrators; and complaints against WMP – including questions I have seen raised around issues such as corruption and racial bias.

5.5 Importantly, I have considered the way in which WMP has sought to interact with other agencies – most notably Telford & Wrekin Council (the "Council"), in a section dealing with 'Multi-Agency Working'. As I have already noted in Chapter 1: Background to the Inquiry and Chapter 3: The Council Response to CSE in Telford, it is important to remember that the Council did not exist until 1 April 1998. References to the Council within this chapter before that date therefore refer to the actions of Shropshire County Council. Also for the purposes of this chapter, and indeed elsewhere in this Report, I refer to the Council's social work child protection response as 'Safeguarding'.

5.6 This chapter should be read, in my view, alongside the following chapter, Chapter 6: Other Organisations, which provides further context surrounding the state of national policing and the role of national policing organisations, and the approach taken to the prosecution of CSE by the CPS, for example. It is also important to consider, in addition to this chapter,

the Case Studies set out in Chapter 8, which include further commentary on WMP's approach to the policing of those specific cases.

5.7 I have been assisted in this chapter by the Inquiry's Policing Expert, Andre Baker, who has been able to guide me in understanding the national approach to CSE investigations specifically, and to the policing of major investigations such as Chalice, and I feel it important to state upfront that I have not seen any evidence which leads me to conclude that WMP's approach to the policing of CSE in Telford over the years has been either ahead or behind that of other forces nationally.

5.8 To assist in the review of this lengthy chapter, I have included at Appendix H a master chronology setting out what I consider to be a key timeline of events in relation to the policing of CSE in Telford. I am also conscious that this chapter is heavy with acronyms – some are ordinary police usage, some are mine; all are used for the sake of clarity, but I encourage readers to have the Glossary to hand.

Legislative Framework and Guidance

5.9 In addressing the approach taken by WMP to the policing of CSE, it is necessary to consider the legislative framework of offences within which police forces nationally have worked over the years. This section sets out, in overview, how the law has changed with reference to relevant sexual offences against children.

5.10 I have also 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.

5.11 This section is not intended to be an exhaustive list of all applicable legislation over the timeline of this Inquiry; instead, I have set out an overarching legislative chronology at Appendix I in order to show the overall genesis of the legislative framework surrounding CSE and safeguarding.

The Criminal Law: Sexual Offences Against Children

5.12 The legislative framework applicable to sexual offences against children in England and Wales changed significantly when the Sexual Offences Act 2003 (the "2003 Act") came into force on 1 May 2004.[1] The 2003 Act remains today the primary legislation covering sexual offences against children. 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").

[1] Sexual Offences Act 2003 (Commencement) Order 2004 (SI 2004/874)

The 1956 Act and Other Statutes Pre-2003

5.13 As this Inquiry's Terms of Reference pre-date the 2003 Act it is necessary to consider the offences available to the police for investigation prior to its enactment.

5.14 The 1956 Act came into force on 1 January 1957. Due to the period of time the legislation was in force and the lack of retrospective effect of the 2003 Act, relevant criminal offences reported to have been committed between 1 January 1957 and 1 May 2003 will nevertheless still be charged by way of offences committed under the 1956 Act, as the governing legislation in place at the time of the offence.

5.15 The 1956 Act created the following sexual offences relevant to CSE:

5.15.1 Section 1 – Rape. The statute as originally drafted says merely *"it is a felony for a man to rape a woman";* the requirement for lack of consent was understood. In 1994, the provision was amended to spell out that a man would be guilty of rape if he knew the victim did not consent or he was reckless as to consent.[2] There was no statutory definition of consent. Originally rape required vaginal penetration; the definition was expanded to include anal rape, and rape of men, in 1994. Rape is punishable by a maximum sentence of life imprisonment.

5.15.2 Section 5 - Intercourse with a girl under the age of 13. This offence was complete upon proof of intercourse. It was punishable by a maximum sentence of life imprisonment.

5.15.3 Section 6 – Intercourse with a girl between the age of 13 and 16. A statutory defence was available where an accused man under the age of 24 and not previously charged with this offence had reasonable cause for a belief that the girl was 16 or over. The maximum sentence on conviction for this offence was two years imprisonment.

5.15.4 Section 14 – Indecent Assault upon a female. Notably, a child under 16 cannot give any consent which would prevent an act being an assault for the purposes of this section. In this way, on an acquittal for rape of a child under 16, consent having been the defence, it was open to a jury to convict of indecent assault.

5.15.5 Section 19 – Abduction of an unmarried girl under 18 out of the possession of their parent or guardian against the parent or guardian's will for the purposes of sexual intercourse with men or a particular man. A statutory defence was available if an accused had reasonable cause to believe the girl to be aged over 18.

5.15.6 Section 20 – Abduction of an unmarried girl under 16 out of the possession of their parent or guardian against the parent or guardian's will.

[2] Section 142 of the Criminal Justice and Public Order Act 1994

5.15.7 Section 25 – Permitting a girl under 13 to be on premises for the purpose of sexual intercourse with men or a particular man; an offence committed by the owner or occupier of a premises.

5.15.8 Section 26 – Permitting a girl between the age of 13 and 16 to be on premises for the purpose of sexual intercourse; an offence committed by the owner or occupier of a premises or a person who has acted in or assisted in the management of those premises.

5.15.9 Section 28 – Causing or encouraging the prostitution of, or the commission of unlawful sexual intercourse with, or indecent assault upon, a girl aged under 16 for whom he is responsible; responsibility being conferred by parenthood, guardianship, or other custody and control.

5.16 In addition to the 1956 Act, section 1 of the 1960 Act created the offence of gross indecency towards a child aged under 14. This legislation was in force between 2 July 1960 and 30 April 2004, and was introduced because the 1956 Act did not create a criminal offence that covered a situation where the accused invited a child to touch them in a sexual manner or committed a sexual act in the presence of a child for their own gratification. The maximum sentence for this offence was originally two years imprisonment, until 1 October 1997 when the maximum sentence was increased to ten years imprisonment. From 11 January 2001 an amendment to the 1960 Act extended the offence to children under 16.

5.17 Under the pre-2003 Act regime, there was no offence of child sexual exploitation. Sexual intercourse between female children and adult men could be indicted in a number of ways on the basis of the offences set out above; for example, as rape (to which consent – or belief in it - was a defence); as indecent assault or unlawful sexual intercourse (to which it was not).

5.18 The 1956 Act reflected its time. None of its provisions were apt to deal with the problems of grooming, trafficking and gang activity about which I have heard during the course of this Inquiry; and there is no doubt that for the vast majority of the currency of the 1956 Act, the maximum sentence for some sexual offences against children remained, by modern standards, shockingly low.

Early Guidance

5.19 In terms of guidance on the investigation of child sexual offences available at this time, pre-2003, I have examined Home Office Circular 52/1988[3] entitled '*The Investigation of Child Sexual Abuse*' which was published in response to growing public concern about *"child sexual abuse* [and] *the need to take effective action to safeguard the welfare of victims".*[4] The circular aimed to provide guidance to the police on the procedures to be adopted in child sexual abuse investigations and included the following:

[3] [redacted] HO 52/1988
[4] HO 52/1988, pg 1

5.19.1 The police are directed to establish a joint investigation with their local social services department. The circular notes that:

"[In] *exceptional cases, urgent action may be needed before the appointment of the joint team. Where unilateral action is desirable, this should be taken only as far as is necessary to protect the child, to preserve evidence (for care or criminal proceedings), or to prevent the escape of the suspect. As soon as possible contact should be made with the other investigator to review the action that has been taken and to enable the investigation to proceed from then on a joint basis".*[5]

5.19.2 Training will help equip professionals with knowledge of *"important professional and personal issues"*[6] raised by child sexual abuse. The circular also alluded to the possibility of joint training arrangements for police and social services to mutually consider the issues they may face in joint investigations; the treatment of victims/survivors; and any personal issues which may arise for investigators, when working with sexually abused children and their families, as well as developing an understanding of each other's role and functions. The circular makes clear that:

"… the training should pay particular attention to the development of interviewing skills and an understanding of the child's behaviour and response to the experience of the interview. Training should also sensitively address the personal issues for investigators that can surface when working with sexually abused children and their families".[7]

5.19.3 Instances of child sexual abuse may not be allegations *"in the normal sense as children will rarely make a formal claim of abuse"*.[8] It stated that cases, referred by others, should be regarded as allegations or potential allegations of abuse. In cases where there is no allegation or complaint but a suspicion of sexual abuse due to *"minor behavioural manifestations or inconclusive physical findings",* the guidance required a multi-disciplinary assessment followed by an investigation into the criminal offence. It is important to note that this advice not to seek traditional evidence but to rely on indicators was made in the late 1980s.

5.19.4 Interviews are required with the source of the referral, the victim/survivor and members of his or her family. These should be led by *"whichever officer is felt to be best qualified in the circumstances".*[9] Information is to be shared *"fully"* by both agencies in order to reach an agreed view on how to proceed.

[5] [redacted] HO 52/1988, pg 4
[6] HO 52/1988, pg 7
[7] HO 52/1988, pg 8
[8] HO 52/1988, pg 3
[9] HO 52/1988, pg 4

5.19.5 Video recording may be used where authority has been obtained from a parent or guardian, in order to reduce the stress caused to victims/survivors from repeated questions.

5.19.6 Police should aim to provide the victim/survivor with *"reassuring, therapeutic surroundings, where medical and, wherever possible, child psychiatric assistance is close to hand".*[10] It is unlikely that a police station or victim/survivor's family home will prove suitable.

5.20 Whilst the guidance in this circular does not relate directly to CSE, the approach to child witnesses and the investigation of a sexual complaint by a child are relevant to this Inquiry. This guidance is plainly of assistance in understanding the framework within which complaints, referrals or suspicions of CSE should have been dealt with by the police prior to the 2003 Act.

5.21 Later in this chapter I set out in further detail my views upon the approach taken by WMP during this time period, and the policies and procedures in place within the force to address complaints of child sexual offences. I also consider specific cases reported to WMP prior to the 2003 Act, and the action taken in those cases in a section below entitled 'Early Intelligence Regarding CSE'.

The 2003 Act

5.22 The 2003 Act marked a significant development in the legislative framework for sexual offences against children. Much of the 1956 Act was repealed, though the historic offences remained in place for allegations made prior to the 2003 Act.

5.23 The 2003 Act created a wide range of distinct criminal offences against children depending on their age and their ability to consent to sexual activity, and applied those offences to conduct irrespective of the child's gender.

5.24 The 2003 Act created the following sexual offences relevant to CSE:

5.24.1 Section 1: Rape – the 2003 Act redefined rape and addressed consent questions afresh. Rape was redefined to include penile penetration of mouth as well as vagina and anus. The offence requires proof of lack of consent on the part of the victim, but consent is for the first time statutorily defined; and while belief in consent was still a defence, that belief had to be 'reasonable'. The definition of consent does not state that children under 16 cannot consent.

5.24.2 Section 5: Rape of a child under 13 – although terminology had changed, this was directly comparable with section 5 under the 1956 Act: the offence is complete upon proof of intercourse: consent is no defence. The new offence was, like its predecessor, punishable by a maximum sentence of life imprisonment.

[10] [redacted] HO 52/1988, pg 8

5.24.3 Section 6: Assault of a child under 13 by penetration - the offence is complete upon proof of penetration and lack of consent does not have to be proved. Maximum sentence life imprisonment.

5.24.4 Section 7: Sexual assault of a child under 13 – the offence is complete upon proof of sexual assault and lack of consent does not have to be proved. Maximum sentence 14 years imprisonment.

5.24.5 Section 8: Causing or inciting a child under 13 to engage in sexual activity – the offence is complete upon proof of causing or inciting relevant conduct and lack of consent does not have to be proved. Maximum sentence 14 years imprisonment.

5.24.6 Section 9: Sexual activity with a child – this offence effectively replaced the offence of indecent assault. Like its predecessor, consent was irrelevant, but reasonable belief in the child being aged 16 or over is a defence. The maximum sentence was 14 years imprisonment.

5.24.7 Sections 10, 11, and 12: Causing or inciting a child to engage in sexual activity, engaging in sexual activity in the presence of a child and causing a child to watch a sexual act – these offences broadly cover the factual situations previously addressed by the 1960 Act, with the belief in age defence as seen in section 9 (above). Consent is no defence. Maximum sentence 14 years imprisonment.

5.24.8 Sections 14 and 15: Arranging and facilitating a child sex offence and meeting a child following sexual grooming - these were entirely new offences covering situations which were not wholly addressed by the predecessor legislation. Maximum sentence 14 years imprisonment.

5.25 It is important to note that a number of the above offences were successfully used in the prosecutions linked to Chalice, the first significant CSE investigation led by WMP into CSE in Telford, which I discuss in detail later in this chapter.

5.26 Sections 47 to 50 of the 2003 Act introduced criminal offences designed specifically to address the sexual exploitation of children, though the term was not originally used in the context of these offences. While the 2003 Act refers to sexual exploitation in the context of trafficking, it defines exploitation by reference to other offences it created.

5.27 The new child sexual offences were:

5.27.1 Section 47: Paying for sexual services of a child.

5.27.2 Section 48: Causing or inciting child prostitution or pornography.

5.27.3 Section 49: Controlling a child prostitute or a child involved in pornography.

5.27.4 Section 50: Arranging or facilitating child prostitution or pornography.

5.28 None of these offences attracted a consent defence; so far as children between 13 and 16 are concerned, a defendant could plead a reasonable belief that the child was aged 16 or over.

5.29 Following a revision in 2015[11] the language of 'child prostitution' and 'child pornography' was removed from the 2003 Act. For the first time a statutory definition of sexual exploitation was introduced, as follows:

"(2) …a person (B) is sexually exploited if—

(a) on at least one occasion and whether or not compelled to do so, B offers or provides sexual services to another person in return for payment or a promise of payment to B or a third person, or

(b) an indecent image of B is recorded or streamed or otherwise transmitted; and "sexual exploitation" is to be interpreted accordingly.

(3) In subsection (2), "payment" means any financial advantage, including the discharge of an obligation to pay or the provision of goods or services (including sexual services) gratuitously or at a discount".

5.30 Words matter; in my view the change in terminology showed recognition that children could not choose to be prostitutes or choose to become involved in 'pornography', a term suggestive of participant consent.

5.31 The 2003 Act was also responsible for introducing trafficking offences applicable to victims of CSE.[12] A criminal offence of trafficking any person into, within or out of the UK for the purposes of sexual exploitation was created.

5.32 As with earlier offences noted above, I have seen that some of these new exploitation and trafficking offences were successfully used in the prosecutions linked to Chalice, and that the conduct exhibited by that offending would not have sat naturally with the range of offences available under predecessor legislation.

5.33 On 3 April 2017, the 2015 Serious Crime Act introduced the offence of sexual communication with a child into the 2003 Act, criminalising sexual communications or communications intended to "*encourage*" such communication.[13] The Inquiry has heard how children have increasingly been groomed by perpetrators using gifted mobile devices as well as social media platforms.

Modern Slavery Offences

5.34 On 31 July 2015, the trafficking offences set out in the 2003 Act were repealed and replaced by offences under the Modern Slavery Act 2015. For an offence to be committed under

[11] Section 68 of the Serious Crime Act 2015
[12] Sections 57-59 of the Sexual Offences Act 2003
[13] Section 15A of the Sexual Offences Act 2003

section 2, it is irrelevant whether the victim consented to travel and the exploitation required does not have to be sexual. The introduction of this legislation sought to acknowledge the prevalence of the many different forms of human trafficking and exploitation offences.

CPS Guidance

5.35 The current CPS guidance on Rape and Sexual Offences (last updated May 2021) comments on the possible circumstances of child sexual exploitation as follows:

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

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

'Grooming' is not a specific form of child sexual exploitation but should be seen as a way in which perpetrators target children and manipulate their environments. It is an approach to exploitation and may be the beginning of a complex process adopted by abusers. Grooming can be defined as developing the trust of a young person or his or her family in order to engage in illegal sexual activity or for others to engage in illegal sexual activity with that child or young person".[14]

5.36 I comment on this and other specific CPS guidance in more detail in Chapter 6: Other Organisations.

The Criminal Law: Child Victims of CSE Treated as Offenders

The Street Offences Act 1959

5.37 The Street Offences Act 1959 (the "1959 Act") came into force on 16 July 1959 and created the criminal offence of loitering or soliciting for the purposes of prostitution ('prostitution' itself not being an offence). There have been various amendments to the 1959 Act over the years, but it remains in force today criminalising *"loitering or soliciting in a street or public place for the purposes of prostitution".*[15] At this time it was possible for a child who had attained the age of criminal responsibility - just eight years old from 1933[16] and ten

[14] [redacted] pg 74-75
[15] Section 1(1) of the Street Offences Act 1959
[16] Section 50 of the Children and Young Persons Act 1933

years old from 1963[17] - to be convicted under this provision. The maximum penalty for an offence under this statute was and remains a financial penalty.

5.38 I have seen a considerable volume of material, including official guidance, demonstrating that for a long period of time child victims of CSE were labelled 'prostitutes' by the authorities, certainly during the 1990s and early 2000s. The evidence demonstrates that behaviour connected to CSE was seen as a 'lifestyle choice', and, given the provisions of the 1959 Act, one which was criminalised. The labelling and perception of CSE as 'prostitution' suggests victims of CSE were, by some at least, viewed as criminals, or engaging in criminal activity at will, by the relevant authorities.

5.39 By way of an example of such official use of the term, Home Office Circular 108/1959[18] outlines the 1959 Act and explains that the motivation for this legislation is to tackle prostitution and *"divert from prostitution women, and particularly girls, who are taken to that way of life".*[19] The circular also explains a system of cautioning and referral to a *"moral welfare organisation"* up until the suspected commission of a third loitering offence, which would then lead to arrest and potential prosecution (known as the 'three strikes' approach). In this circular, the Secretary of State expresses a belief that the number of people likely to be diverted from prostitution may be small and *"many prostitutes take to that way of life from choice".*[20] Nevertheless, the Secretary of State expressed the belief that *"no opportunity should be neglected of putting girls and young women who are in danger of drifting into prostitution in touch with a social welfare agency which may be able to persuade them to take up regular employment or to go home to their parents".*[21]

5.40 The wording and remarks in this circular are of course, now, very outdated, but indicate official recognition of the view that children could become engaged in 'prostitution' by 'choice', rather than as vulnerable victims of sexual exploitation.

5.41 It is sobering to reflect that it was not until 2015 that the 1959 Act was changed so as to provide that the criminal offence of loitering/soliciting could only be committed by a person over the age of 18. The current CPS guidance demonstrates the change in attitude towards children exploited in this way:

"The young people concerned, whether boys or girls are likely to be extremely vulnerable and present complex emotional problems. When dealing with young people involved in this activity police should remove them to a place of safety.

The sexual exploitation of children for payment should be prosecuted under sections 47-50 of the Sexual Offences Act 2003, which covers the prosecution of those who coerce, exploit and abuse children through prostitution.

When reviewing a case involving exploitation of children it is essential that prosecutors are aware of and familiar with the inter-agency guidance entitled "Safeguarding Children and

[17] Children and Young Person's Act 1963
[18] [redacted]
[19] [redacted] HO 108/59, pg 1
[20] HO 108/59, pg 2
[21] [redacted] HO 108/59, pg 2

Young people from Sexual exploitation". The aim of this guidance is to both safeguard and promote the welfare of children, and to encourage the investigation and prosecution of criminal activities by those who coerce, exploit and abuse children".[22]

Safeguarding Children Involved in Prostitution: Supplementary Guidance to Working Together to Safeguard Children – 2000 (the "2000 Supplementary Guidance")[23]

5.42 The 2000 Supplementary Guidance published by the Department of Health begins with a foreword referring to involvement in 'prostitution' as a *"tragedy"* and that children involved in 'prostitution' should be treated as *"victims of abuse".*[24] The guidance aims to enable police, health, social services, education and all other agencies and professionals to work together to:

5.42.1 Recognise the problem;

5.42.2 Treat the child primarily as a victim of abuse;

5.42.3 Safeguard children and promote their welfare;

5.42.4 Prevent abuse and provide children with opportunities and strategies to exit from 'prostitution'; and

5.42.5 Investigate and prosecute those who coerce, exploit and abuse children through 'prostitution'.

5.43 The 2000 Supplementary Guidance acknowledges that there is no single pattern of how children are drawn into 'prostitution' and aimed to clarify the nature of the problem. It states that *"a child involved in prostitution cannot be considered to be a miniature adult, capable of making the same informed decisions as an adult can about entering and remaining in prostitution".*[25] It makes clear that children should be treated as children in need *"who may be suffering, or may be likely to suffer, significant harm"*.[26]

5.44 In terms of the legislative framework and approach of law enforcement agencies, the 2000 Supplementary Guidance indicates that the primary law enforcement effort must be against perpetrators and coercers who break the law and who should be called to account for their abusive behaviour. It does not recommend the decriminalisation of street prostitution, however, as this would risk *"creating a perverse incentive to encourage children into prostitution, and could encourage coercers and abusers… to concentrate on drawing children into it"*.[27]

5.45 This guidance highlights section 65 of the Crime and Disorder Act 1998 which prevented a 'prostitute's caution' being issued to a female under the age of 18. There is also the

22 [redacted] pg 107-108
23
24 pg 6
25 pg 12
26 pg 12
27 pg 13

clarification that police should *"not normally proceed with criminal justice action without prior inter-agency discussion to consider the young person's needs and circumstances".*[28]

5.46 Importantly, the focus of the 2000 Supplementary Guidance was on diversion - using a welfare-based approach to children that should be adopted in all cases. The initial presumption was that a child does not solicit voluntarily, and a persistent and 'voluntary' return to soliciting should never be taken at face value. It goes on to clarify that *"the criminal justice process should only be considered if the child persistently and voluntarily continues to solicit, loiter or importune in a public place for the purposes of prostitution".*[29] Agencies were advised to ensure their recording of incidents was *"meticulous"* to assist criminal action against perpetrators of CSE and help reduce the burden on child victims/ survivors when providing evidence.

Policing Prostitution: Association of Chief Police Officers' ("ACPO") Policy, Strategy and Operational Guidelines for dealing with exploitation and abuse through prostitution – 2004 (the "2004 ACPO Policy")[30]

5.47 The Inquiry heard from a police officer[31] operational at the time the 2004 ACPO Policy was introduced. He recalled ACPO publishing earlier guidance to all forces following pilot studies in the late 1990s in Nottingham and Wolverhampton concerning policing and prostitution. This earlier guidance recognised a number of key issues that needed to be addressed, including:[32]

5.47.1 Children up to the age of 16 should be treated as likely to suffer "*significant harm*" within the meaning of the Children Act 1989;

5.47.2 The police should <u>not</u> caution children as 'common prostitutes' but remove them to a place of safety;

5.47.3 ACPCs (Area Child Protection Committees) should have an action plan;

5.47.4 The police should investigate and identify those who have exploited the child;

5.47.5 The need to address safety and looking long term;

5.47.6 The need to prevent the prosecution of children for soliciting unless persistent;

5.47.7 The need to deal with children as victims and adopt appropriate terminology; and

5.47.8 The requirement for all forces to set strategies in dealing with children involved in 'prostitution'.

28 [redacted] pg 17
29 pg 31
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32 pg 11

5.48 The 2004 ACPO Policy comments that previous "*ACPO guidelines and joint circulars on child abuse through 'prostitution' have resulted in the effective elimination of prosecution for children under the age of 18*".[33] This policy produced Home Office data which showed that 296 females under the age of 18 were cautioned for 'prostitution' in 1993, compared with 11 in 2002.[34] The data did not specify the prosecution figures for females. In relation to males under the age of 18, there was only one caution for 'prostitution' and five prosecutions in 1997, compared with one caution and zero prosecutions in 2002.[35]

5.49 In relation to children and sexual exploitation the policy stated:

"In many cases, prostitution starts with offences being committed against children. The number of children involved in prostitution is unknown, but Operation Ore has demonstrated the significant level of criminal activity against children worldwide. Sexual abuse of children alters their value judgements, damages their self-esteem makes them vulnerable to exploitation, and has the potential for repercussions in adult life and a route into prostitution.

Self-esteem can also be lost through chaotic parenting, emotional blackmail, involvement in domestic violence and/or drug usage, leading to increased vulnerability to exploitation. Exploitation often has its roots in these social problems; this is an area where proactive investigation and action may have the most beneficial, preventative and long-term effects".[36]

5.50 I deal with prevalence of offending in Chapter 2: the Nature, Patterns and Prevalence of CSE, and with consequences in Chapter 9: Attitudes and Impact.

5.51 I have seen further (and broader) ACPO guidance on '*Investigating Child Abuse and Safeguarding Children*' from 2005[37], which reiterates the expected position that children involved in 'prostitution' should be treated as victims, and those who exploit them as offenders. The guidance sets out what is expected of police officers:

"Children involved in prostitution and other forms of commercial sexual exploitation should be seen primarily as the victims of abuse. The principal law enforcement effort should be against abusers and those who coerce children into prostitution and other forms of sexual exploitation. Officers should recognise situations in which children are being sexually exploited or are at risk of sexual exploitation. Such situations may become apparent to officers carrying out unrelated investigations or executing search warrants for other matters, for example, drugs. Research shows that children abused by prostitution or sexual exploitation are often hidden from public view. Where such a child is discovered through other police operations, measures should be taken to protect the child. A notification should be made to the CAIU and every effort should be made to preserve evidence which could lead to a prosecution for offences linked to abusing children. Any such child should be

33 [redacted] pg 29
34 pg 12
35 pg 12 and pg 13
36 pg 29
37

treated as a child in need or a child who may be suffering or is likely to suffer significant harm".[38]

5.52 I have also reviewed the second edition of this guidance published in 2009, which reiterates these sentiments.[39]

Conclusions – Legislation and Guidance

5.53 At the time of the parliamentary debate about what would become the 2003 Act, the Home Secretary said:

"*Until now our sex offences laws were based on the Victorian era – their values and the world they lived in. Change was needed to reflect the values of today's society and offer protection against crimes which did not exist generations ago*".[40]

5.54 The White Paper 'Protecting the Public'[41] expanded upon the then proposed new provisions:

"*There may be circumstances where sexual activity takes place with the ostensible consent of both parties but where one of the parties is in such a great position of power over the other that the sexual activity is wrong and should come within the realms of the criminal law*".

5.55 Although the 2003 Act did not use the term 'child sexual exploitation' (or not for a decade), CSE was plainly one of its targets. Its utility and success is demonstrated by the results in the Chalice prosecutions. There is no doubt that under the previous statutory regime, CSE offences were more difficult to prosecute and that the sentencing powers in respect of some offences were shockingly inadequate. Of course, the previous regime still applies to historic offences committed before the commencement of the 2003 Act.

5.56 As to children criminalised for being exploited by 'prostitution', it is clear to me that from the early 2000s there were limited circumstances that should have led to police taking any action against children for offences under the 1959 Act. I have seen within the evidence indications of occasions in the 1990s and early 2000s when WMP considered taking such action, one example relating to a vulnerable child who kept running away to Wolverhampton. The view expressed by an officer at a strategy meeting was as follows:

"If [the child] *is prostituting herself in Wolverhampton would it be beneficial to obtain a Caution of Prostitution through Wolverhampton Police, as this would empower* [the child] *to make a statement re* [the perpetrator]. *There are many suspicions surrounding* [the perpetrator] *but a lack of evidence".*[42]

[38] [redacted] pg 17
[39] [redacted]
[40] https://www.theguardian.com/commentisfree/libertycentral/2009/jun/01/sexual-offences-act-2003
[41] https://webarchive.nationalarchives.gov.uk/ukgwa/20131205100653/http:/www.archive2.official-documents.co.uk/document/cm56/5668/5668.pdf
[42] [redacted] pg 23

5.57 I view this as being considered in a thoughtful way, as a method of engaging with the victim/survivor to encourage complaint rather than primarily as a punishment. Nevertheless, the stigma of a caution would remain. I saw similar action considered during Chalice, in relation to one victim/survivor who was felt to be so heavily ingrained in CSE, after an "*unprecedented*" over 100 missing episodes in the space of a year, that again, it was a last resort method to try to disrupt the activity rather than criminalise it.[43] It is in fact not clear that in either case arrests were made or that cautions followed; and it is plain from the material I have seen that this course was being considered with great care and as a last resort.

5.58 The evidence does not enable me to conclude whether the 2003 Act reflected the changes in society that also led to police officers no longer standing for exploitation, or whether it was a progressive Act which spurred those officers to action. I suspect that the reality is less binary. What is clear in my view is that the current statutory regime provides more effective tools against CSE and that those tools have been sensibly used by WMP.

Force Structure and Constitution

5.59 In order to understand the way in which CSE has been dealt with by WMP over the period relevant to the Inquiry's Terms of Reference, it is first necessary to understand the structure of the force, how this changed over time, and which departments have been responsible for investigating child sexual offences.

Divisional Structure

5.60 The Inquiry was told[44] that from 1989 to 1991 WMP comprised six divisions: Kidderminster, Redditch, Worcester, Hereford, Shrewsbury and Telford; each headed by a Chief Superintendent who reported to a Chief Superintendent based at WMP Headquarters in Hindlip, Worcestershire.

5.61 In April 1991, the six divisions were re-organised into nine sub-divisions: Wellington, Shrewsbury, Malinsgate, Leominster, Hereford, Kidderminster, Bromsgrove, Worcester and Redditch; each headed by a Superintendent. These subdivisions became the primary operational policing units with Superintendents having local control of day to day policing.

5.62 The divisional structure within WMP changed in 2005 and was replaced by five Basic Command Units ("BCUs") covering Herefordshire, North Worcestershire, South Worcestershire, Telford & Wrekin and Shropshire. Each was commanded by a Chief Superintendent. WMP noted "*the Force operated in a devolved regime to allow local policing solutions for local policing problems*".[45]

43 [redacted]
44 [redacted]
45 [redacted]

5.63 In 2010, the BCUs were replaced by Territorial Policing Units ("TPUs") each, again, reporting to a Chief Superintendent, and vulnerable people were dealt with by the public protection/ protecting vulnerable people units.

5.64 In June 2011, it was announced that the West Mercia and Warwickshire forces would operate in alliance (the "Alliance"). WMP explained that:

"*… one of the prime catalysts for the forming of the Alliance was the necessity for the two Forces to reduce their combined costs by over £30 million pounds in line with the Government's Comprehensive Spending Review*".[46]

5.65 WMP alone needed to reduce its operating costs by over £20 million by 2015/16.

5.66 A single organisational structure was developed for officers below the rank of Deputy Chief Constable, and the Alliance formally began operating on 1 November 2011.

5.67 However, in October 2018 WMP indicated that it would withdraw from the Alliance. The Inquiry heard witness evidence that the "*benefits dried up for West Mercia*".[47]

5.68 A senior officer reflected on the Alliance years:

"*When we agreed to go into the alliance, we worked very closely and I think they could very much see the benefits and the efficiencies of it. They put a lot of time and effort into culture which was the right thing to do to get people to see themselves as working in an alliance, and it takes a long time, but if you need detectives from Leamington to come to Telford because you've got something, then that should happen, and we worked hard and we got there, and the frustration was then that it started to splinter at the most senior levels of the organisation… It should have been one force that was always the issue. Very difficult to try and run as a single force but with two separate governance structures, that was always something that was doomed to fail, and* [Police and Crime Commissioners] *PCCs were sort of the nail in the coffin* [because an elected] *PCC was pretty much never going to say 'well I'll give up then and hand over'… It needed to be mandated by the Home Office*".[48]

5.69 The Alliance ended on 8 April 2020.[49] As to the current position, the Inquiry was simply told:

"*Following a period of complex negotiations between the two Forces, the Strategic Alliance ended on the 8th April 2020. The Forces then entered into new Collaboration Agreements relating to four ongoing functions: File Storage; Transactional (HR and Finance) Services; Forensic Services and IT. These are due to conclude by September 2021*".[50]

46 [redacted] pg 28
47 pg 32
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49 pg 15
50 pg 33

5.70 Within the Division itself, as one would expect, different departments or units exist to deal with different types of crime. I have set out below the arrangements within WMP in relation to child protection over the years, as they have been explained to me, in order to understand how CSE would have been managed by WMP at the pertinent time.

Child Protection Arrangements

Early 1990s

5.71 From 1989, each division had a Community Affairs Department ("CAD"), centrally managed at Hindlip, responsible for responding to child sexual abuse, raising child protection concerns and engaging with Safeguarding.

5.72 The role of liaising with Safeguarding was, at that time, reserved for female police officers. WMP notes that during this period:

"*It was the norm for female officers to be given responsibility for victims of sexual assault, domestic abuse and child abuse*".[51]

5.73 Where allegations of "*serious*"[52] criminal offences were reported, these were passed on to the divisional Criminal Investigation Department ("CID") for investigation. It is not clear to whom investigative responsibility for 'non-serious' criminal offences would have fallen.

5.74 In May 1992, WMP established specialist Child Protection Units ("CPUs") to deal with incidents of child abuse across Shropshire and Telford & Wrekin divisions. I have been told that arrangements were also introduced in WMP at this time, in accordance with the Home Office *'Memorandum of Good Practice'* released in 1992 for the interviewing of child witnesses, and that an interview suite was set up specifically for this purpose at Shrewsbury.[53]

5.75 CPUs were initially based in two offices in Shrewsbury and Donnington Police Stations.

5.76 In relation to CPUs, the Chief Constable's Annual Report of 1992 explained that:

"*Based on inter-agency co-operation, particularly with Social Services Departments, the units dealt with those matters of concern reported to the police where a child is at risk of physical, sexual or emotional harm. This work also extends to extra familial abuse and where the abuse occurs in residential settings*".[54]

5.77 There were three CPUs, each headed by a Detective Sergeant. Telford was covered by Area 3, described as 'Shrewsbury, Malinsgate, Wellington'. The CPUs were to be supported by CID.

[51] [redacted] pg 106
[52] [redacted] pg 3
[53] [redacted]
[54] [redacted] pg 3

5.78 It was explained to me by one of the CPU officers of the early 1990s that: "*we* [the CPU] *interviewed the children but the perpetrators were interviewed by CID. We weren't part of CID then and we'd present all the evidence we had to them including any medicals that we'd taken children to*" – with the expectation that CID would then follow up in investigating any offences.[55]

5.79 Following a Her Majesty's Inspectorate of Constabulary ("HMIC") recommendation, in 1993 WMP appointed a Detective Superintendent as overall head of the CPUs. A Chief Superintendent took on overall supervision of CID.

1996 - "FPUs"

5.80 In 1996 the remit of the CPUs was broadened to include domestic abuse, and divisional Family Protection Units ("FPUs") were created.[56] Divisional FPUs were each headed by a Detective Chief Inspector.

5.81 According to WMP's Corporate Submission to the Inquiry, FPU teams dealt with all referrals of familial sexual abuse (children under the age of 17) and familial physical abuse (children under 14) along with sexual abuse committed by a carer where the victim was under 18. WMP explained: *"all types of non-familial abuse would usually be investigated by divisional CID officers*".[57] This was, I understand, to include offences amounting to CSE.

5.82 WMP's Corporate Submission clearly refers to the CPU and FPU as separate and co-existing. In contemporary material, however, it is not clear whether they co-existed. In the late 1990s, FPU was the dominant term. This raises an important issue: as I have set out above, the remit of the CPU was broader than the remit of FPU, encompassing all matters of concern relating to sexual harm of children wherever such offending occurred, as opposed to familial matters only. This is particularly relevant to CSE which, in the usual context of the term and as intended by the definition used in this Inquiry, tends to be non-familial offending. It seems to me that the failure to distinguish between these two units with different remits - and, on the evidence I have seen, the apparent primacy of the FPU over the coming years - had the potential to create a gap in specialist provision, although the Inquiry was told that changes in name did not affect the reality of provision.

5.83 WMP told me that CID itself was subdivided into reactive and proactive squads – reactive squads dealt with significant crime complaints, which would have included crimes amounting to CSE, and proactive squads dealt with ongoing areas of concern including burglary, drugs, car crime and race crime, for example.

5.84 This led to the situation in Telford, after 1996, where different teams were responsible for dealing with child sexual offences according to the relationship between suspect and victim: such offending within a family was dealt with by the FPU, while outside the family the offending would be dealt with by the reactive CID team.

55 [redacted]
56 pg 5
57 pg 5

5.85 WMP reports that, by 2004 "*FPUs were now an integral part of mainstream divisional CID, overseen by respective divisional DIs & DCIs who were accountable for performance*".[58] The responsibility of the FPUs was simultaneously broadened (in familial cases) and narrowed (in carer cases) by age of victim, as the FPUs were now tasked with all referrals of familial sexual and physical abuse on children under the age of 17 years or committed by a carer where the victim was under 17 years of age.

5.86 The Inquiry asked WMP what resources were dedicated to tackling CSE in the middle 2000s, and received the response:

"HR data indicates in around 2006 there were 10 officers in the Telford Public Protection Unit. It has been assumed that the PPU would have incorporated the FPU as the term Public Protection Unit is used consistently throughout the HR data over the specified period 1989-2020".[59]

5.87 There is no mention in this response of the CPU, although references made within WMP's Corporate Submission tend to suggest it either co-existed with, or had become the PPU.[60]

5.88 Further, in 2006 a central Public Protection Strategic Vulnerability Team was established at Hindlip comprising "*specialists in a number of areas, including: domestic abuse, child protection, missing persons, online sexual offences and ViSOR* [Violent and Sexual Offender Registration]*. There were also 2 x MAPPA* [Multi-Agency Public Protection] *Co-ordinators and an analyst*".[61]

2007 - "CAIUs"

5.89 In 2007 the FPU teams became Child Abuse Investigation Units ("CAIUs"), and again were divisionally based.[62] WMP has explained the CAIU's primary role was to investigate child abuse with a team of specialist investigators and non-familial abuse remained the responsibility of CID.

5.90 It is plain that there is no consistency as to terms used to describe the child protection response team. I have seen a report that implies a greater confusion, and one which clearly impacted upon victims/survivors:

"*Historically Public Protection Units ("PPUs") have been locally owned by divisional command teams and have seen significant difference in composition, role, remit and processes. It is clear that investment in Public Protection had varied over time and that each unit has evolved in isolation influenced by local factors, but not in a way that supports a consistent and corporate model and ultimately presented a postcode lottery for victims*".[63]

58 [redacted] pg 5
59 pg 4
60 pg 10
61 pg 7
62 pg 7
63 pg 1

5.91 On 15 January 2008, a report of the then Chief Constable of WMP noted police authority investment of £2.9 million in a "*building protective services*" programme designed to "*provide an additional 93.5 personnel across the range of protective services*".[64] Notably, the text defined *"protective services"* without any reference to serious sexual offending or CSE.

2009 - "SOIT"

5.92 I have seen evidence that sometime before May 2009 a Sexual Offences Investigation Team ("SOIT")[65] appears to have been drawn from interested officers within reactive CID. I was told by an officer that at this time, Telford 'trialled' a sexual offences team of six officers; the SOIT was "*a fourth pillar within CID after reactive, proactive and FPU. It was investigating all sexual offences that otherwise would have fallen to reactive*".[66]

5.93 The SOIT was formed to investigate sexual offences generally (known in other forces as a 'RASSO' – Rape and Serious Sexual Offences – Team), and was to stand as a separate unit in CID along with reactive, proactive and the PPU. However, this team was absorbed quickly by the Chalice intelligence gathering and investigation, which I deal with later in this chapter.

5.94 I heard evidence that after Chalice, SOIT was disbanded after a WMP report[67] determined there was no role for it. Although WMP's Corporate Submission makes reference to a 2012 document headed '*CSE SOIT West Mercia and CSE'*, I have been told the document no longer appears to exist. In any event, references within the disclosed material to SOIT are scant and there are none after the Chalice trials in 2012. It was confirmed to me by witnesses that SOIT was effectively dispensed with at this time, as officers returned to their original departments after Chalice.[68]

5.95 A senior police officer involved in the Alliance negotiation process, which as I have indicated was taking place in 2011, told the Inquiry that during the 'scoping exercise' for the Alliance he had noted with approval Warwickshire's dedicated specialist rape unit, which he was keen to replicate in West Mercia, not least because it would have removed the split in investigative responsibilities between FPU/PPU and reactive CID in respect of familial and non-familial sexual offending. However, I was told that this was vetoed at ACPO level on cost grounds. This aspiration could have been fulfilled, in my view, by the continuation of the SOIT team.

5.96 I have subsequently seen confirmation that the strategy for managing the emerging threat of CSE "*was not examined during the planning phase of the Strategic Alliance*"[69], and instead, WMP sought to agree a 'CSE Position Statement' on behalf of the Alliance in 2012. I was provided with a copy of the position statement, which indicated that "*responsibility*

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67 [redacted] pg 34, pg 35
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for the development of the strategy will lie with the PVP strategic lead".[70] PVP is an acronym for 'Protecting Vulnerable People' and came over time, it appears, to be used interchangeably with PPU or the 'Public Protection Unit', which WMP told the Inquiry had been in place since 1989.

5.97 I discuss the CSE Position Statement and other policies and procedures adopted by WMP in respect of CSE in more detail below.

Child Protection Arrangements Post Chalice

5.98 A staffing chart[71] shows that between 2011 and 2015 Telford CPU (as it then was) had a total of seven staff – initially two Detective Sergeants and five Detective Constables, then two Detective Sergeants, four Detective Constables and a civilian investigator. The 2015 numbers were fewer than any other CPU in the Alliance. WMP states that "*this reflected the structure and resourcing across the Alliance*"[72], though when three dedicated CSE teams were created in 2015, they were equal in staff numbers.

5.99 WMP notes that in 2012, the structure and governance arrangements for the PPU/PVP team at Telford "*remained as per 2010*"[73]; with PPU/PVP retaining responsibility for familial abuse and CID taking responsibility for non-familial cases. It seems that the CPU/FPU now fell under PPU/PVP.

5.100 However, the Inquiry has been informed that from 2012 a 'CP ("Child Protection") Team' "*oversaw all partnership related aspects of CSE putting various measures in place to improve localised practice".* It is not clear how the CP Team featured within CPU or whether this was an alias/ replacement. However, I understand that the work of the CP Team included:

- *"CSE pathways for Police, Children's Services and CSE Family Support Workers;*
- *Creation of a CSE activity spreadsheet, disseminated to officers with specific guidance regarding the definition of CSE, the new process, to ensure tagging of CSE incidents and referrals were made to CSE Family Support Workers;*
- *Introduction of Risk Assessment Meetings between Detective Sergeants and CSE Family Support Workers, allowing an assessment of risk to those young persons being exploited; and*
- *Police attendance at the CATE Pathway Multi-Agency Meetings*".[74]

5.101 WMP notes that the effect of this was that the CP Team took responsibility of CSE matters that were connected to "*partnership engagement"* and *"victim pathway activity",* but investigations continued to be managed by local CID teams, who came under the command

70 [redacted]
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72 pg 9
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74 pg 34

of local policing areas.[75] Prior to this, partnership engagement relating to CSE matters was held by the officer in the case who may have had *"limited experience".*[76]

5.102 WMP's Corporate Submission indicates that in 2014-2015 there was a review of services to protect people from harm.[77] The review was driven by reduced funding: "*the existing 'single consistent policing model' was not sustainable within the reduced funding envelope"*. The review was named '*Strengthen and Deepen the Alliance ("STRADA")*'.

5.103 In what was likely a result of the STRADA programme, in 2016 the Alliance partially addressed the long-standing split between responsibility for familial and non-familial child abuse. The result was the 'Pathfinder' model which was intended to amalgamate PPU/PVP and CID into a single 'omni-competent' department of detectives.

5.104 WMP notes that "*the 'Pathfinder' model was partly intended to address increased demand within public protection teams*"; however, the scheme was not introduced in Telford or Shrewsbury and the separate CID and PVP teams "*returned to be governed/managed locally*".[78]

5.105 In other areas of WMP with which I am not concerned, the training demands of the Pathfinder programme became problematic; WMP struggled to train the 'omni-competent' cohort it had envisaged.[79] As to Telford's (perhaps fortuitous) exemption from the scheme, WMP says:

"Despite searching numerous locations and speaking to a number of individuals who were in post at the time, we can find no corporate memory of who made representations in respect of the Pathfinder model in Telford".[80]

2015 – The First CSE Team

5.106 The alternative to Pathfinder for Telford was the creation in 2015 of the first dedicated 'CSE' Teams within WMP, with one team based in the north of the force area, and one based in the south. The North Team covered both Shrewsbury and Telford and comprised a Detective Sergeant, three Detective Constables and a CSE Coordinator, who could now refer CSE daily briefing material direct to the Team.

5.107 The teams fell under the supervision of a PVP Detective Inspector and the governance of the central PVP strategic team. The business case for the creation of the Team noted:

"*Over the last five years Telford and Wrekin has seen an increase in reporting of child sexual exploitation … Operations* [Gamma]*,* [Zeta] *and now* [Delta] *have highlighted the*

75 [redacted] pg 34
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77 pg 12
78 pg 13
79 pg 97
80 pg 6

requirement for standalone teams … intelligence and information from a number of sources continues to demonstrate that CSE within Telford and Wrekin remains a distinct concern".[81]

5.108 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 (albeit other non-familial child sexual offences were still investigated by CID). 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 – particularly in light of the previous existence of the SOIT team, which had been established some six years previously and then, remarkably, disbanded following Chalice.

5.109 I also find it relevant that the CPS evidence shows that it deployed specially trained staff in CSE cases much sooner: RASSO units with specialist staff were created in 2012 to guide CSE investigations and prosecutions in recognition of the need for specialist knowledge and the complexities involved in sexual exploitation. WMP did not introduce any such teams at that stage.

5.110 The Inquiry has seen material, however, which indicates that CSE became a standing agenda item in the monthly tasking meetings from 2015, suggesting that information was being shared outwardly from the CSE Team to inform staff briefings.

5.111 In January 2017 the North CSE Team separated into two teams, one for Shropshire and one for Telford, with the Telford team being increased in numbers to comprise of a Detective Sergeant, four Detective Constables, an analyst and a CSE Coordinator. In April 2017 a further Detective Constable was added to the team, whose role included victim contact, and attending CSE-related strategy meetings and risk panels. Governance of the CSE Team, at this point, moved to local policing command.

5.112 Also in January 2017, WMP introduced the role of 'Vulnerability' Detective Chief Inspectors for each Local Policing Area ("LPA"), leading on "*strategic aspects of vulnerability including partnership working*".[82] There was also a central Strategic Vulnerability Team; DVD training materials were produced in a package called 'See Past the Obvious'; and 37 Sergeants were trained as trainers.

5.113 Telford LPA recruited a CSE Analyst, funded from the LPA's budget. The Analyst sat within the CSE Team. It is understood that the CSE Team itself remains "*protected from abstractions and do not carry vacancies, nor are they used to bolster staffing outside of CSE investigations, regardless of the demand placed on the LPA*".[83]

2019 – "CE" Team

5.114 By 2019, Telford's CSE Team was renamed the Criminal Exploitation team ("CE Team") and its remit broadened to all forms of child exploitation. WMP reports that an increase in reporting of criminal exploitation offences led to the team being overwhelmed, and as a

81 [redacted] pg 17
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83 pg 17

result it was allocated more staff, and by 2021 amounted to one Detective Sergeant and seven Detective Constables.

5.115 WMP suggests that scrutiny and accountability of decisions in relation to CSE matters are now dealt with on multiple levels[84] including:

- *"The PCC and Chief Constable have formal 'holding to account' meetings monthly, focussing on specific thematic areas, as well as informal meetings weekly;*
- *Force tasking and co-ordination meetings are held on a monthly basis (force and local). CSE features as a control strategy priority… and any emerging threats and trends are discussed and recommendations made regarding resourcing, capacity and capability…; and*
- *On a daily basis, daily management meetings are undertaken at a local level chaired by operational commanders or crime managers in order to review crime and incidents of note within the last 24 hours to ensure that there has been an appropriate response to address any threat, risk and harm and if necessary rectify."*

5.116 I deal with the 'holding to account' meetings with the PCC separately, as part of Chapter 6: Other Organisations.

5.117 WMP told the Inquiry that it has used external consultants to evaluate its investigation model and structure and that it has a plan for change, which includes a focus on more specialised CID roles and local policing to support CID to investigate complicated crimes like CSE.[85] I regard this as a somewhat nebulous proposal; it is not clear to me what this means for future CSE provision in Telford.

Conclusions – Child Protection Arrangements

5.118 WMP had specialist provision for child abuse cases from the early days of my Terms of Reference.

5.119 The CAD appears to have been a Safeguarding liaison body rather than an investigative one, with CID retaining responsibility for "*serious criminal offences*" involving child abuse.

5.120 While the rebranding of CADs as CPUs in 1992 broadened the remit to include non-familial child abuse, it is not clear that any investigative role was afforded to the CPUs; and in 1996 following the further rebrand of CPUs as FPUs, the focus was again drawn tightly on familial cases.

5.121 The conclusion to be drawn is that throughout this period reactive CID was responsible for investigating what would now be termed CSE, with the result that different teams investigated child sexual abuse depending on the relationship between the child and the perpetrator. Given that the primary challenge in investigating and prosecuting child sexual

[84] [redacted] pg 17-18
[85] [redacted] pg 18

abuse cases is engaging with often vulnerable child witnesses, this seems to me to be a distinction that did not need to be drawn and one which would not have been useful. I consider, instead, that the experience of the CPU/FPU officers would have been helpful in pursuing CSE cases.

5.122 It is necessary that I note the existence, however fleeting, of the CAIU. This was an evolution of the FPU and certainly an investigatory team, according to WMP, but again limited to familial work. Reference to the CAIU quickly seemed to disappear without any explanation, with reversion to the language of CPUs.

5.123 Rebranding is a feature of all modern state service provision. I caution myself that it would be too cynical to think that renaming a group is always intended to provide only the impression of progress. No doubt some such exercises will reflect useful change. I also remind myself that WMP has, on the evidence I have seen, come nowhere close to the bureaucratic churn that I have seen in the Council's response to CSE (as discussed in Chapter 3: The Council Response to CSE in Telford). Despite that, it is important that I note that for over ten years – at least from 1996 until 2009, and the creation of the SOIT - there was a service gap whereby non-familial sexual abuse of children was not dealt with by a specialist unit dedicated to investigating offences involving children.

5.124 The decision not to maintain the SOIT after Chalice was a failure which I consider in further detail later in this chapter. Suffice it to say at this stage, that 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. I have no doubt upon the evidence I have received that this delay was primarily a costs driven decision at a time when WMP was in a difficult financial situation. It is not entirely clear to me how Telford avoided the Pathfinder programme, which was overambitious and under-resourced, but the decision to exempt it and to put in place the CSE Team was a sensible and appropriate response to an obvious problem that had gone unaddressed for too long. I deal with a possible explanation for Telford's exemption in the section below entitled "Inspections and Reviews".

5.125 As regards the continuing existence of the CSE (now CE) Team, I have made specific recommendations around the ringfencing of this team in the Recommendations sections at the beginning of this Report.

Policies, Procedures and Training

5.126 Bearing in mind the structures and processes set out above, the Inquiry asked WMP to explain, and provide copies of, the relevant child protection policies, procedures and training that have existed within the organisation over the period relevant to the Terms of Reference. This section considers the answers provided by WMP in its Corporate Submissions, and provides comment as to how those policies, procedures and training appear to have been put into practice over the years, based on other evidence seen by the Inquiry and opinions offered by the Inquiry's Policing Expert, Andre Baker.

Child Protection Policy and Procedures

5.127 The Inquiry was told that WMP initially issued a Child Protection Policy in 1989 following a review of the CAD "*in the wake of the Cleveland Report and Home Office Circular 52/1988*".[86] Whilst reference was found to this policy within the Chief Constable's Annual Report for 1989, an actual copy of the policy could not be found by WMP.[87] As noted above, the first dedicated CPUs were established three years later, in 1992. It is assumed that officers within the newly established CPUs were therefore familiar with the 1989 Child Protection Policy.

5.128 In 2000, WMP reissued the 1989 Child Protection Policy. The Inquiry has reviewed this revised version, and notes that it made no mention of exploitation or of 'child prostitution', which as I have noted earlier was the term more commonly given to what is nowadays referred to as CSE. This was the case notwithstanding the publication of the 2000 Supplementary Guidance. Sexual abuse is mentioned in basic terms within this revised document, describing examples of the physical manifestations of the acts of abuse, and is taken to include "*encouraging children to behave in sexually inappropriate ways*".[88]

5.129 It was not until 2004 however, following the Laming Review into the death of Victoria Climbie and in light of recommendations that followed, that WMP published its Child Protection Force Procedure ("CPFP 2004"), which the Inquiry believes is the first time that any WMP documents explicitly dealt with child exploitation. It was referenced in this way:

> *"PROTECTING CHILDREN FROM EXPLOITATION*
>
> *Vulnerable children are identified and targeted by individuals who abuse children through prostitution, irrespective of whether the child is living with their own family, looked after away from home or has run away.*
>
> *Also recognised as being potentially vulnerable are those children who are brought to the UK as illegal immigrants.*
>
> *The majority of children do not voluntarily enter prostitution, they are coerced, enticed or desperate. It exposes them to abuse and assault and may even threaten their lives.*
>
> *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 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".*

5.130 The CPFP 2004 therefore acknowledged that children were being abused through 'prostitution', and that the exploitation was as a result of coercion and threats rather than

[86] [redacted] pg 223
[87] [redacted] pg 112
[88] [redacted] pg 4

behaviour that was voluntarily entered into. The procedure expects 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 WMP.

5.131 The CPFP 2004 tied in with the recently enacted 2003 Act and associated Crime Recording Standards (as mentioned further below) for child sexual offences, requiring that every complaint or referral should result in a crime being recorded. WMP says that this meant a supervisory officer (usually a FPU Detective Sergeant, or a higher ranking officer in their absence) would be involved in any referral or strategy meeting with other agencies involved in child protection.

5.132 Also 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 '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*".[89]

5.133 It is not clear to me, however, 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.

5.134 In 2007, WMP introduced its Investigating Child Abuse Policy and Procedure[90] (the "2007 Child Abuse Policy"). This policy was stated to be owned by the Detective Superintendent for PPU, and the ACPO Lead for child abuse investigations and safeguarding children was to be the Assistant Chief Constable - Specialist Operations. The 2007 Child Abuse 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*".

5.135 The 2007 Child Abuse Policy is stated to have been written taking into account the legislation and guidance of the time, and cross refers to the 2005 National Centre for Policing Excellence Guidance on Investigating Child Abuse and Safeguarding Children ("NCPE Guidance").[91] I have noted that the NCPE Guidance includes a specific section on 'children abused by prostitution or sexual exploitation'. The NCPE Guidance recognises that children involved in 'prostitution' should be treated as victims of abuse, and that often they may be "*hidden from public view*"; that officers must therefore recognise situations where children may be at risk from such exploitation, noting that "*such situations may become apparent to officers carrying out unrelated investigations… for example drugs*". It also

89 [redacted] pg 47
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makes clear that in such situations, the CAIU should be notified and a multi-disciplinary assessment should be made to consider how best to protect the child from harm.

5.136 The 2007 Child Abuse Policy includes 112 pages of procedure, setting out how concerns will be handled and referred between agencies; how incidents will be logged and how intelligence will be handled. Insofar as CSE, or CSE-related offences are concerned, it notes in short-form the point expressed above by the NCPE Guidance: that abuse may come in the form of 'child prostitution'/exploitation[92]; however there is no dedicated section considering this in any further detail. This seems to me to have been an oversight in such an extensive policy, and in light of the rafts of other existing literature on the topic, which had now been in circulation for some years – in particular the ACPO 2004 Policy[93], and the earlier 2000 Supplementary Guidance.[94]

5.137 When asked, WMP referred back to the cursory references set out in the documents as per the above – and stated that officers were simply "*signposted*" to such guidance in the CPFP 2004 – rather than seeking to embed that guidance within its own policies and procedures.[95] WMP went on to say:

"*With reference to Home Office Circular 109/59, the supplementary Safeguarding Children Involved in Prostitution 2000… WMP force policy and procedure has also evolved with regard to child prostitution and exploitation to reflect national best practice guidance*".[96]

5.138 WMP has indicated that in practical terms, at this time in the mid-2000s its approach would be as follows whenever an initial incident was reported indicating any child protection concerns, including CSE:

"*Each morning a check would be undertaken by staff of OIS* [Operational Information System] *logs to identify incidents that had been tagged for FPU. Primarily, the Control Room undertook this role because, from an understanding of the circumstances/situation, they recognised a role or interest for FPU/CAIU, or it could be at the request of an officer (uniform or CID) who had asked them to tag it for FPU/CAIU attention.*

FPU/CAIU Detectives would then research those incident logs coupled with an associated crime (using OIS, CRIMES, GENIE and the paper FPU files).

Incidents such as domestic abuse and other safeguarding matters of gravity would also be discussed each morning at the 9am briefing chaired by the duty Superintendent where ownership and responsibility for tasks relating to investigation and safeguarding was given".[97]

92 [redacted] pg 24
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95 pg 156
96 pg 156
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5.139 In terms of referrals to other agencies, it was explained that FPU/CAIU would create safeguarding referrals to be sent to the Council, but that this was often done in an ad hoc way. The Inquiry was told:

"One of the main formats for information sharing and potential joint investigation was via direct telephone link between Social Services managers and FPU/CAIU Detective Sergeants. These were unscheduled but formal and were known as strategy discussions.

Relevant information was shared between both agencies and there would be a jointly agreed decision and action plan as per 'Working Together'. A crime record was later recorded".[98]

5.140 Indeed this chimes in some ways with what I was told by a number of witnesses regarding liaison between WMP and Safeguarding taking place in person or by telephone; however those witnesses seemed to suggest that the discussions were less formal, and more on an 'as needed' basis.[99]I discuss multi-agency working in more detail below.

5.141 The 2007 Child Abuse Policy was written in anticipation of a two-year review, due to have taken place in May 2009, however I have not been provided with any confirmation of whether such a review took place, and if so, whether the policy was considered effective; either way, it appears the policy was next refreshed in 2011.[100] However I can see very few changes, if any at all, to the overriding policy, and have not been provided with the full procedure that sits behind it – leading me to the view that this was not substantively updated, despite a significant number of publications on CSE, and Chalice, taking place in the intervening years.

Policies and Procedures under the Alliance

5.142 In October 2012 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' – albeit this appears as a written report from an Acting Superintendent to the Assistant Chief Constable, rather than in a published statement form.[101] The document remarked that CSE had not been examined during the planning phase of the Alliance, and went on to comment that:

"*The true scale of the CSE problem is yet to be identified, particularly when considering 'Localised Grooming' (definition excluding online grooming, trafficking, peer on peer abuse or other forms of sexual exploitation).*

The [Child Exploitation and Online Protection Centre] *CEOP Thematic Inspection 'Out of Mind, Out of Sight' established that 'where police, children's services and voluntary sector agencies have worked together, co- ordinated by LSCB's to identify and address child*

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sexual exploitation, a significant number of cases have come to light. Agencies which do not proactively look for child sexual exploitation will as a result fail to identify it'.

It is therefore recognised that CSE is a complex issue and, across Warwickshire and West Mercia, a coherent strategy is required to seek to reliably identify CSE where it is encountered."

5.143 The CSE Position Statement noted that the development of strategy would "*lie with the PVP strategic lead*" and that there was a need to address a number of strands within the control strategy, including developing:

5.143.1 Information sharing partnerships on the model of the Telford CATE Team;

5.143.2 Systems to adequately capture CSE intelligence, including use of the new CRIMES CSE marker;

5.143.3 A force procedure for investigation of CSE; and

5.143.4 Training for frontline staff and officers including specially trained officers ("STOs") on the emerging knowledge and understanding of CSE.

5.144 The Inquiry has reviewed the Alliance Child Sexual Exploitation Delivery Action Plan (the "Plan") dated 2013,[102] which followed. WMP told the Inquiry that this plan was "*introduced in order to drive strategic and tactical activity specific to CSE"*[103] 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.[104] The Plan is in table form and has 42 actions. Each action has a connected task, activity, progress and status. The Plan grouped the actions against four high level 'tasks' as follows:

- "*Work as part of multi-agency to raise awareness and understanding of CSE;*
- *Use professional investigation, effective identification and targeting of perpetrators and potential perpetrators to bring offenders to justice;*
- *Utilise robust offender management in pursuing high harm causers;* [and]
- *Demonstrate clear leadership by the police service within the multiagency response*".

5.145 The Strategic Vulnerability Team at Hindlip held responsibility for implementing the Plan and allocated the work to a Warwickshire Detective Inspector and a West Mercia Detective Sergeant, who "*drove activity to progress actions by working closely with PVP leads*".[105]

102 [redacted]
103 pg 115
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105 pg 122

5.146 The action plan contains limited information on any precise action being taken, but in relation to professional investigation of CSE[106], 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.

5.147 This is perhaps unsurprising, given the evidence of how specialist CSE investigation teams were developed during Chalice and the acknowledgement in the 2012 CSE Position Statement that STOs needed to be developed further in this area.

5.148 In 2014, the Alliance introduced the 'Alliance Investigation Allegations of Child Abuse Procedure'.[107] This procedure, implemented in August 2014, contained no content with the specific title of CSE[108], but in seeking to explain child sexual abuse ("CSA"), included reference to CSE, 'grooming' and 'trafficking', and encouraging children to 'behave in sexual ways'. In summary, despite scant references within it, I find that this procedure lacks any focus on the issue of CSE. The absence of focus on CSE within this procedure is perhaps indicative of the findings from the later National Child Protection Inspections in November 2014 (which I discuss later in this chapter), which identified serious failures in the approach and investigation of CSE allegations by WMP.

5.149 In a similar vein, two years later the Alliance introduced a new Child Abuse Policy,[109]implemented in May 2016 (the "2016 Policy"), yet this also appears to lack detail on the specific approach of the Alliance to child abuse, in addition to having no focus on the issue of CSE. The only reference to CSE within this policy is to explain that *"child abuse can also include offences relating to human trafficking and child sexual exploitation."*[110]

5.150 The absence of focus in the 2016 Policy concerning issues specific to CSE is perhaps a contributory factor to the findings of an internal review of the Alliance CSE position in 2016 (*'Protecting Vulnerable People - Review of Child Sexual Exploitation (CSE) in the Alliance – September 2016')*[111] – discussed further below. I am aware that, despite the benefits identified in having an independent and bespoke CSE Team, the Alliance was considering 'mainstreaming' CSE teams at this time, which would have likely resulted in transferring specialist teams back into local policing units. This review was also mindful of the College of Policing CSE Peer Review conducted in February 2015 (as discussed in more detail later in this chapter), where a number of areas for development were identified in the Alliance CSE response.

5.151 In 2017, a further strategy document was published by the Alliance, in relation to vulnerability generally, rather than CSE specifically.[112]This strategy contains one direct reference to exploitation within a definition of vulnerability, but not in a context specific to CSE. WMP has told the Inquiry that it supplemented the release of the strategy document with one-day training programmes focused on 'Seeing Past The Obvious' materials,[113] and

106 [redacted] pg 2
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108 [redacted] pg 9
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110 [redacted] pg 3
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113 [redacted] pg 110

that this training did have a CSE focus, including a section on the *"signs and symptoms"* for officers to consider and with focus upon a DVD as a leading slide. WMP told the Inquiry that this training was delivered to 37 Sergeants who *"delivered shorter versions of the awareness training to all operational officers."* [114]

5.152 I have not reviewed evidence of how this training and knowledge was disseminated in practice, or been in a position to consider how effective it may have been. I find it relevant to note, however, that a HMIC inspection of WMP in the same year (2017[115], considered below) assessed WMP as 'Requires Improvement' against the category of 'Protecting Vulnerable People'.

5.153 Another two years hence, and the Alliance brought together its strategies for vulnerability and safeguarding into one Overarching Policy for 2019.[116] Astonishingly however, in my view, this policy continues to reference exploitation only in the context of wider vulnerability, or by cross-referencing the earlier procedures, as discussed above, or other national guidance. There is no specific reference to CSE, albeit the policy does recognise:

"[the] *need to be open-minded and understand individuals' complex lives, recognising where underlying issues exist such as Adverse Child Experiences ("ACE") or a possible Mental Health diagnosis. Providing a tailored service, which takes account of a person's vulnerability, will allow the right agencies to develop approaches which will support vulnerable people to protect themselves and others from harm".*[117]

5.154 I do note, however, that general reference is made to 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.

5.155 It is not a surprise to me therefore, that the HMIC Police Effectiveness, Efficiency and Legitimacy ("PEEL") Effectiveness Inspection in 2018/19[118] (considered further below) maintained its assessment of WMP as 'Requires Improvement' in an overall assessment of its 'Effectiveness'. In relation to the category 'Protecting Vulnerable People', WMP was again assessed as 'Requires Improvement'.

5.156 WMP explained to the Inquiry that it has sought to update its learning and practice since national guidance was first published in 2009,[119] 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*

[redacted] pg 24
https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-police-effectiveness-2017
[redacted] pg 48
https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-assessment-2018-19-west-mercia.pdf
Safeguarding Children and Young People from Exploitation 2009 - https://www.basw.co.uk/resources/safeguarding-children-and-young-people-sexual-exploitation-supplementary-guidance-working

culture across the organisation".[120] I am afraid to say that my assessment of the policies and procedures provided to me does not appear to support that assertion.

5.157 I note that a refreshed Child Abuse and Safeguarding Policy was introduced by WMP, post Alliance, in January 2020, although this appears to be based on the Alliance Child Abuse Policy 2016 (discussed above) and contains no significant changes regarding focus on CSE.

Recording of Child Sexual Offences

5.158 Alongside its own policies for investigating child sexual offences, 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.

5.159 Prior to 1995 all crimes were recorded by WMP on a paper-based system managed by each LPA. Detective Chief Inspectors would be responsible for reviewing the crimes recorded, and statistics would be submitted to Headquarters on a monthly basis for the purposes of reporting to the Home Office.[121] I understand that "*the local DCI had the discretion as to which crime reports were sent to Hindlip HQ*". This remained the case until the mid-1990s.

5.160 In 1995, WMP adopted a computerised centralised crime recording system under the acronym "CRIMES". This was less sophisticated than we might at this distance have thought, involving submission of written reports which were faxed to a centralised bureau (the "Central Data Unit") for logging onto the CRIMES electronic system. The HOCR were adopted into the system, which meant that all recorded crimes resulting in charge, caution or other admission (for example, being taken into consideration at sentencing) were to be regarded as 'detected'.[122]

5.161 In the year 2000, an HMIC inspection of crime recording procedures across all forces in England and Wales found evidence of offences being wrongly classified, incorrectly recorded and/or downgraded. The report also found that forces were interpreting the rules differently and 'detections' were being chased due to performance targets. This applied across the gamut of criminal offences; not just in relation to child sexual offences.[123]

5.162 As a result the NCRS was launched in 2002 setting out three basic principles:

- *"All reports of incidents, whether from victims, witnesses or third parties and whether crime related or not, will result in the registration of an incident report by the Police*.
- *Following the initial registration, an incident will be recorded as a crime (notifiable offence) if, on the balance of probability, (a) the circumstances as reported amount to a crime defined by law (the Police will determine this, based on their knowledge of the law and counting rules), and (b) there is no credible evidence to the contrary.*

120 [redacted] pg 61
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122 [redacted] pg 41
123 pg 9

- *Once recorded a crime would remain recorded unless there was additional verifiable information to disprove that a crime had occurred."*[124]

5.163 This system, I suspect, was intended to take away any discretion previously held by Detective Chief Inspectors under the old recording regime, meaning that – in theory at least – a consistent approach to the recording of child sexual (and all other) offences should have been taken across WMP from this point onwards.

5.164 Insofar as how child sexual offences were considered under the child protection arrangements discussed above, the Inquiry was told that where a concern had been raised and necessitated a referral to Safeguarding, information would be shared and an action plan would be agreed between agencies, prior to any crime being recorded. WMP noted that often, these inter-agency discussions would be regarding "*children who had suffered neglect or other forms of abuse…*" and it would be this (neglect) that would be "*recorded on CRIMES as the primary offence*". WMP confirmed:

"*The exploitation of a child would be given the primary criminal term, rape or indecent assault for example. If the offence was inter-familial and required ABE interview, that enquiry would be owned by the FPU/CAIU. All other offences would be owned by CID*".[125]

5.165 However, as noted above, the system at this time was reliant upon the Central Data Unit to categorise and record the crimes faxed to them. WMP went on to say in its Corporate Submission that this would be done "*depending on the gravity of the substantive offence*" and that "*the determination as to the CRIME header was for the submitting officer, although the Force did employ Crime Screeners to ensure crime data integrity*".

5.166 In terms of oversight, WMP explained that a Detective Sergeant would usually oversee the recording of "*general safeguarding cases*", but a Detective Inspector would supervise "*more complex, multi victim cases or child death cases*". I am not clear at all what this meant for child sexual offences; who would oversee the recording of these; and what the reality was in terms of the way in which those offences would – statistically – be collated and reported to the Home Office. I have, however, sought to comment separately in another part of this Report (Chapter 2: Nature, Patterns and Prevalence of CSE in Telford), on CSE statistics insofar as these have been made available to me, in the context of the prevalence of CSE in Telford over the years.

5.167 I infer from the material provided to me that the system for recording CSE-related crimes remained as per the above until a further HMIC review took place in 2014 looking at 'Crime Data Integrity'.[126]

5.168 This review looked again at all 43 police forces at the time, and the way in which crimes were being reported. WMP was found to be 74% compliant in converting logged incidents into reported crimes, and the force was tasked with the following as one of its areas for improvement:

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125 [redacted] pg 13-14
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"*The Force 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*".[127]

5.169 In all cases, not just for WMP, HMIC recommended that the Home Office guidance in respect of recording crimes be amended to make clear that crimes reported by third party professionals (doctors, teachers, health workers and social workers) should always be recorded as crimes. This 'victim focussed' approach remains the approach today, meaning that any reports of CSE offences made by professionals must be recorded as a crime by the police.[128]

5.170 I am satisfied, from the information provided to me by WMP, that the force did at this stage take a number of steps to improve its crime recording standards in all areas, including appointing three full time auditors and establishing a HOCR training programme for staff at both junior and senior, and clerical levels.[129]

5.171 The CRIMES system was replaced by 'ATHENA' in October 2017.[130] This coincided with further changes to the HOCR in 2016/2017 to include 'crime flags', two of which were 'CSE' and 'CSA'. The definitions were apparently identical - but for the substitution of CSA with CSE - as follows:

"CSE/A definition - 'Forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (e.g. rape or oral sex) or non- penetrative acts (e.g. masturbation, kissing, rubbing, touching outside of clothing etc.) They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet)".[131]

5.172 ATHENA required officers to "*record their own crimes*" – i.e. those they had investigated – and therefore officers were responsible for attaching the appropriate flags when recording crimes. WMP explained that the quality of crime recording and particularly application of specific 'flags' to crime reports suffered during this period and that this led to a partial reversion, in that responsibility for flagging – if not reporting – was returned to crime bureau staff.[132]

5.173 A further HMIC inspection in 2019 recognised the efforts of WMP to improve its crime recording standards and it was one of only 11 forces to be graded 'Good', noting that it

127 [redacted] pg 51
128 pg 43
129 pg 43
130 pg 171
131 pgs 53-54
132 pg 54

had "*developed a positive culture towards crime recording*" and commended its quality assurance processes for correct incident and crime reporting.[133]

'Tasking & Coordination' and Strategic Oversight

5.174 The process of understanding threat, then tasking and coordinating appropriate resources in reply 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. I view this process as particularly important in respect of CSE, as the complex issues involved often place a heavy demand upon police resources, with many investigations requiring collaboration across different policing teams.

5.175 In explaining its organisational structures and responsibilities for CSE, WMP told the Inquiry that in 2009:

"[WMP] *held Tasking & Coordination ("T & C") Meetings, chaired by the ACC which assessed/reviewed force wide "Threat, Risk & Harm" and ensured accountability and an appropriate response to relevant matters/incidents, including resourcing to support LPAs. These meetings followed local LPA specific T & C meetings chaired by LPA commanders."*[134]

5.176 Further, following the introduction of CSE Teams in 2015, WMP told the Inquiry that these teams *"reported into daily tasking meetings and monthly tactical meetings"*[135] with support being provided by the PVP Detective Inspector.

5.177 Evidence provided by WMP indicates current practice since 2013 involves tasking and coordination meetings taking place on a monthly basis at both force and local policing level, with CSE featuring as a *"control strategy priority".*[136]

5.178 The Inquiry asked WMP to disclose all tasking documents (divided into years from 2002 to 2018) available for analysis, which included:

5.178.1 Telford Strategic Intelligence Assessments;

5.178.2 Strategic Tasking and Coordination documents (main meeting and review meetings);

5.178.3 Tactical meeting minutes;

5.178.4 Chief Superintendent Briefing documents - containing summaries of crime statistics and current initiatives in the Division; and

5.178.5 Daily Divisional Briefing sheets.

133 [redacted] pg 53
134 pg 8
135 pg 12
136 pg 17

5.179 To assess the frequency of occurrence of CSE as an issue within those tasking and coordination and other strategic meetings over time, the above documents were searched to identify and review those relevant to the issue of CSE. Relevant documents were identified by searching for key terms within them, relevance identified by the presence of one or any of the following terms: 'CSE'; 'Prostitution'; 'Grooming'; 'Child'; and 'Sexual'. While I accept this process may not identify all activity within tasking documents relevant to the Terms of Reference, I believe it was sufficient in obtaining a broad indication of when issues relating to CSE arose within those meetings.

5.180 The results of this analysis were as follows:

5.180.1 872 documents were provided that dated between 2003 and 2005. Of these documents, 16 were identified as relevant (1.83%). The relevant documents consisted of nine Daily/Divisional Briefings, six Divisional Strategic Assessments and one Tasking and Co-ordination document.

5.180.2 2,834 documents were provided that dated between 2006 and 2010. Of these documents, 262 were identified as relevant (9.24%). The relevant documents consisted of 253 Daily/Divisional Briefings, four Strategic Assessments, three Partnership Tasking documents, one SSO Joint Action Group minutes and one Missing Persons Profile.

5.180.3 539 documents were provided that dated between 2011 and 2015, Of these documents, 114 were identified as relevant (21.15%). The relevant documents consisted of 17 Daily/Divisional Briefings, 33 Electronic Briefings, four Targeting Tasking documents, two social media extracts, 10 Weekly Priority Meeting minutes, one crime report with a CSE marker, 13 Monthly Tasking and Coordination minutes, 13 Weekly Tasking minutes and 21 Weekly Risk Meeting minutes.

5.180.4 279 documents were provided that dated between 2016 and 2020. Of these documents, 187 were identified as relevant (67.03%). The relevant documents consisted of 36 Weekly Risk Meetings, 16 Tasking and Coordination Meetings, one Alliance Control Strategy and 134 Electronic Briefings.

5.181 I have considered the relevance of the above tasking and coordination data further below, in my conclusions.

Training in the Handling of Child Sexual Offences

National Requirements

5.182 As regards the national training picture for CSE, I have noted that the first CSE-specific guidance for officers was released in 2013 entitled *'Responding to Child Exploitation'*.[137] Prior to this, training revolved around the applicable legislation and earlier guidance on sexual offences and child protection. Prior to the 2003 Act therefore, training relating to

[137] [redacted]

child sexual offences was delivered in accordance with the prescribed offences set out in the 1956 Act.

5.183 In 2002, an HMIC inspection of rape investigations across England and Wales noted that:

"*The training available to Police personnel does not conform to a minimum standard. As a consequence a variety of training methods have been developed resulting in a lack of consistency in approach by the service in general".*[138]

5.184 This was around the same time, in the early 2000s, when Centrex was established to provide a standardised curriculum for police training (for the investigation of all offences, not just rape). Centrex was replaced by the National Policing Improvement Agency ("NPIA") in 2007, and then the College of Policing ("COP") in 2012.[139] Various guidance documents have been provided by this body over the years, known as 'Authorised Professional Practice' ("APP"), with a view to ensuring consistency of officer training nationally.

5.185 I discuss the NPIA, COP and APPs in further detail in the following chapter, Chapter 6: Other Organisations.

WMP's Approach to Child Sexual Offences Training

5.186 Insofar as WMP's training is concerned, the Inquiry was told that in 1988 WMP launched specialist child abuse courses, tailored for both investigators and managers, and that these courses were run in conjunction with Hereford and Worcester and Shropshire social services departments.[140] I was pointed to the West Mercia Annual Report 1990, which explained that one of the principal objectives of the CADs (and, I therefore assume, the CPUs that followed) was "*the developing of relationships with other agencies to effectively deal with child abuse and schools liaison programmes*".[141]

5.187 It appears that officers within CPU were, in the years following, put through these child abuse investigation courses – and this drew praise in 1994 from HMIC:

"*HM Inspector was pleased to see the Force has developed an impressive advanced course on child abuse investigation to cater for the training needs of Child Protection Units".*[142]

5.188 WMP explained that all officers received training on sexual offences, including Unlawful Sexual Intercourse ("USI"), during their initial training, however in the early days (as already mentioned above) "*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*".[143]

138 [redacted] pg 106
139 pg 61
140 pg 67
141 pg 67
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143 pg 106

5.189 In terms of procedure, it has been an expected part of joint working for the police and social services to conduct joint investigative interviews with child complainants of abuse since the Criminal Justice Act 1991, with those interviews to be videoed and to stand as their evidence in chief.[144] I have noted that WMP was quick to set up child abuse interview suites, and had already begun the process of training officers in this regard, as mentioned above.

5.190 A Memorandum of Good Practice for the interviewing of child witnesses followed in 1992, and WMP explained in its Corporate Submission to the Inquiry that much of the training around this was driven by the Area Child Protection Committees ("ACPCs") and that there were "*occasional special events laid on for the particular needs of Police Officers and social workers. Such events frequently drew upon the expertise of outside training consultants, but it seems as though there was little co-ordination or coherence to these individual initiatives beyond an adherence to the tenets of the Memorandum*".[145]

5.191 I have commented upon the role of the ACPCs in Chapter 3: The Council Response to CSE in Telford, and I have seen information to suggest that WMP contributed to funding a trainer for the ACPC.[146] As regards the sole indication I have seen of joint training organised by the ACPC though, it is not clear whether or not WMP were participants, though I have been told by a witness who attended ACPC meetings that they were confident some police officers must have been present.[147]

5.192 WMP has said that in 2003 the Sexual Offence Investigation Trained Development Programme was commissioned. It was intended to run from 2004. However, "*delivery of the course never materialised*". WMP's Corporate Submission does not make it clear why, but it may be that the lack of a dedicated sexual offences team was an important feature.[148]

5.193 The CPFP 2004 (as discussed above) came into being the following year, and provided that child protection officers working within FPU should hold the rank of Detective, and that they "*will receive training and development opportunities commensurate to that role".* It further states that:

"*An effective and efficient police response to Child Protection benefits from Child Protection officers who have accumulated expertise in this acknowledged specialism*".[149]

5.194 The core role of a child protection officer, at that time, included:[150]

- "*Co-ordination of Divisional response to child protection referrals;*

144 pg 66
145 pg 68
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147 pg 23
148 pg 108
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150 pg 83

- *To act as a focal point for related inter-agency liaison, including Crown Prosecution Service;*
- *Deal with the investigation of child protection referrals/allegations of abuse to include interviewing alleged perpetrators*
- *The co-ordination and maintenance of FPU records and maintenance of recording systems in line with Force requirements, relevant to child protection;*
- *Ensuring appropriate support is available to the victim(s);*
- *Monitoring all withdrawal statements and ensuring appropriate advice/information is available prior to withdrawal;*
- *Monitoring the outcomes of investigations/prosecutions;*
- *Liaising closely with Domestic Violence colleagues and providing assistance where appropriate; and*
- *Acting as "consultants" to Divisional staff as appropriate."*

5.195 In 2005, Centrex released 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".*[151] WMP confirmed that this training then became mandatory for any staff involved in child abuse investigation.

5.196 In 2007, a Specialist Child Abuse Investigators Development Programme ("SCAIDP") was introduced and training delivered to CPU officers.[152] This was a national course, and those officers who were fully trained would be entered onto the national SCAIDP register.

5.197 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. Presumably interviewing would fall to ABE trained CID or FPU officers, depending on the nature of the offending.

5.198 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'), though exploitation was to become a recurrent theme in further training over the next decade.

5.199 Under the Alliance arrangements, and in light of Pathfinder being introduced in other parts of the force, the number of officers required to undergo SCAIDP increased significantly, and the course was extended to a two-week accredited course incorporating the general investigator training known as 'PIP 2' (Professionalising Investigations Programme, Level

[151] [redacted] pg 82
[152] [redacted] pg 83

2 – Serious and Complex Investigations). However, the consequence of this was that a number of officers failed to complete the course due to the demands of the course alongside competing pressures of the day job.[153]

5.200 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*".[154]

5.201 In terms of levels of officer training, WMP has provided the Inquiry with long lists of courses attended by officers over the years, which relate to child abuse, child sexual offences or child protection. From a review of those lists, and as noted above, there were no courses relating specifically to CSE, exploitation, 'child prostitution' or grooming until 2010. In terms of mandatory virtual training, delivered by online sessions through WMP's 'Managed Learning Environment', the Inquiry notes that CSE-specific modules were introduced, but not until 2014/15.[155]

5.202 Finally, I have been told that WMP officers and staff complete specific 'N-CALT' training packages in relation to modern slavery and human trafficking, which were first introduced in 2009 and updated again more recently in June 2020. This training package includes guidance on the National Referral Mechanism ("NRM") process and what is known as the 'Duty to Notify', namely the obligation upon the police to notify the Home Office and the NRM when encountering a victim of modern slavery or human trafficking. WMP has 20 nationally accredited specialist advisors currently distributed across LPAs, who are available for early investigative advice and best practice guidance on modern slavery issues. WMP indicated that a seven minute briefing presentation has been delivered to public facing officers and staff by the specialist advisers throughout WMP.[156]

5.203 I discuss the NRM process in more detail in the following chapter, Chapter 6: Other Organisations.

Conclusions – Policies, Procedures and Training

5.204 As to the 2007 Child Abuse Policy, it seems to me that:

5.204.1 WMP was slow to incorporate CSE learning and knowledge within its policies in a way that was accessible and useful – WMP's 2007 Child Abuse Policy had but

153 [redacted] pg 97-98
154 pg 97-98
155 pg 85 and pg 100
156 pg 163

a mention of, and no elaboration on, CSE, despite there having been ACPO guidance in existence for many years;

5.204.2 Regardless of the advice in the document that safeguarding was every officer's responsibility, it is not clear what steps were taken by WMP to ensure that all officers knew that this included looking for signs of CSE, whether by dissemination of the policy (though at 112 pages this would be unwieldy and impractical) or through training;

5.204.3 the reference within the 2007 Child Abuse Policy to other guidance meant that the policy was incomplete, and even those officers who ploughed through it all would not have had a complete picture; and

5.204.4 the failure to review the policy after two years as envisaged, and the really very minor changes after four years, tend to suggest that this policy was not in the forefront of WMP's thinking: these were years, after all, when WMP had been through the Chalice investigation, which was unlike anything it had undertaken before. I would have expected some learning to be reflected in the reviewed policy.

5.205 So far as the CPFP 2004 and the various iterations of child abuse procedures that followed are concerned, I find it increasingly surprising that the versions lack any real focus on CSE even up to those brought in post-Alliance when WMP had instigated a specialist CSE Team; illustrating the disconnect between such policies and procedures and the reality of WMP's work.

5.206 If a policy or procedure is to mean anything, it must reflect the threat and inform officers of best practice in dealing with that threat. It must be a working tool that is observed in practice, and demonstrated in a force's policing response. The overwhelming impression I have formed from the evidence is that, whilst WMP had policies and procedures in place, in many cases these were not sufficiently detailed, and cannot, in my opinion, have been comprehensively known or acted upon by all officers in the force.

5.207 The relevance of the tasking analysis is, in my view, as an indicator first, of the seriousness accorded to CSE related reports and second, of the degree to which information was being shared within WMP about the CSE threat.

5.208 As to the first, 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. This failure by WMP to recognise CSE during this period is a theme to which I return in the 2000-2006 section of this chapter, below. Despite other statistics showing an upward trend (as discussed in Chapter 2: the Nature, Patterns and Prevalence of CSE in Telford), 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%. It is important to note that there is no suggestion that CSE increased by an equivalent percentage – which I calculate would be somewhere in the region of 3,600% - during that

time. As I have said, I consider that these figures serve as an illustration of the importance placed on CSE reports by WMP during these time periods.

5.209 As to the second, I have considered the frequency of mention of relevant terms at the higher level meetings as an indication of the extent to which concerns about CSE were being officially reported up the chain of command. In the 2003 to 2005 period, there was only one instance of a CSE relevant match in a T & C Meeting record: surprising as that is, it pales into insignificance against the fact that during the time when Chalice was beginning there was apparently not a single high level T & C Meeting considering CSE. As I will show later in this chapter, this coincided with a reluctance within WMP senior management to heed properly what was being said about CSE, in particular by its refusal to convene a Gold Group to address the issue.

5.210 It is not clear to me the extent to which those officers who were responsible for attending referrals and strategy meetings, or those officers who were responsible for crime recording, were intended to be or were actually involved in escalation of information up the chain of command.

5.211 So far as training is concerned, the introduction of the CSE specific courses on the 'Managed Learning Environment' was relatively late; and as I will show, occurred at a time of renewed priority being accorded to CSE across WMP.

Multi-Agency Working

Introduction

5.212 During the course of the Inquiry I have had sight of documentary evidence which demonstrates that multi-agency meetings were clearly taking place between WMP and Safeguarding (and, on occasions other third parties such as Education) during the earliest period with which this Inquiry is interested, i.e. the 1990s, and that there were multiple conversations at such meetings about (or meetings specifically convened to deal with) issues around 'child prostitution' or sexual exploitation, which in more modern times would be termed CSE. Whatever the terminology, the meeting notes demonstrate to me that both agencies were aware of, and actively discussing, concerns of this nature.

5.213 Later in this chapter, I specifically address the evidence obtained by the Inquiry in relation to the intelligence being gathered by WMP during this early period; what that intelligence revealed, and the action taken. I then consider this in the context of three particularly pertinent case studies, which I have found to be of considerable significance. For the purposes of this section, therefore, I have concentrated on looking at a few examples of meetings that were held, and the ways in which authorities were working together – rather than the cases or the issues themselves – in order to assess the role being taken by, and the approach of WMP to multi-agency working. I address other aspects of multi-agency working between WMP and the Council's Licensing department, for example, in Chapter 4: Taxi Licensing and the Night-Time Economy.

5.214 I have also considered the structures in place within WMP over the years, and the applicable policies and procedures, insofar as these governed the way in which officers were required, or expected to engage with other authorities or third parties.

Early Multi-Agency Working

Structures for Joint Working and Information Sharing

5.215 An officer who had worked within WMP during the late 1980s/early 1990s told the Inquiry that it was following the enactment of the Police and Criminal Evidence Act 1984 that *"the police then became slightly more open and we would tell other agencies what we were doing"* and that *"there was beginning to be a proper liaison between social services and the police".*[157]

5.216 I have seen evidence that in 1990, officers from the CAD attended 946 case conferences, investigating allegations of child protection incidents. No distinction is made as to whether these involved familial, non-familial, sexual or other forms of child abuse, but it does indicate to me the scale of meetings that were taking place at that time,[158] and it is clear to me that this was being driven primarily by a small number of child protection officers.[159]

5.217 This was before the creation of the CPUs, which as I noted earlier in this chapter, were first established in 1992, and fell within the CAD. The Inquiry has been told that, around this time or perhaps shortly after, the CPU was relocated from the main police station in Telford to premises at Donnington that were next door to Safeguarding.[160]

5.218 At this time, I understand that there were approximately four officers in the CPU; two being Constables who attended case conferences set up by Safeguarding. Also in attendance at those conferences would be health visitors, teachers and social workers.

5.219 In terms of the process for engaging with Safeguarding at this time, the Inquiry was told that:

"… generally we'd have a referral from social services… and we would get together with a particular social worker that had been assigned the case and discuss how we were going to investigate and what the first thing was that we would be doing".[161]

5.220 An officer also explained:

"… *We were basically given jobs individually by* [the Detective Sergeant] *because he'd generally, he'd be the person that would go to a meeting with social services. They'd relay*

157 [redacted] pg 67
158 and [redacted]
159 pg 6
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information to him and then he would come to us and obviously give us particular lines of work if you understand what I mean. We'd all have a caseload then".[162]

5.221 Another officer explained to me insofar as child protection was concerned, that multi-agency working was helped greatly by the introduction of the Memorandum of Good Practice in 1992[163] which demanded a joint investigation and approach to interviewing child witnesses. The witness explained that this meant child protection officers would speak with Safeguarding on an *"almost a daily basis"*, explaining:

"… you'd liaise with them, you'd speak with them, you'd meet with them and let them know everything that was going on. They'd have full access to the papers".[164]

5.222 I also heard evidence from more than one CPU officer that, certainly in the late 1990s and early 2000s, it would be routine for officers and social workers to visit the family home together, and speak to children suspected of being vulnerable or at risk in front of their parents. In hindsight, however, one officer acknowledged that:

"*… with the parents present it was perhaps not surprising the girls did not speak up, as it would have been very difficult for them to have made complaints of CSE or abuse if their parents were not aware of what was going on*".[165]

5.223 These descriptions are very much borne out in the material that has been made available to me, and which I believe demonstrates that there was early engagement between, at the least, Safeguarding and WMP, in discussing cases of child protection for the earliest period of this Inquiry's Terms of Reference – and I discuss this material in more detail below. What is also clear to me however is that the majority of that engagement focussed upon what one might call 'typical' cases of child abuse or neglect, and primarily within the family setting – and there was far less focus upon cases of sexual exploitation.

5.224 This is in keeping with what I believe to have been a feature of culture and practice at the time, which I deal with separately in Chapter 9: Attitudes and Impact. However, this is not exclusively the case, and I have been provided with evidence that confirms that both WMP and the Council's Safeguarding department were aware of 'child prostitution' and incidents of obvious sexual exploitation of children, and that these were discussed in multi-agency meetings well over twenty years ago.

Examples of Early Multi-Agency Meetings

5.225 As mentioned above and as will be discussed in more detail in the following section, I have seen the files of certain children from the early 1990s, and their cases have provided me with insight into the way in which multi-agency meetings took place, and the role played by WMP at this point in time. From the police perspective, I have considered these cases,

[162] [redacted] pg 7
[163] Memorandum of Good practice on Video Recorded Interviews with Child Witnesses for Criminal Proceedings, Home Office/DoH 1992 https://lx.iriss.org.uk/sites/default/files/resources/040.%20Research%20Review%20of%20the%20Memorandum%20of%20Good%20Practice.pdf
[164] [redacted] pg 7
[165] [redacted]

and select other material, upon which I feel able to make specific assessment of the approach taken by WMP to multi-agency working.

5.226 The earliest material seen in this regard, relates to a series of meetings that took place in November 1998 in relation to a number of children, and concerns around their involvement in "*child prostitution*".[166] The minutes show that detailed discussions took place about the whereabouts and activities of the children; named suspects and associates, and their locations; and steps taken regarding care or temporary placements of the children, which in certain cases involved liaising with the housing department within the Council. Those present at one particular meeting included: a member of the Council's Initial Response Team; a representative from the Housing Team; a social worker for one of the children; one member of the Council's resource team; and one police officer.

5.227 In terms of follow up actions and mutual working, the meetings anticipate how the children can be encouraged to engage in Memorandum Interviews with the police, and the first step being for an officer and social worker to visit the children individually with a view to encouraging them to make disclosures. Information is also to be passed to the Education Department, to consider from an educational welfare point of view.

5.228 It is noted at multiple points in the minutes that information must be shared contemporaneously between all agencies concerned, so that appropriate action can be taken.

5.229 However, the minutes demonstrate that there was a clear lack of engagement between North and South Wrekin Safeguarding teams (who, at that time, appeared to have split responsibility for the children, depending on where they resided), and information was not being shared by the South, either with the North social workers or with WMP. When a police officer attended South Wrekin Safeguarding in person, to enquire as to what follow up was being taken in relation to concerns about one of the children under their care, that officer was told "*the Case Manager* [name] *had been on holiday therefore had not been available*" to attend meetings or follow up actions. The officer expressed their dissatisfaction, recounted in the minutes as follows:

"*During* [their] *visit to South Wrekin Social Services,* [officer name] *verified that West Mercia Police were 'not best pleased' with the way in which the matter has been handled and recorded* [their] *concerns over the seriousness of the scenario surrounding these very vulnerable young people*".[167]

5.230 I deal with the North/South split and its resolution in more detail at Chapter 3: The Council Response to CSE in Telford.

5.231 At one point, the minutes also state that "*liaison with West Mercia Police broke down, resulting in there being no representation*" at a key strategy meeting.[168]

166 [redacted] pg 192 to 196
167 pg 192
168 pg 192

5.232 This particular meeting in November concludes:

"The meeting recorded the grave concerns voiced today and unanimously felt the urgency to realise the seriousness of the situation surrounding the girls. To this end, [name] *proposed that everyone take responsibility to call a Strategy meeting at any time should it be felt that the plans put into place are not working to protect the girls".*[169]

5.233 Another joint strategy meeting seen by the Inquiry evidences a conference held between the police and Safeguarding in December 1999[170], in relation to concerns raised about a man in his late thirties 'entertaining' a number of children of primary and high school age at his home. A number of the children were known to Safeguarding, and the man concerned was also known to the police due to previous allegations and action taken in relation to activity involving a number of children. A Detective Constable and Detective Sergeant from the FPU were in attendance at the meeting; together with two managers from the Council's social care team. The discussions were short, focussing on immediate next steps to try to elicit further information from the children concerned about "*what takes place at the flat*", as well as talking to a relative of the man in question – however it was recognised that one of the children might be a "*weak link*", and there were concerns that any action taken should avoid "*alerting* [the suspect] *to* [the police] *enquiries*".

5.234 There are no records citing what happened in the follow-up to this meeting, suffice to say, however, that at least two of the children mentioned in that meeting are names known to the Inquiry as children who went on to be involved in CSE over the subsequent decade, and whose cases were reconsidered in later CSE investigations by WMP.[171]

5.235 Indeed, one of the children mentioned in the December 1999 meetings is mentioned again in what I consider to be a crucial multi-agency strategy meeting which took place in the Autumn of 2000.[172] I have been provided with minutes of that meeting, at which two police officers were present from the Domestic Violence Unit, together with members of the Council's Initial Assessment Team and the Family Support Team, as well as the Deputy Head of one of the local Telford schools. The meeting was convened under the Council's child protection procedures and, it states, has been called:

"*To discuss the above named girls who are either past or present pupils at* [name of school] *and collate information surrounding concerns about them mixing with older Asian men in Wellington, predominantly around the area of* [a named street]".[173]

5.236 The Deputy Head opened the meeting by describing the concerns noted by members of staff at the school over a two and half year period, that a number of children were absent from school or being collected "*by older Asian 'boyfriends'*" and that "*several girls have received expensive gifts from these men*". Reference was made to events involving multiple children, who had admitted to staff that "*money was exchanged for bed and breakfast*"; that "*alcohol was offered to them*" and that the children were scared and had been

169 [redacted] pg 196
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173 [redacted] pg 2

threatened. Disclosures had been made indicating the families of the children were also being threatened by the 'boyfriends', and – most importantly, in my view – connections were made to recently deceased Lucy Lowe as having been involved in the same circle of children and the 'boyfriends'.

5.237 At this point, the attendees were made aware of "*major concerns*" in relation to another child who was known to the Family Support Team. Discussions also took place in relation to a child currently on the Child Protection Register; whose parents had already alerted the authorities to concerns, and who had "*been seen in school with bruises, cuts and burns… but will not talk to anyone about them including the police*", although she did provide names of the Asian men she was associating with. Tellingly, in my view, it is reported that this child "*knew the situation with Lucy Lowe… but would not tell anyone*" – which indicates to me that the professionals at that meeting may have suspected that Lucy Lowe had been subjected to CSE at the time she was murdered just a few months previously.[174]

5.238 The level of knowledge of those present at this multi-agency meeting in 2000 goes even further. A social worker asks the police officers "*if there had been any queries regarding* [a named 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 a recommendation is that "*police and social care to speak to parents and girls individually*".[175]

5.239 Unfortunately it appears that, in a further meeting some months later,[176] the decision is taken that there should be "*no further action*" in relation to the children, as there was "*no evidence of prostitution*" following joint interview. 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.

5.240 What is clear, however, is that these documents provide irrefutable evidence that by late 2000 active discussions were taking place at key multi-agency meetings, at which WMP officers were present, about children known to be at current risk of 'child prostitution'/'exploitation'.

5.241 It is against this backdrop of knowledge that I go on to consider the next decade of multi-agency meetings involving the police.

2004 Onwards

5.242 As noted earlier in this chapter, the Inquiry was told by WMP that by 2004 the FPUs had become "*an integral part of mainstream CID*" and that specialist child protection officers

174 [redacted] pg 4
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176 [redacted] pg 16

staffed that department, but that those officers would only deal with referrals of familial abuse; non-familial referrals would be retained by mainstream detectives.[177]

5.243 I have noted that 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 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*".[178]

5.244 The policy at the time, therefore, required CID officers to access the published material via, and seek guidance from the FPU about what steps should be taken to deal with child exploitation referrals, even though the FPU only dealt with cases of familial abuse. This seems to me to have been an entirely circular process – I assume the rationale being that because FPU officers held the day to day relationship with Safeguarding, they were presumed to have the requisite knowledge and experience to give advice on cross-agency working and how to manage exploitation cases; it is not clear to me why such cases could not have been managed by the FPU directly.

5.245 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. The child would be interviewed by Safeguarding and the police together, and this would be recorded on what was known as a 'VW1' form, which would then be signed by the child. At that time, the officer describes the mainstay of their casework as "*intra-familial rapes, sexual assaults, physical assaults and chastisement, or neglect*". [179]

5.246 Insofar as attending multi-agency meetings with Safeguarding was concerned, such as child protection conferences or strategy meetings, I understand that these would usually be attended by ranking officers of Sergeant or above; Detective Constables within the FPU would not usually attend, and the police would not be involved in making any decisions at those meetings, or indeed with drafting child protection plans – this would remain the responsibility of Safeguarding, albeit officers may provide some input for example in relation to any policing elements such as bail conditions.[180] I note, here, that in the earlier meeting minutes between 1998 and 2000 as set out above, the officers attending were all in the rank of Constable; whether there had been an intentional change post-2004, that a more senior officer should attend, is not clear to me.

177 [redacted] pg 5
178 pg 13
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5.247 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*"[181] – suggesting to me that perhaps, prior to this, liaison between the two was considered to be more ad hoc, and at the will of individual officers and social workers, rather than in accordance with any established practice or policy for information sharing. That said, I do remind myself that the CAD role included liaison with other agencies as far back as 1989, and as demonstrated above, there was clearly a significant amount of cross-agency working and information sharing involving the police, for at least a decade before.

5.248 As to what happened in practice following a referral, during this period, WMP explained that there would be a routine check of incident logs by control room staff to identify those which had been tagged for FPU (or CAIU, as it then became). 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'.[182] These were "*unscheduled but formal … known as strategy discussions*", and the main method for these was stated to be via direct telephone contact. There would then be a jointly agreed decision and action plan – as envisaged by the 'Working Together' guidance.

5.249 WMP explained that, in such cases, the neglect or abuse which founded the referral would often then be recorded on CRIMES as the primary offence.[183]

5.250 WMP further clarified:

"The exploitation of a child would be given the primary criminal term, rape or indecent assault for example. If the offence was inter-familial and required an ABE interview, that enquiry would be owned by the FPU/CAIU. All other offences would be owned by CID".[184]

5.251 This confirms the position set out above, that CID would become responsible for engaging with Safeguarding when investigating non-familial child sexual offences. When asked whether any other agencies would be alerted as to the risk of any identified CSE offences, WMP told the Inquiry:

"*Partnership information sharing was in many ways equivalent to today's practice even in the absence of the electronic transfer of information which was not available at the time*".[185]

5.252 I take this to mean that the less-formal process prevailed, of discussions taking place routinely over the telephone, or by visiting other agencies, rather than via the submission of specific forms and paperwork.

Multi-Agency Working During the Period of Chalice

5.253 I have, later in this chapter, dedicated an entire section to Chalice and the way in which that long-running CSE investigation was managed by WMP, together with Safeguarding

181 [redacted] pg 6
182 pg 13
183 pg 14
184 pg 14
185 pg 14

and other agencies. So far as multi-agency working specifically was concerned, I heard witness evidence that during the initial phase of Chalice there were a number of multi-agency meetings which were designed not only to address the needs of the victim/survivor, but also to ensure the wider family had support, and to ensure other professionals were aware of what was happening (such as schools).[186] Having considered the minutes available to me, these appear to be the Council's 'CATE' ("Children Abused Through Exploitation") meetings,[187] which a police representative began to attend in 2007. Although these meetings were expressed to be successors[188] to the sexual exploitation meetings which had discussed individual cases,[189] they were at least initially strategic meetings which seemed to identify themes rather than to deal in specifics.[190]

5.254 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 meeting in October 2007, the FPU representative reacted to the suggestion that the Council's clusters share information by suggesting:

"*This may give the police clearer information, but there is also the issue of confidentiality and trust.*"[191]

5.255 It was left to a representative of Safeguarding at that meeting 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.[192]

5.256 Chalice was introduced to the Council by WMP at a meeting in June 2008.[193] I have also seen the minutes of a multi-agency meeting in July 2008 at which individual children were discussed and in which information was shared by the police and others.[194] Thereafter the CATE minutes seem to serve the purpose of reporting on the quality of information sharing rather than to be a vehicle for that sharing. In September 2008 such minutes note "*Police Update… Information sharing is very positive.*"[195]

5.257 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:

"*There was no issue around trust because we were passing reams of information to police … around our concerns on the ground with young people*"[196], and

186 [redacted] pg 3
187 [redacted]
188 [redacted]
189 [redacted]
190 [redacted]
191 [redacted] pg 3 and [redacted] pg 3
192 [redacted]
193 [redacted]
194 [redacted]
195 [redacted]
196 [redacted] pg 37

"*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.*"[197]

5.258 Dramatically, the joint working was occasionally for the safety and security of the Council's CATE staff, as in this account:

"*I'd already rang one of the police officers for Operation Chalice, told him where I was, I was in this taxi on the way for this girl who said she was trapped in this flat and he gave me the number of a local police station there and would be contacting them … I mean they would have told us what we needed to know I'm sure, and if they thought we were in any danger they wouldn't have let us put ourselves in danger.*"[198]

5.259 I have also heard evidence that Chalice officers were available to CATE workers out of hours and were "*passionate about the work they were doing and trying to keep young people safe";* that officers would attend Team Around the Child ("TAC") meetings with CATE workers; and that on the day that suspects were arrested, officers accompanied social workers to gain the confidence of victims.[199]

5.260 It is clear to me that Chalice signified a period of intense, daily, close working relations between, in particular WMP officers and the CATE Team and that these largely focussed on supporting the victims and working to obtain sufficient disclosures to support a prosecution outcome. I note, though, that the closest links were almost completely informal, and at the start of Chalice even FPU officers were nervous about receiving information from the Council, which speaks of a fundamental misunderstanding of the purpose of, and exceptions to, data protection.

5.261 I am fortified in that view by noting that in 2013 the NewStart Networks Report stated that, there was "*a consensus that prior to CATE, multi-agency working had been more difficult, but that when the Police came on board and CATE was established (2008), the situation improved*".[200]

5.262 I found another witness's account to be particularly helpful - if rather scathing - in their appraisal of WMP's role in multi-agency working and CSE at around this time - that

"*… the police do a good job, but… they cannot do everything and must rely more on a multi-agency approach… the police score some inadvertent home goals on occasion, by attempting to take on too much or by "badging" achievements/campaigns with the police logo as opposed to that of the partnership*".

197 [redacted] pg 58
198 pg 13
199 pg 60
200 pg 30

5.263 The witness felt that a more "*inclusive approach would … engender more trust and confidence* [in the agencies] *collectively*".[201]

5.264 It seems to me that during this period between 2009 and 2012, WMP learned some important lessons in relation to the value of multi-agency working; and whilst there had not necessarily been a change in inter-agency approach insofar as it still came down to officers working closely with Safeguarding, the difference was of course the approach that was being taken to victims/survivors – who were for the first time being seen as such, and were being handled by specialist officers who had identified them as such. One of the Chalice officers explained that the CATE team *"revolutionised the way CSE was dealt with in Telford… it was a "fantastic model".* They went on to explain that:

"The team was finding a lot of the victims did not want to engage with the police and they needed support in order to make a report… the victims needed somebody to listen and accept categorically what they were saying. The CATE team were able to build that relationship and… it was vital to the [police] *investigation".*[202]

5.265 The Inquiry was also told by this officer that the Chalice team worked in partnership with a number of different organisations and that information sharing was key in order to proactively identify potential victims. This meant liaising not just with CATE but also schools and medical professionals, as they are often the first organisation to see something is not right with a child. They recognised that, historically, conversations were probably not happening between all of those agencies in the way that it should, and that it was perhaps "*too easy to hide behind confidentiality*"[203] when it comes to information sharing.

5.266 I also note here that, in the middle of Chalice the CEOP *'Out of Mind, Out of Sight'* national thematic inspection was published in 2011. Its conclusions were essentially general; in so far as the police (nationally) were concerned, this was offered:

"Each policing team that may come into contact with victims or offenders needs to have an understanding of child sexual exploitation. Training should be provided to appropriate police units and teams, including CAIUs, CID, PPUs and community policing. Police forces should also develop a strategy to ensure that cases of child sexual exploitation are identified and progressed appropriately."[204]

5.267 Additionally, in 2012 the Alliance CSE Position Statement was published, as mentioned above, which identified the current and planned CSE multi-agency activity. CSE Safeguarding Panels with partner agencies were also established in 2012, where reported CSE incidents were brought to panel and reviewed on a monthly basis. WMP says the panels "*developed partnership working and information sharing"*[205]*;* they appear to have been a formalisation of the previously ad hoc information sharing developed between the CATE

[201] [redacted] pg 20
[202]
[203] [redacted] pg 29
[204] https://www.basw.co.uk/system/files/resources/basw_95410-10_0.pdf
[205] [redacted], pg 114

Team and Chalice. The panels met monthly to review and evaluate intelligence in relation to individual cases.[206] WMP views these panels as:

"… pivotal in the sharing of and evaluating intelligence in individual cases with West Mercia Police being a permanent sitting partner. For example, the Panel could commission support and involve diversionary services". [207]

5.268 I have not been referred to any instance of CSE Safeguarding Panels commissioning services of any kind; the information sharing aspect appears to have been realised through multi-agency CSE 'risk panels'. A member of the CATE Team reflected on the risk panels:

"*It's been positive, yes. I don't feel that anybody's not been able to share information with me or withheld information or there's been hoops to jump through. I don't feel there's been any barriers."*[208]

5.269 In practice I have seen examples of plainly relevant intelligence in respect of children at risk being shared at safeguarding panels;[209] it seems to me the system works and the formalisation of the good practice that developed during Chalice is to be welcomed.

5.270 I believe it is also relevant to note that in 2013 the NewStart Networks Report stated at page 30 that staff who were interviewed indicated that:

"*Police holding CSE cases in PPU presented as problematic as they hold and co-ordinate information but are not then responsible for investigation. This can create issues in communication, consistency and ownership between agencies*".

5.271 However, I refer back to the "*consensus"* mentioned above, that multi-agency working was felt to have improved when WMP came on board and after CATE was established.[210]

Harm Assessment Units

5.272 In 2013, three 'Harm Assessment Units' ("HAUs") 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 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".[211]

206 [redacted] pg 158
207 pg 158
208 pg 53
209 pg 32
210 pg 30
211 pg 10-11

5.273 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.[212]

5.274 Initially Telford was covered by HAU North, which also covered Shropshire and was divided into two equally staffed teams of three officers and two support staff, though notably the HAU North CSE Coordinator was based in Shrewsbury until April 2017.[213] It is unclear to me why the Coordinator would not be sited in Telford, where an established CSE problem was known.

5.275 WMP has explained that before the existence of HAUs, 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 the Council (or other partners) there would be no record of what information had been shared.

5.276 It was a specific role of the CSE Coordinator to take on the overnight review of command and control and intelligence logs for CSE indicators and consider the action to be taken as a result.[214]

5.277 There was, therefore, now a formalised information sharing process in place, following the conclusion of Chalice in 2012, for CSE referrals to be made via the HAU, direct to CATE – rather than via individual officers in child protection. One witness, who was involved in Chalice, explained to me the HAU became involved in the day-to-day course of identifying and referring cases of CSE to the CATE Team, where there was a concern about a child. This witness had in fact suggested in 2013 that, as a point of learning, the Team would benefit from co-location with 'partners' to enable closer working, however this was not to happen for some time still to come, as I note below and as I also discuss in the 'MASH' section of the Council chapter (Chapter 3: the Council Response to CSE in Telford).[215]

The MASH and Co-location

5.278 In late 2015 the Telford HAU was co-located with the Council's Family Connect team to create a Multi-Agency Safeguarding Hub ("MASH") under Council management.[216]

5.279 WMP notes that "*multi-agency safeguarding hubs were introduced following a review commissioned by the Alliance ACPO team in 2015 with regard to the existing HAU model with a view to developing the merging MASH ideology across both forces*".[217]

5.280 It continued:

212 [redacted] pg 46
213 pg 24
214 pg 16
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217 pg 38

"*… negotiations with partner agencies led to the splitting of the three pre-existing HAU hubs, aligning resources, based on demand, to each of the five local authority areas and co-locating these with partner agencies*".

5.281 The objective of the MASH was described in its operating procedures:[218]

"*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. The specific objectives for the MASH are:*

1. *Improved decision making at the point of contact/referral as a result of increased information being available. By building a more accurate picture the MASH will allow a more effective and targeted response resulting in better outcomes for children and adults*

2. *Early identification of harm and risk. The MASH creates an environment that enables the analysis and research of partnership information. This can be further developed using multiple risk factors to identify children and adults within the Alliance who are at risk of future harm*

3. *Reduced repeat engagement with statutory services. As a result of improved early identification and targeted support issues are resolved before they escalate*

4. *Discharge the principles of Working Together".*

5.282 The operating procedures also explained the importance of staff understanding the information sharing legislation but emphasised that the ethos behind the MASH was to "*share information with confidence in partnership*". The procedures also warned against creating *"unnecessary bureaucracy"* that would hinder the information sharing process and explained the MASH was a *"sealed envelope"* where all relevant police information would be shared[219].

5.283 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. It is not clear to me whether there was scope for the hearing of views from outside the triage team or for subsequent re-referral; it is reminiscent of the description I have heard of the operation of the Council's FAST team a decade before, where decisions were regarded as final.

5.284 As to the working of the MASH, a PEEL report in 2018[220] noted that none of the HAUs nationally met the most effective arrangements of the daily sharing of information although some came close. Notwithstanding this, the report stated that the Telford HAU and MASH

218 [redacted]
219
220 [redacted] pg 20

enjoyed *"close partnership working and good information sharing"* and were based at the same location. I discuss the PEEL report, together with inspections, later in this chapter.

5.285 In all, I take the development of the HAU as a sensible one; it appears to have had close ties with CATE and with Shropshire's equivalent unit. I have said the same regarding the MASH, in Chapter 3: The Council Response to CSE in Telford.

The Current Position

5.286 WMP told the Inquiry that the introduction of specific CSE teams in 2015 demonstrated its *"investment in the multi-agency response to CSE"*. It said:

"*The subsequent growth* [of the teams] *included appointments of further detective officers, CSE co-ordinators, Intelligence officers and training staff who have all worked closely with the CATE team and wider local authority departments. This has further developed since, with the investment in further resources... and today we see a continuing close working relationship between the police CE team and the local authority CATE team".*[221]

5.287 The Inquiry heard evidence from a WMP officer that members of the CSE (now CE) Team attend the fortnightly multi-agency CSE risk panels, and that information is shared more widely with Council departments including Licensing.[222] The relationship with the local intelligence department was said to be useful with daily assessment and sharing of relevant material.

5.288 The Inquiry was told that in more recent times, child protection officers will prepare reports detailing all of the police involvement with the child/family prior to a child protection conference taking place with Safeguarding. Since 2015, if the case relates to a child involved in, or at risk of CSE, then an officer within the CE Team would attend the relevant meetings with Safeguarding, rather than a member of the Child Protection Team. Equally, if information is shared during a child protection conference that indicates a child is at risk of CSE, and the police are not already aware of this, then this information would be taken back to the CE Team for action to be considered.[223]

5.289 I must note other aspects of WMP's involvement in areas of multi-agency practice for CSE, which have since been established more recently, including the following:[224]

5.289.1 The CE Team is now responsible for reviewing relevant intelligence – and where there are issues with the way in which intelligence is marked, and which may prevent sharing, a Detective Sergeant within the CE Team seeks to resolve the issue with an intelligence manager with a view to ensuring all intelligence capable of being shared is provided to partner agencies.

5.289.2 The LPA maintains a care home coordinator working within the CE Team to engage with care homes and to identify CSE risks. There is a monthly meeting

221 [redacted] pg 159
222 pg 23
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attended by care home managers with the manager of the CATE Team and the CE Team care home coordinators in order to raise any concerns and identify action, which will be recorded by the CSE Sergeant. When a new looked after child arrives in the area the placing authority provides information to WMP and notification is made to the CE Team Coordinator in the event the child is deemed a CSE risk.

5.289.3 An HRU Sergeant attends the Council's Day and Night-Time Economy Meetings while from 2018 'Team Telford', a group comprising senior PVP officers, a local authority Assistant Director and Heads of Business provided a strategic lead for partnership working.

5.289.4 The LPA also shares weekly details of all licensing visits – of which there might be as many as 50 a week - with a number of partners including the CSE Team. Additionally the Telford Street Pastors share a multi-agency report weekly on a Monday after a weekend's patrol.

5.289.5 There has also been a protocol put in place with a local college whereby registration numbers of unauthorised vehicles on site will be shared with the police for checks to be completed.

5.290 It is clear to me that, with the introduction of these measures, there has now been for some time regular joint working between WMP and its colleagues within the Council – whether that be Safeguarding, Licensing, Housing, Health or Education. I do not take issue or single out any of these measures as one requiring improvement – they are, I believe, eminently sensible and necessary in order to ensure a coordinated, multi-agency (and multi-targeted) approach to CSE.

5.291 So far as information sharing by WMP's CSE Team is concerned, it was noted by WMP following a review of Chalice in 2018 and considering the multi-agency pathways for CSE that are in place now, 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".*[225]

5.292 I consider this review in more detail later in this chapter, however I note here its overall findings in relation to WMP's role in multi-agency working:

"*Integration with partner agencies is a strength within the LPA, with staff from the Children Abused Though Exploitation (CATE) team attending fortnightly meetings with police. There are seven workers within the CATE team, who work on a 1-2-1 basis with any child involved in CSE. Any Police Officer or staff member, together with external agencies can refer into the team. Additionally the Telford Multi Agency Targeted Enforcement Strategy (MATES)*

[225] [redacted] pg 41

has been initiated on the LPA and this further cements integrated multi-agency co-operation, cross cutting multiple enforcement activities including CSE".[226]

5.293 This was (and is) of course eminently sensible, and 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. In many ways, however, I find that all of this is a slightly different version, and expansion of the sort of liaison that I have seen was taking place – albeit perhaps less formally – in the late 1990s and early 2000s. The authorities were talking to each other then, just as they do now. The difference is, of course, that the professionals concerned now know what they are dealing with; there is a name for it, and there is a process, and there are blueprints for action in the forms of Chalice and the CATE Team.

Conclusions – Multi-Agency Working

5.294 The evidence I have seen shows that there certainly was multi-agency working in the 1990s and 2000s – CAD officers attended a great many child protection conferences in 1990 alone. Given the evidence I have set out in relation to methods of the police receiving referrals from the Council, I assume that CPU/FPU continued this work. It is not clear to me, however, the extent to which officers in those units referred cases to Safeguarding; with regard to CSE cases specifically, these remained the responsibility of CID for years until the inception of the CSE Team. During most of that time, and certainly until the creation of the HAU, referral to Safeguarding appears to have been an entirely informal process at the discretion of the officer in the case.

5.295 In information sharing, as with so much else, Chalice was a success because of those individuals involved. It is quite plain to me that during the currency of the operation both police and CATE staff 'lived and breathed' the lives of the victims/survivors. For those involved, information sharing was not a mantra, it was about active protection of children at risk.

5.296 Notwithstanding the positives of Chalice, which I go on to discuss in more detail below, this appears to mean that working with the Council to share information was essentially on an ad hoc basis, notwithstanding that '*Working Together*' and the associated 2000 Supplementary Guidance set out that local arrangements for such children should be consistent. It seems to me the advent of HAU and Safeguarding/Risk Panels in 2012 gave the necessary degree of consistency to the process for the first time and that the co-location of the police in Family Connect refined it further.

5.297 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

[226] [redacted] pg 7

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[227]: a situation which I consider would be inconceivable today.

5.298 As part of my Recommendations at the beginning of this report, I discuss the way in which agencies have worked together historically, in particular in relation to matters such as information sharing, and I have made recommendations which seek to enhance this aspect of multi-agency working.

National and Regional Intelligence Management

5.299 This section is intended to set out the structure in which WMP operated with regard to management of intelligence. Analysis or criticism of these structures are beyond the Terms of Reference of the Inquiry and accordingly it is presented primarily as background.

National Intelligence Management

5.300 The National Criminal Intelligence Service ("NCIS") was formed in 1992 from the National Drugs Intelligence Unit. It was put on a statutory footing by the Police Act 1997 with a general function to:

5.300.1 Gather, store and analyse information in order to provide criminal intelligence;

5.300.2 Provide criminal intelligence to police forces; and

5.300.3 Act in support of such police forces.[228]

5.301 The same Act created the National Crime Squad ("NCS"), [229] with a general function to prevent and detect serious crime "*which is of relevance to more than one police area in England and Wales*" and an ability, at the request of a force's chief officer, to "*support the activities of the force*".

5.302 NCIS and National Crime Agency ("NCA") were merged with parts of Her Majesty's Revenue and Customs ("HMRC") in 2006 to become the Serious Organised Crime Agency ("SOCA").[230] CEOP was formed in 2006 as a department of SOCA.

5.303 In 2013 SOCA became subsumed within the new NCA;[231] and CEOP is now a command of the NCA. The Inquiry explains the role of the NCA and its predecessors in Chapter 6: Other Agencies. It should be noted that prior to the existence of the NCA and the Regional and Organised Crime Unit for the West Midlands ("ROCUWM") (discussed below), WMP would liaise with NCIS, NCS and the SOCA to gain information about national CSE threat assessments and intelligence.

[227] [redacted]
[228] Section 2 of the Police Act 1997
[229] Section 48 of the Police Act 1997
[230] Section 1 of the Serious Organised Crime and Police Act 2005
[231] Section 1 of the Crime and Courts Act 2013

Grading of Intelligence

5.304 Prior to the mid to late 1990s, officers graded intelligence reports with a '4x4' matrix system as follows:

5.304.1 The 4x4 system was based on four source codes:

- A - where there is no doubt of the authenticity, trustworthiness and competence of the source, or if the information is supplied by a source who, in the past, has proved to be reliable in all instances;
- B - source from whom information received has in most instances proved to be reliable;
- C - source from whom information received has in most instances proved to be unreliable; or
- X - the reliability of the source cannot be assessed.

5.304.2 The source codes sat alongside four information (or evaluation) codes:

- 1 - information whose accuracy is not in doubt;
- 2- information known personally to the source but not known personally to the official passing it on;
- 3 - information not known personally to the source but corroborated by other information already recorded; or
- 4 - information which is not known personally to the source and cannot be corroborated.

5.305 In the mid to late 1990s, a dissemination section and third 'x4' was added by forces nationally. This covered the disposal or passing on of the intelligence to the appropriate level of policing for possible further development or action.

5.306 In 2005, the Home Office/Centrex published the National Intelligence Model ("NIM"), where all police forces were required to grade intelligence by a '5x5x5' matrix; here the last '5' being the handling of the intelligence, the action taken and the disposal/ dissemination of the intelligence. The NIM also introduced control strategies (nationally, regionally and by forces); strategic and tactical intelligence; and tasking and coordination groups (at similar levels). Most forces had the grading matrix printed on the relevant forms to guide officers. I have seen that WMP had these gradings printed with guidance on the relevant forms in use.

5.307 The 5x5x5 matrix uses the following criteria:

SOURCE EVALUATION

- A - Always reliable;
- B - Mostly reliable;
- C - Sometimes reliable;
- D - Unreliable; or
- E - Untested source.

INTELLIGENCE EVALUATION

- 1 - Known to be true without reservation;
- 2 - Known personally to source but not to officer;
- 3 - Not personally known to source but corroborated;
- 4 - Cannot be judged; or
- 5 - Suspected to be false or malicious.

HANDLING CODE

To be completed at time of entry into an intelligence system and reviewed on dissemination

- 1 - May be disseminated to other law enforcement and prosecuting agencies, including law enforcement agencies within the EEA, and EU compatible (no special conditions);
- 2 - May be disseminated to UK non-prosecuting parties (authorisation and records needed);
- 3 - May be disseminated to non-EEA law enforcement agencies (special conditions apply);
- 4 - May be disseminated within the originating agency only; or
- 5 - No further dissemination: refer to the originator. Special handling requirements imposed by the officer who authorised collection.

5.308 In 2015, however, the criteria changed again, to a '3x5x2' intelligence assessment model. This approach reduced the source gradings to three; maintained the intelligence valuation on a scale of 5; and reduced the handling code to just two options, as follows:[232]

SOURCE GRADING

- 1 – Reliable;
- 2 – Untested; or
- 3 – Not reliable.

INTELLIGENCE ASSESSMENT

- A – Known directly to the source;
- B – Known indirectly to the source but corroborated;
- C – Known indirectly to the source;
- D – Not known; or
- E – Suspected to be false.

HANDLING CODE

- P – Lawful sharing permitted (with other government departments, private and voluntary sectors); or
- C – Lawful sharing permitted with conditions (i.e. conditions are placed on the recipient as to how that information may be used).

Regional Intelligence Management

Regional Organised Crime Units ("ROCU")

5.309 In 2015 the national ROCU network was formed. ROCUWM appears to have been in existence at least in an equivalent form since 2013,[233] though WMP suggests it was brought formally into being in 2014.[234]

5.310 The purpose of ROCUs is to assist police forces in tackling serious and organised crime by providing them with specialist policing capabilities, enabling the investigation of Organised Crime Groups ("OCGs") regionally, nationally and across policing boundaries. There are currently ten ROCUs that cover the 43 police forces of England and Wales.

[232] Intelligence report (college.police.uk)
[233] [redacted]
[234] [redacted] pg 37

5.311 ROCUs have prescribed capabilities that include Regional Intelligence Units ("RIUs"), Undercover Policing, and Specialist Surveillance and are designed to complement and support regional forces in their approach to organised criminal activity.

5.312 Prior to the existence of ROCUs, regional police forces collaborated in different ways. The West Midlands region used a Regional Task Force which included a RIU, a Regional Surveillance Team and an Asset Recovery Team. Prior to these task forces, NCIS formed regional hubs and used seconded staff for their operations. The Inquiry notes that before the existence of ROCUs there was no standardised form of cross border collaboration to share serious criminal intelligence.

5.313 ROCUs differ in size and structure dependent on regional characteristics but should have access to the range of prescribed capabilities to be effective. An important function of ROCUs is to establish a consistent point of contact between regional forces and the NCA in the formation of a national policing network. The importance of ROCUs was highlighted in the Serious and Organised Crime Strategy released by the Government in 2013.[235]

5.314 In 2015 HMIC reviewed the capability and effectiveness of ROCUs as a whole. It acknowledged that the capabilities made available to ROCUs had grown in recent years and that they had improved as organisations. Notwithstanding this, the review made clear that:

> *"… most ROCUs have evolved in a piecemeal way since they were created and they continue to develop inconsistently. ROCUs are structured in a variety of different ways, ranging from highly ambitious and effective cross-force collaborative units to smaller scale and less effective arrangements for sharing police force capabilities. This variation in ROCU structures creates a risk that, in some places, local and regional capabilities are collectively insufficient to counter serious and organised criminal threats effectively, and ensure that forces are meeting their obligations under The Strategic Policing Requirement. It also means that capabilities may be duplicated unnecessarily within forces. As a result, opportunities to build and strengthen a consistent national approach to tackling serious and organised crime are being missed".*[236]

5.315 The Inquiry has noted how the ROCUWM has developed since its inception: in 2016, a new Confidential and Intelligence Unit was formed within the unit; in 2017, Serious Organised Crime Units ("SOCUs") and surveillance teams were added; in 2018 it developed a regional threat assessment capability including the creation of a Covert Unit; and in 2020 there was the addition of a County Lines taskforce. The ROCUWM has also grown in number, with a current staffing of 550 employees - five times more than when it was established.

Strategic Governance Groups

5.316 I have seen material dating from 2009 showing the existence of a regional intelligence group with representation from SOCA, the four regional police forces and British Transport Police as well as Central Motorways Group and HMRC. WMP and other force attendees were

[235] Serious and Organised Crime Strategy, HM Government, October 2013, Cmnd 8715 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/248645/Serious_and_Organised_Crime_Strategy.pdf
[236] HMIC - Regional Organised Crime Units – A review of capability and effectiveness: November 2015, pg 5

representatives of their respective Force Intelligence Bureaus ("FIB"). The minutes reveal that there were monthly meetings to "*discuss emerging threats in the region*" and to produce a tactical assessment. The meeting noted CSE problems in Shropshire, thought to be related to the large number of children's homes, and Chalice in Telford.[237]

5.317 On a regional level and before the existence of ROCUs, serious crime governance groups were established in 2007/8 and became known as Threat Reduction Boards ("TRBs"). Although established in 2007/8, the evidence provided to the Inquiry suggests that regular meetings of the TRBs, with WMP and ROCUWM or its predecessors, only started in November 2012; although "*there were ad-hoc operational meetings that were held at force lead or SIO request*". The West Midlands CSE TRB was, at that time, led by Staffordshire Police.[238] The Inquiry understands that the TRB was well embedded by 2013 and WMP was represented by police officers who attended the board.

5.318 In November 2012, WMP joined the regional CSE TRB. The CSE TRB comprised the four local police forces and representation from UK Human Trafficking Centre ("UKHTC"), the Central Motorways Patrol Group and the RIU (predecessors of the ROCU). The pre-existing structure within WMP for dissemination of intelligence - a central FIB; local policing area based intelligence units; a central intelligence team; and an intelligence processing unit - was said to be unchanged though the WMP FIB operated across two forces. WMP says that this:

"*… did not lead to any reduced capacity and arguably enhanced information sharing across the two forces, who were on the same IT systems and benefitting from co-location of staff. The creation of a daily Alliance intelligence conference call (threat identification meeting) further enhanced the flow of information and intelligence across both forces and onwards to the West Midlands ROCU*".[239]

5.319 The West Midlands CSE TRBs were chaired by a senior police officer[240] and had defined terms of reference. The role of chair was rotated through the four police forces in the West Midlands region.[241] The scope of the TRB included on-street sexual grooming gangs/ groups, domestic trafficking, online abuse/use of technology and international trafficking of children for the purposes of exploitation. The TRB reported quarterly to the Threat Reduction Assurance Forum ("TRAF").

5.320 The Inquiry understands that the CSE TRB marked the start of national coordination of CSE threats at a regional level, with the assistance of ROCUs (and their predecessors). They provided analytical support and shared information and resources throughout the region crossing policing boundaries. In addition to this, information could be received and provided on a national level.

5.321 Due to some changes initiated by the NCA, between 2013 and 2017 these TRBs were replaced by Strategic Governance Groups ("SGGs") which were overseen by Regional

237 [redacted]
238 [redacted] pg 172
239 [redacted] pg 37
240 [redacted]
241 [redacted] pg 172

Tactical Tasking and Coordination Groups. These were chaired by the National Police Chiefs' Council ("NPCC") and act on issues from the SGGs that require escalation.

5.322 The SGGs report into national strategic groups on a quarterly basis. These national groups shape the strategic response/action plan for policing. SGGs perform against three threat pillars, one of which includes 'Vulnerability'. They exist for differing types of threat including modern slavery and human trafficking and county lines.

5.323 The Inquiry understands from representations made by ROCUWM that SGGs are a positive force for information sharing and tackling CSE (and other crimes), as policing leads are brought together to address issues that cross regional policing boundaries. The SGGs also progress regional strategic action plans against problem profiles developed by analysts at the time.

5.324 A CSE SGG was formed in August 2013 and its stated purpose was to:

"… reduce the threat to the UK posed by Organised Crime Groups who sexually abuse children seeking to identify, disrupt and dismantle those causing the greatest harm through improved targeted enforcement".[242]

5.325 Evidence gathered by the Inquiry indicates that, at this time, the group was progressing work on identifying CSE hotspots with a focus on street grooming.[243] The membership of this group includes the four regional West Midlands police forces and the ROCU. SGGs are currently chaired by an Assistant Chief Constable, but have previously been chaired by senior officers from ROCUWM.

5.326 The CSE SGG progresses the CSE regional strategic action plan. These plans are based on the ACPO National CSE Action Plan and detail the objectives, stakeholders, activity and measures across what is known as the 'four Ps' (Pursue, Prevent, Protect and Prepare). The Alliance developed its own CSE Action Plan in 2013, upon which I comment further below.

5.327 In 2019 the structure changed, and SGGs now have Thematic Delivery Groups ("TDGs") that sit underneath them to assist in the delivery of the SGG's work. The Inquiry understands these groups were suspended during the pandemic but recommenced in June 2021 with the Child Sexual Abuse and Exploitation ("CSAE") TDG sitting under the Vulnerabilities SGG. The TDGs are chaired by a Superintendent and attended by the regional forces and partner agencies.

5.328 At the time ROCUWM provided its evidence to the Inquiry, consideration was being given to how the SGGs share information with regional forces and a potential for SGGs to feed into regional forums attended by Chief Officers and PCCs from the region. The Inquiry welcomes this development, as it is clear that a more linked approach to sharing

[242] Previously the CSE TRB, [redacted] pg 173
[243] [redacted] pg 173

information would increase the understanding of threats and risk concerning CSAE across the region.

CSE Problem Profiles and Threat Assessments

5.329 As part of the evidence disclosed to the Inquiry, I have reviewed a number of 'Problem Profile' documents, prepared both regionally by the ROCUWM, and by WMP and neighbouring forces. The earliest problem profile I have seen is dated 2010,[244] and relates to a different force area; the first formal problem profile I have seen for WMP was dated 2013 (although I note further below that an earlier assessment of CSE had taken place in 2008, albeit in a different report form).[245] It is not entirely clear to me when the practice of conducting these problem profiles commenced nationally, or whether they had a different name previously.

5.330 I make reference below to those early assessments conducted by West Midlands Police ("WMiP"), purely to provide an understanding of the level of knowledge regarding CSE activity within the region at that time, and because the WMiP assessments also make reference to activity within Telford.

WMiP Assessments

WMiP 2010 Problem Profile - Operation Protection (the "2010 Problem Profile")[246]

5.331 The basis of this problem profile stemmed from a WMiP intelligence collection plan. This was instigated following information from Derbyshire Police that there was sexual exploitation of young females by groups of males in the West Midlands area. The investigation by WMiP into this intelligence was given the name 'Operation Protection'.

5.332 The 2010 Problem Profile[247] found that *"organised grooming and sexual abuse of vulnerable young girls is occurring on every LPU within the force"* **–** that force being WMiP, not WMP. However in relation to CSE offences, it identified that the problem was not one that was confined to the West Midlands force area alone. It noted that, in West Midlands specifically *"a quarter of all stranger rapes reported in West Midlands since October 2009 involve Operation PROTECTION victims*" – indicating the prevalence, at that time, of CSE in the region – but more widely commented that[248]:

- There was an *"urgent need for central co-ordination of robust processes at LPU, Force and regional levels to address intelligence gaps".*
- *"A high level of organised criminality has been evidenced both within the force and regionally*".

244 [redacted]
245 [redacted]
246 [redacted]
247 [redacted] pg 6
248 [redacted] pg 6

- "*Victims are often forced into prostitution, with intimidation and force used to maintain compliance*".

- "*Repeat locations for offences include hotels, parks and private dwellings".*

5.333 The 2010 Problem Profile also identified 139 female victims/survivors, the majority of whom (58%) were under the age of consent. Additionally, the profile identified that *"Half of all victims live in parental homes, whilst 41 per cent live in care."*[249] Notwithstanding this, this profile identified that *"'Looked after Children' are disproportionately at greater risk of abuse than those living in parental homes".*

5.334 The 2010 Problem Profile also found that half of the victims/survivors were or had been reported as missing.[250]

2012 WMiP Problem Profile - Operation Protection 2 (the "2012 Problem Profile")[251]

5.335 This document represented an update to WMiP's 2010 Problem Profile. It identified that the threat to children of sexual exploitation still existed in the West Midlands and in February 2012, 45 potential victims/survivors were identified (42 of them female). The 2012 Problem Profile identified many similar victim and offender characteristics as the 2010 Problem Profile, but important additions included the following:

"Girls are transported to different locations across the force, away from LPUs they reside in and onto various locations across the region and country where they are abused by multiple males.

Some girls now fulfil the role of facilitators who befriend new vulnerable girls and introduce them to their abusers.

Although victims have been given educational opportunities and sexual health awareness, engagement with services varies from good engagement with regular contact to others who don't engage at all."[252]

5.336 The identification of the 2010 and 2012 Problem Profiles demonstrates that neighbouring police forces (and fellow forces within the regional intelligence groups) were aware of the CSE threat from, at least, 2010 and that assessments were generated to assist in understanding the threat and risk posed.

5.337 As noted above, I have not been provided with a problem profile of this same nature generated by WMP until 2013, although I do note that a similar exercise of threat identification was undertaken in 2008, prior to Chalice – and which I discuss in more detail below.

249 [redacted] pg 6
250 pg 6
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252 pg 10

Alliance Assessments

5.338 As discussed above, I have been provided with a copy of the Alliance CSE Delivery/Action Plan for 2013;[253] but I have also seen a copy of the Alliance CSE Problem Profile for the same year (see below) in order to draw comparison of the threat posed, and the response offered.

2013 Problem Profile (the "2013 Problem Profile")[254]

5.339 The 2013 Problem Profile was created on 31 July 2013 from CSE offending statistics within the Alliance (from 1 April 2012 to 31 May 2013), which concluded as follows:[255]

5.339.1 172 offences in total were recorded – 15 committed by groups and 145 by lone offenders. Of these 172 offences, 36 occurred in the Telford & Wrekin Policing Area which was the highest figure within the Alliance.[256]

5.339.2 The most common age range for offenders was between 18 and 25 years old, whose victims/survivors were aged between 13 and 14.

5.339.3 The vast majority of offenders were white males (90%).

5.339.4 66% of victims/survivors and offenders were acquaintances.

5.339.5 40% of victims/survivors had been reported missing previously and half of those had been reported missing on more than one occasion.

5.339.6 31% of CSE offenders had previous offending recorded against them – half of these offences related to violence.

5.339.7 Violence or inducements were *"not frequent"* in CSE offending (a comment I regard with some scepticism in the light of the evidence I have seen).

5.340 I note in particular here the statistics demonstrate the strong link between missing episodes and victims of CSE, given that I have also been made aware of the findings of a child protection focused inspection of WMP in 2013 (see the section below "Inspections and Reviews"), which commented that:

"*… despite a number of children being identified as having gone missing in excess of three occasions no further assessment or harm reduction activity was instigated. The force should review this area of activity to ensure opportunities to protect children at risk of harm are not being missed.*"[257]

253 [redacted] pg 4
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256 pg 11
257 pg 4

5.341 The 2013 Problem Profile concluded that:

"There is no current intelligence to suggest increases in CSE. Though, there is always the possibility that something like Operation CHALICE will emerge. However, infrastructure is being developed with the aim of catching such problems early and 'nipping them in the bud.'"[258]

5.342 It considered, overall, that gang and group CSE offences in the Alliance were *"likely to be sporadic, emerging on occasion 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."*[259] It was recognised that the key to tackling CSE was raising awareness and encouraging the reporting of incidents; I do not read the comment as suggesting there was a natural ebb and flow absent police action.

5.343 It is clear to me, therefore, that the Alliance understood the link between missing persons and CSE victims, but the 2015 HMIC PEEL Inspection of Effectiveness (discussed in more detail later in this chapter), still raised some fundamental issues, with the risk from missing episodes identified as a 'Cause of Concern' in the approach taken by WMP

2014 Problem Profile (the "2014 Problem Profile")

5.344 By the time a further Alliance problem profile was produced in September 2014[260], Telford & Wrekin had developed its own CSE panel. These panels already existed in the areas of Shropshire, Herefordshire and Worcestershire.[261] The aim of the CSE panels was *to "bring together all agencies with a responsibility for safeguarding children and to share data on cases of CSE."*[262]

5.345 As before, key findings were produced using CSE statistics within the Alliance from April to August 2014, which revealed the following: a total of 456 offences recorded - confirming a continued upward trend in CSE offences. Whilst this was significantly higher than in the 2013 Problem Profile, it was explained that:

- Of those 456 offences: *"194 have been committed and recorded between April and August 2014. The remaining 262 have been recorded between April and August 2014 but committed in months/years prior to this period."*[263]

- Further, only 48 of the 456 offences related to Telford, with South Worcestershire having the highest number at 113.

258 [redacted] pg 5
259 pg 5
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261 pg 34
262 pg 3
263 pg 5

5.346 The statistics for 2014 also revealed across the Alliance as a whole that:[264]

5.346.1 38% of offences were committed by lone offenders; gang or group based offenders amounted to only 3%.

5.346.2 26% of offences were "*obscene publications*", whilst 16% related to sexual activity with a child under the age of 16.

5.346.3 Rape accounted for 12% of offences; sexual assault of a female 10% and sexual activity with a child under 13 years old represented 6% of offences.

5.346.4 In relation to gang/group based CSE victims, 50% were aged between 16 to 17 years. 17% of all CSE victims/survivors were in this age range.

5.346.5 Through CSE panels, 292 children were identified as vulnerable since April 2013.

5.346.6 'Children in care' were, again, identified as particularly vulnerable to CSE. 20% of the 138 children's homes in the Alliance area were within Telford. It is notable that the fact a child was in care could not be recorded on the WMP CRIMES system, but it could be recorded on the COMPACT (missing persons system) – however there were many children who were vulnerable to CSE who had not been missing and therefore did not have their details on the COMPACT system. This left a significant intelligence gap, and one which I comment on separately both below in the section on missing persons and also within Chapter 2: Nature, Patterns and Prevalence of CSE in Telford.[265]

5.346.7 399 CSE perpetrators were identified, 95% of which were males. It was noted that some male offenders were getting younger, as offenders aged 16 to 17 accounted for 10% of the overall CSE offences.

5.346.8 50% of all CSE offences were committed against females aged 14-17 by males aged 16-34.

5.347 The 2014 Problem Profile showed overall, on the data provided, that contrary to the predictions the previous year, there was a general *"upward trend"*[266] in CSE cases across the Alliance, albeit the Telford area no longer had the highest number of recorded CSE offences.

5.348 As noted further below in this chapter, I have seen evidence from the National Child Protection Inspections in 2014 that indicates that, despite this upwards trend in CSE prevalence, WMP's response to CSE was poor during this period, with several areas for improvement identified. I am aware that HAUs were backlogged and resources stretched and there was, at that point, no dedicated CSE team to tackle the rising number of cases.

264 [redacted] pg 5
265 pg 36
266 pg 5

5.349 A key recommendation in the 2014 Problem Profile was to:

"Identify an appropriate person (CSE Coordinator/CSE Team/HAU) to review recorded offences/crimed incidents with a CSE possible category in order to progress according to offending type and level of threat".[267]

5.350 It seems to me that the 2014 Problem Profile was recognising the Alliance's limitations in managing the continually emerging CSE threat, and following the various assessments and inspections in 2014, the decision was made to introduce a dedicated CSE team.

2015 CSE Assessment[268] *(the "2015 CSE Assessment")*

5.351 The 2015 CSE Assessment was prepared as an update to the 2014 Problem Profile;[269] albeit this was not referred to as a 'Problem Profile', I see it as serving the same purpose and indeed it made key findings in respect of the Alliance position in managing CSE.

5.352 In reviewing the 2015 CSE Assessment it was clear that the accurate collection of data and therefore analysis of CSE was dependant on the appropriate use of a CSE interest marker, to identify on police systems those offences which related to CSE offending. I discuss the introduction of CSE markers elsewhere in this report (Chapter 2: Nature, Patterns and Prevalence of CSE in Telford), however insofar as this affected the intelligence gathering and sharing capabilities generally, I note that the ROCU CSE practitioners newsletter[270] had made clear that the detailed recording of CSE data including email addresses, user names and social media forums used by perpetrators was vital information for the police, in order to assist in identifying offenders. These details were often being omitted.

5.353 The 2015 CSE Assessment stated:

"A CSE interest marker was first used within West Mercia during 2012: however it was not widely adopted to flag incidents and offences linked to CSE until June 2014. Since this date the CSE marker has been applied to 678 offences and crimed incidents in West Mercia."[271]

5.354 The Assessment also noted that there was a disparity in figures across the Alliance as a whole, and made the important point that "*effective analysis of trends overtime is reliant on interest and warning markers being used effectively and appropriately".*[272]

5.355 I also note the following statistics from 2015:

5.355.1 A total of 38% of children considered within the CSE offending data had been recorded as missing at some stage. This shows almost no change to that same statistic since 2013.

267 [redacted] pg 8
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269 pg 4
270 pg 7
271 pg 16
272 pg 16

5.355.2 An issue of consistency between partnership data and police data was identified. It was estimated that the consistency was between 37% and 64%.

5.356 By way of comparison, the 2015 CSE Assessment stated:

"The last review examining the concordance between police data and Worcestershire Social Services was conducted in May 2015. It found that around 80% of the CSE cases recorded on Frameworki [sic] as strategy discussions were recorded on CRIMES similarly. There is still some way to go, since it could be argued that safeguarding partners should have consolidated data with 100% concordance."[273]

5.357 This indicates the data concerning the identification of a CSE case on partner local authority systems is not always consistent with that held by the police. A local authority may record a case as CSE but that record is not one reflected by police systems. The Inquiry has seen – and I have commented on elsewhere – how accurate data is an essential element in understanding the threat posed by CSE. It is essential that there is consistent data available to the police and local authority as to children at risk of exploitation, and that can only be achieved by each organisation sharing its identification of risk cases.

5.358 I note that the issues around the reliability of CSE markers continued into 2016, and that a review conducted by WMP in September 2016[274] identified that the use of CSE markers by officers was still inconsistent, resulting in the risk of demand in the area not being fully understood. I discuss this particular review in more detail below, however suffice to say here that the 2016 review also identified that at that point, WMP (still) did not have separate CSE analytical support, which I find quite astonishing, given all that was known about the issue following Chalice, and in light of the previous three years of statistics showing an upwards trend.

Regional Assessments

5.359 In 2016, ROCUWM created a regional CSE problem profile which included the following information:[275]

5.359.1 The number of CSE victims that existed;

5.359.2 The average age of victims; and

5.359.3 The technology used by offenders to target victims.

5.360 The Inquiry has examined the 2016 Problem Profile,[276] which resulted in 67 recommendations: four national, 12 regional and 51 local. The profile identified trends and CSE hotspots in the region which included Telford. The Telford hotspot was identified by data relating to the concentration of crimes within a certain radius. The information was gathered from many sources including referrals to safeguarding teams about potential CSE

273 [redacted] pg 12
274 [redacted] pg 12
275 [redacted] pg 169
276 [redacted] and [redacted] pg 174

in the area. The identification of this hotspot led to a police investigation but no information was disclosed that indicated criminal offences had been committed.

5.361 In 2017 the ROCUWM produced a regional CSE quarterly threat update. Since this threat update, a product has been published quarterly to coincide with the SGG timetable. Evidence provided to the Inquiry shows that four TRB meetings were held between November 2012 to August 2013 and 17 SGG meetings were held between February 2014 and September 2019.[277]

5.362 The quarterly threat updates provide briefings on a number of areas including the current CSE threat level and ongoing CSE-related operations; emerging trends and regional performance; national strategic updates and the regional CSE action plan.[278]

5.363 The threat update January 2018 to March 2018 identified the CSE threat as 'high' and performance data setting out CSE crimes reported and committed over the period were compared. Additionally, performance against the regional strategic action plan was assessed. There were 69 actions, 72.46% were complete, 15.94% ongoing and 11.60% outstanding.[279]

5.364 As the ROCUWM has an operations database that records CSE operations for the region, this is also part of the information provided in the threat update. In the January to March 2018 update, there were 39 ongoing CSE operations across the region broken down into specific areas (i.e. WMP – but not specifically Telford). The update also compared the type/model of CSE in the region based on categories such as trafficking, lone offender, boyfriend model, group offending and online.

Operational Support from the ROCUWM

5.365 ROCUWM capabilities are used to provide a broad range of support to forces including using tactics to identify child sexual offending in cases where regional forces request assistance. An example of this is where offenders use digital based opportunities to commit sexual offences against children.

5.366 The ROCUWM has direct access to CSE threat data held by each West Midlands force area, including WMP, which ROCUWM collates, analyses and shares in order to produce regional data on CSE operations and performance. Each force in the West Midlands area returns an update to the ROCUWM on a monthly basis for this purpose.

Impact of the ROCUWM on WMP Management of CSE

5.367 The Inquiry accepts that the ROCUWM has had a positive impact upon the management of CSE within West Mercia insofar as it created a single gateway for the transfer of CSE intelligence and assessments.

277 [redacted] pg 9
278 [redacted]
279 [redacted] pg 3

5.368 The information obtained via ROCUWM exists in addition to WMP's own intelligence gathering processes. Any such intelligence is either disseminated by RIUs or via a FIB. In accordance with the WMP control strategy, the FIB and RIUs attend a daily intelligence conference call chaired by a Detective Inspector Intelligence Manager. The purpose of the meeting is to identify threats, including CSE, and ensure these are owned and controlled. The Inquiry understands that child exploitation is a control strategy priority and an intelligence requirement.

5.369 The daily intelligence conference call is followed by a management meeting. During this meeting, any threats that require wider dissemination or support are sent through the FIB to the ROCUWM. The Inquiry understands that the ROCUWM can also receive external requests for intelligence/ information sharing and forward them to the FIB for onwards dissemination.[280]

5.370 From April 2021, the ROCUWM will provide a strategic home for the regional Tackling Organised Exploitation ("TOEX") Programme and TOEX team management will report into ROCU leadership teams. The TOEX programme and its regional teams are discussed further in the National Policing Bodies section to this report.

Funding of ROCUs

5.371 In 2016 all ROCUs were given three years' Police Transformation Funding ("PTF") to review child sexual abuse. They were also provided with two dedicated CSE staff (Inspector and a Crime Analyst). The Inquiry understands this allowed the force to link in with the Government Agency Intelligence Network ("GAIN"), HMRC and the NCA. This funding facilitated the creation of the first CSE problem profile in 2016 explained above.

5.372 Following the expiration of the PTF allocation in April 2019, the ROCUWM did not continue to allocate funding in order to continue with the two dedicated CSE roles. The Inquiry has been informed that PTF did continue for a half funded CSE/A role, but ROCUWM chose not to continue the role in the manner in which it was originally implemented. The Inquiry has been informed that ROCUWM instead *"subsumed this functionality within a wider ROCUWM Strategic analytical team."*[281] The Inquiry understands that as a consequence there was no second CSE dedicated staff member in 2019.

5.373 In 2020, there was PTF for one year for one dedicated CSE role. The evidence indicates that there was an intelligence officer (Constable) and an intelligence analyst as the dedicated roles within the CSA/E Team.

5.374 Though the regional CSE analyst had been lost, Telford LPA's analyst (within WMP) remained in post within the CSE/CE Team until they moved in April 2021 into proactive CID. In June 2021, the national funding for the CSA/E post ceased, but ROCUWM retained the post within its own funding allocation.

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281 [redacted] pg 5

5.375 The Inquiry understands that the ROCUWM has supported WMP (and the Alliance) during CSE investigations.

5.376 This technical and detailed evidence that I have considered makes it plain there is now in place a sophisticated structure and system for the sharing of information relating to CSE: I have been given details of investigations that led to arrests and convictions based on ROCUWM derived intelligence. However for reasons of information sensitivity, I have not been able to apply the same scrutiny to ROCUWM material as I have to historic WMP operations. Notwithstanding that I consider the current structures must be a significant information resource for WMP in tackling CSE.

WMP Internal Intelligence Management

Recording and Sharing of WMP Intelligence

5.377 I have heard evidence from WMP that intelligence management has since 1995 broadly been managed in a consistent way, by its FIB and Local Intelligence Officers ("LIOs"). Intelligence is sent – in differing ways through the years – to the FIB and local policing teams, who review intelligence reports and carry out appropriate follow-up.

5.378 Since the late 1990s, intelligence reports were graded according to set criteria – as I have set out above. Dissemination of intelligence will take place if "*the intelligence supervisor/Detective Sergeant*"[282] identifies a need so to do[283] - if for development, it would be handed to an intelligence officer, if for investigation, then it would go direct to the appropriate department (such as CID).

5.379 In the 1990s, intelligence was recorded on handwritten intelligence reports (known as C44s) which were used to share intelligence across WMP, prior to any direct entry digital system being available. During this period, much like the crime recording approach, officers would grade their own intelligence reports (based on the matrix approach explained earlier in this section) and an *'Inputter'* would add the contents of the report to, what was then, the Central Intelligence and Firearms System ("CIFS"). This system was the central repository for intelligence at that time. As noted earlier, during this timeframe intelligence was graded using the 4x4x4 system, however WMP has explained that intelligence reports would *"often"* have no categorisation and *"where categories had been included by officers these were rarely changed."* Indeed, WMP has explained that reports were not subject to grading on a routine basis until the late 1990s.[284]

5.380 Notwithstanding this, I have been told that during this period, an Intelligence Supervisor/Detective Sergeant would review reports received. This officer would use their professional judgement to decide which intelligence required "*development*" before allocating the report to an Intelligence Officer, or passing it directly to a department for

[282] [redacted] pg 44
[283] [redacted] pg 165
[284] [redacted] pg 43-44

investigation.[285] This suggests further that escalation of information was reliant on individual decision making rather than being a formal process.

5.381 HMIC considered WMP's approach to intelligence sharing in its baseline assessment carried out in 2006 (which I deal with in more detail later in this chapter) and commented on the position thus, indicating it was content with WMP's level of performance:

"*There is regular sharing of data and intelligence through the regional intelligence group, which is chaired by the force's director of intelligence… The community safety department has identified and established information- sharing protocols with other agencies, such as the prison service and the courts service. The force contributes to regional assets, including RART, Regional Intelligence Unit ("RIU") and Regional Task Force ("RTF") teams, which are dedicated teams that can be deployed dynamically. The force crime squad liaises and exchanges intelligence with other agencies.*"[286]

5.382 WMP explained that by 2008, officers would submit electronic intelligence reports via the 'restricted' area on the force intranet. This was part of the electronic CRIMES system.

5.383 It is important to note that electronic recording did not mean that the reporting officer would create the intelligence record directly: the original report would go via first, a source coordinator, who would "*sanitise and update*" the report and second, an 'inputter' who would link logs, and add any appropriate warning markers based on the contents of the report. Those markers were separately searchable. WMP explained:

"The Inputter would then receive the intelligence log and input it onto the system. Inputters at this stage would link logs, add warning markers and add the relevant categories based on the contents of the log text (multiple categories could be added). There was a set list of categories to choose from and this is still a searchable field… As well as categorising, the Inputters would make all the necessary links, add warning markers to GENIE and/or submit the forms to the PNC [Police National Computer] *Bureau (as it was known then) for PNC warning markers, if applicable."*[287]

5.384 CRIMES did not provide details of the use to which the intelligence was put, if any, but it was possible to log an action to an intelligence report to which a Detective Sergeant would be required to reply. WMP told the Inquiry that:

"*In accordance with previous and current practice, where CSE intelligence is received contact should be made with the local Child Protection Unit.*"[288]

5.385 WMP further noted that:

"*… there has never been a system to automatically 'flag' either an address or a person based on frequency of intelligence. Any flagging attached to a nominal or an address is*

[285] [redacted] pg 43-44
[286] pgs 32-36
[287] pg 43-45
[288] pg 16

officer generated, based on professional judgment and usually when there is an ongoing investigation or risk of significant harm is identified."[289]

5.386 I have been informed that between November 2012 and September/October 2017, the system was revised and called 'CRIMES Review'. [290]

5.387 In October 2012, the Alliance CSE Position Statement was the catalyst for WMP to introduce a CSE marker for the CRIMES system. WMP explained that *"There was a need for intelligence to be considered through existing tasking and co-ordination systems to consider threat and harm."*[291]

5.388 WMP further explained that, where CSE intelligence is received, *"contact should be made with the local Child Protection Unit."* The CRIMES intelligence system also allowed the user to raise a *"log action"* which could be allocated to a Detective Sergeant who would be required to reply and confirm the outcome of an individual intelligence report.[292] This development demonstrates that CRIMES was perhaps a more interactive system, communicating with those officers who required a response to intelligence input.

5.389 When the CRIMES system was replaced by the digital ATHENA system in 2017, the Intelligence Processing Unit ("IPU") became the central repository for all submitted intelligence. This remains the case today. Currently when an officer submits an electronic intelligence/information report via Athena it goes straight to the IPU who are based at Hindlip. The system uses a High, Medium or Low method of assessment for the urgency of response required in response to intelligence received. Staff within the IPU are also responsible for categorising and disseminating the intelligence reports using their personal judgement and experience – and thereafter reports may be sent to local intelligence departments, known as Field Intelligence Teams. In addition to this, WMP explained that the force has *"a 24/7 intelligence capability in the form of I24"* – a system that:

"… sits within our Command and Control Centre. I24 deal with 'live' time intelligence and high threat/risk/harm that requires deployment or alternative intervention."

5.390 I24 therefore appears to provide an immediate response to those *"out of hours"* intelligence reports that are deemed high threat/risk/harm.[293]

5.391 WMP told the Inquiry that when using ATHENA, the expected approach to intelligence reporting changed:

"A certain expectation is placed upon the reporting officer to take action before submitting an intelligence report. This ensures that risks are dealt with in a timely fashion and it avoids the intelligence report replacing the normal safeguarding processes that should occur."[294]

289 [redacted] pg 45
290 pg 166
291 pg 9
292 pg 167
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294 pg 167

5.392 This tends to suggest that submission of an intelligence report may have on occasions been treated as a sufficient response to CSE intelligence. WMP continued:

"*Where CSE intelligence is obtained, inputters should assess the report and where relevant request the submission of a 'child incident report' if one is not already recorded … Contact should be made with the CSE team.*"[295]

5.393 A 2018 '4Ps Review' of WMP's CSE services at Telford LPA (the "2018 4Ps Review" – discussed further below)[296] explains that, in addition to the use of ATHENA to input intelligence, the CSE Team would monitor a system called COMPACT, which is a digital system used for missing children. This system allows 'ghost profiles' to be created for individuals identified as being at risk of harm, and rapid flagging if the individual is reported missing, including email notification to the CSE Team.

5.394 I discuss the approach taken by WMP to missing persons and the COMPACT system in more detail later in this chapter.

Tracking and/or Flagging Intelligence

5.395 The Inquiry asked WMP how intelligence is tracked and/or flagged, and was told that a system to automatically 'flag' either an address or person based on the frequency of intelligence has never existed. Flagging of intelligence is completed by an officer and based on professional judgement, and is usually undertaken when *"there is an ongoing investigation or risk of significant harm is identified."*[297]

5.396 However, WMP explained that in October 2012 the force introduced a CSE marker for its intelligence recording system, before it joined the regional CSE TRB in November 2012.[298] This allows officers to place CSE *'warning markers'* on individuals using intelligence systems, including the Police National Computer, depending on the nature of the intelligence concerned.[299]

5.397 In relation to CSE information markers, the 2018 4Ps Review noted that:

"*Any person identified as a perpetrator of CSE has an 'information marker' recorded and thus intelligence in relation to them is monitored*. *It is however acknowledged within the LPA there is difficulty managing those with only 'intelligence markers' and no previous offending behaviour.*"[300]

5.398 This was in relation to the MAPPA process and the Offender Management Unit, which generally manages only those who have been convicted.

295 [redacted] pg 167
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297 [redacted] pg 45
298 [redacted] pg 9
299 [redacted] pg 46
300 [redacted], pg 13

5.399 The same review states that tags on the intelligence systems were removed which caused an *"issue"* for the officers from the CSE and Safer Neighbourhood Teams ("SNT") who reported an increase in *"self-briefing time"*. This was a consequence of having to *"manually search"* systems for relevant intelligence in their area. It was also indicated the introduction of the ATHENA system hampered the accessibility of some intelligence reports.[301]

5.400 As part of the review, the CSE Team reported:

> *"… confusion of staff following the implementation of both Child Sexual Exploitation (CSE) and Child Sexual Abuse (CSA) markers i.e. some staff do not know which one is the most appropriate to use."*[302]

5.401 Whilst the process of identifying victim/perpetrator roles within ATHENA was reported as good, the allocation of specific CSE markers against individuals was *"less utilised".* The officer conducting the review believed *"an opportunity is being missed due to a marker not being a mandatory option, hence not always completed by officers."*[303]

The Use of Intelligence in Managing CSE

5.402 The Inquiry has been informed that WMP collates intelligence and provides this to officers investigating any criminal activity. The intelligence can be disseminated by Intelligence Units or via the FIB. In accordance with the WMP control strategy, the FIB and Intelligence Units attend a daily intelligence conference call chaired by a Detective Inspector Intelligence Manager. The purpose of the meeting is to identify threats, including CSE, and ensure these are owned and controlled. The Inquiry understands that child exploitation is a control strategy priority and an intelligence requirement.[304]

5.403 I have read other evidence about how WMP inputted and processed intelligence for onwards dissemination to their officers. In respect of CSE, WMP told the Inquiry that the CSE Coordinator in Telford checks intelligence systems every morning for any report relating to CSE.[305]

5.404 I understand that any reports that contain intelligence on CSE are passed to a Detective Sergeant in the CE Team (formerly CSE Team) to review. Should the officer deem it necessary, uniformed officers may be tasked to conduct more investigative work on the intelligence or the CE Team will commence an investigation from the outset.[306]

5.405 The Inquiry has been informed that, as a result of Chalice, suspects identified but not arrested were actively managed by WMP's intelligence teams and the CSE Team with the use of a CSE marker on the intelligence systems.[307] The 2018 4Ps Review identified that

301 [redacted] pg 5
302 pg 14
303 pg 14
304 pg 124
305 pg 146
306 As above.
307 [redacted] and [redacted] pg 13

those suspects arrested but not convicted were *"not as accurately monitored."* The review found that from the 32 individuals arrested but not convicted as a result of Chalice:

- Seven had no markers;
- Nine had CSE markers;
- Seven had OCG markers; and
- Four had a violent marker.[308]

5.406 This evidence demonstrates the importance of the accurate processing and tagging of intelligence to facilitate the identification of CSE risk. I would, therefore, expect there to now be a system in place for all Chalice nominals – and future suspects deemed to be a high CSE risk – to be given CSE markers on WMP's systems.

Conclusions – Intelligence Management

5.407 To conclude, it appears that the system of inputting intelligence to share across WMP had deficiencies before 2008, as I have heard that intelligence reports would often have no categorisation and/or go unchanged by those who supervised/reviewed them. There was also no routine grading of reports until the late 1990s – and even then, I consider that this was sporadic. It is therefore likely that officers who were searching for intelligence concerning CSE would have been hampered. As noted above and as has been explained to me by the Inquiry's Policing Expert, it was national policy to grade information/intelligence from the 1990s and this was crucial to enable reviewing officers to consider the reliability and value of the intelligence and what action should be taken as a result.

5.408 As noted above, by 2008 an electronic CRIMES system of inputting intelligence to share was introduced. This system retained the involvement of an *"Inputter"* but gained the assistance of a *"Source Coordinator"* who would review and sanitise the report. I have seen no evidence that this improved the system, but the further check and review may have increased the prospects of important information within the report, such as that relating to evidence of CSE, being outlined and flagged in the appropriate way.

5.409 As the flagging, marking and escalation of intelligence is a matter of judgement for the individual officers/inputters involved in the process, the presence of any intelligence relating to CSE is dependent on the relevant officers recognising the indicators of CSE. In theory, therefore, as the awareness of CSE and its indicators increased, one would hope so would the quality of the relevant intelligence available on WMP systems. However, this must be balanced against the general knowledge and ability of officers to place appropriate CSE markers on the intelligence systems, and for them to have been sufficiently trained in both the warning signs, and on the system itself. There is evidence of some confusion and difficulty in this regard, which I believe is likely to have hampered the use of CSE intelligence in the appropriate way.

308 [redacted]

5.410 The evidence suggests that the use of CSE intelligence markers to manage those suspects who were arrested but not convicted in Chalice was not entirely successful. Seven suspects had no CSE markers and only nine had CSE markers at the time of the 2018 4Ps Review. It is my view that WMP ultimately failed to use the CSE marker system to the fullest extent. In my Recommendations at the beginning of this Report, I make clear the importance of data collection to providing an accurate picture of the prevalence of CSE in Telford. The handling, logging and dissemination of intelligence together with the proper use of any CSE marker system is central to this process.

Early Intelligence Regarding CSE

Introduction

5.411 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, many comprising corroborative information of past reports, and many of which appeared to be shared with senior officers, as well as with Safeguarding. This file of historic 1990s material was pulled together and reviewed as part of Chalice, and became known as 'D2276' - the document number assigned to the file on HOLMES. WMP told me that HOLMES, meaning 'Home Office Large Major Enquiry System', *"is a stand-alone system that comprises a database of all the information relating to a major incident, including nominal data and contact details and all the documents relating to that incident."*[309]

5.412 Having reviewed D2276 and the associated intelligence material in detail, I consider this to be crucial information held by WMP – and the earliest material which has been made available to the Inquiry – documenting clear reports and concerns of CSE activity at several locations within Telford. It signifies to me a key point in Telford's CSE history, which therefore merits specific discussion in this chapter, not only to consider what was done with that intelligence at the time in the late 1990s/ early 2000s, but also the response in 2010, when that material was reviewed as part of Chalice.

5.413 Given the significance of this material, I have carried out a three-pronged approach in order to consider the context within which the above information was received and dealt with by WMP:

5.413.1 The Inquiry has selected and carried out a full analysis of the cases of three young persons identified in this early intelligence material (referred to below as Children A, B and G) – to consider what was known about them; what information was gathered and shared; what were the responses and actions; and what were the ultimate outcomes for those individuals;

5.413.2 The Inquiry has tracked, as far as possible, how information from the early intelligence material has been acted upon throughout the early 2000s prior to

309 [redacted]

the commencement of Chalice and then, specifically, what happened both during and after Chalice, with that material; and, finally

5.413.3 I have sought the advice of the Inquiry's Policing Expert, André Baker, to consider whether the actions taken in response to this information were in keeping with common policing expectations, knowledge and standards of the time; and equally, whether there were any missteps, omissions or failings – either by individuals or the organisation as a whole. I have also considered the views of the Inquiry's Safeguarding Expert, Jane Wiffin, in relation to these particular cases from a Safeguarding point of view, so that both aspects may be considered, as well as the way in which the two authorities worked together at this time.

5.414 I then conclude this section by touching upon the period immediately following these case studies, between approximately 2000 and 2006, as this was the time leading into the beginnings of Chalice, which I deal with in the next section of this chapter.

The Emergence of Early Intelligence Relating to CSE

5.415 In July 2010, an action was raised by the then Senior Investigating Officer ("SIO") on Chalice and assigned to three officers to "*conduct a review and ensure all NIRs* [National Intelligence Records] *relating to Operation Chalice have been assessed by the HOLMES team and our* [WMP's] *disclosure obligations are met.*"[310] The following week, a bundle of documents was logged on the Chalice system with the following description:

"*Child Prostitution File for Review. Historical (1999 to 2003) Lever Arch File containing Police Intelligence relating to possible Child Prostitution within the Telford area run by Asian males (*[a named suspect] *running brothel at* [a named premises, referred to as Premises A], *Wellington etc)*".[311]

5.416 This is the file referred to as D2276. The bundle contained the following:

5.416.1 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,[312] containing information relating to 'child prostitution' at identified addresses in Wellington. This report will be referred to herein as the 'September 1999 Report'.[313]

5.416.2 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,

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analysed according to 'pimps' and 'victims' mentioned within those reports. This report will be referred to as the 'October 1999 Report'.[314]

5.416.3 An intelligence report from November 1999, written by a Detective Constable, discussing sexual offences being committed against children in Telford. This will be referred to as the 'November 1999 Intelligence'.[315]

5.416.4 A file prepared by another Detective Constable in PPU almost four years later, in May 2003, and entitled 'Prostitution Wellington'. This file will be referenced as the '2003 Report'.[316]

5.417 As mentioned above, a Chalice officer was subsequently assigned in 2010 to review the four reports and associated material within D2276, and I discuss that review later in this section. However, it is necessary to first consider the detail of the information contained within this early bundle.

The September 1999 Report

5.418 In July 1999, a Police Sergeant based in Wellington tasked one of his Constables, via a written report known as an A30, to "*pay attention*" to a "*suspected brothel in Arleston*" and "*be seen outside the address taking numbers of vehicles etc in an effort to frighten away the punters*".[317] The communication enclosed what appears to have been a briefing note (but which is referred to as an 'Action Plan'), stating that:

"*It is suspected that girls are being used at this flat* [Premises A] *as prostitutes … Another brothel that is being looked into by USG is* [a named premises, referred to as Premises B]. [A named premises, referred to as 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 service to the house mainly dropping off Asian youths.*"

5.419 As a result of that briefing note, it appears that the Police Constable reviewed a number of 'C44' intelligence report forms, all from the previous month (June 1999), before responding to his supervising Sergeant in September 1999, to confirm that "*something unusual is going on*" at a number of premises in Telford.

5.420 The various intelligence reports from June 1999 were as follows:[318]

5.420.1 Three separate intelligence reports submitted by one Intelligence Officer, citing "*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*"; that [Premises C] "*was being used by two prostitutes, 14 years of age…*" and that the source providing the intelligence, who was considered

314 [redacted]
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reliable, "*had seen sexual acts take place with the girls.*" The officer included names of potential victims/survivors, owners of the premises, and vehicle registration numbers. These reports were variously copied to the LIO in Telford; an Inspector in Wellington; and a Detective Inspector in the Intelligence Unit.

5.420.2 One intelligence report submitted by a Detective Constable in proactive CID, which references an older Asian male who "*is still using young girls as prostitutes and taking them into Shrewsbury, he is also using an address in Wellington.*" One particular child from Wellington, who is noted as being "*regularly used by him*", is said to have been "*raped by another Asian… in Regent St.*" This report is copied to the LIO in Telford; an Inspector in Wellington; a Detective Inspector in PPU, and a Detective Sergeant in the FPU.

5.420.3 An intelligence report submitted by another police staff member, stating that he had received information from a source that "*two young girls (aged 13/14) were seen… going to* [Premises A]" wearing what is assumed to be school uniform (with the school identified); when the two children left, more were seen to arrive, leading the informant to have "*concern[s] about the reason for those visits.*" This report was copied to a Detective Sergeant in the FPU; the LIO in Telford; an Inspector in Wellington, and a Beat Manager for Wellington.

5.420.4 A further report from another Detective Constable, again referring to a "*brothel/prostitution services at* [Premises A]". The report notes that "*two girls (details unknown) are taken there by taxi.*" The names and dates of birth of two Asian males are provided in the report, which is then seemingly shared with (copied to) the LIO; the Uniform Support Group ("USG"); a local Police Inspector; and an Intelligence Officer, who had submitted similar reports previously.

5.420.5 Another intelligence report, submitted this time by a Police Constable, based on information provided by a source who claimed – as stated above by other sources – that, "*two Pakistani men (I/D unknown) are 'running' two girls (prostitutes) from a flat…* [in proximity to Premises A]*, Wellington.*" The informant states that "*this has been going on for about 6 months*" and proceeds to describe the children. The report goes on: "*there are frequent male visitors to the flats …* [multiple] *men a day visit*" and it is suspected that "*there is a connection to* [named] *telephone boxes*" within half a mile radius of Premises A. This report is copied to one of the Intelligence Officers and an Inspector based in Wellington.

5.421 In July 1999, the author of the September 1999 Report himself logged an intelligence report following observations he had on the "*suspected brothel*" at [Premises A] some days earlier, where he confirmed that numerous Asian men had been calling at the premises, and that there also appeared to be exchanges suspected to involve drugs. He also described two children – bearing very similar descriptions to children mentioned in other reports –

who were noted as "*wearing 'tartish' clothes* [and who] *went to the telephone kiosk on a number of occasions.*"[319]

5.422 Having received the results of the observations, in response to his 'Action Plan', the receiving Police Sergeant forwarded the September 1999 Report to a fellow Sergeant – it is understood by way of local information sharing. It is noted that 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, below), stating "*This is now filed no action. For your information re child prostitution.*" This was signed by a different Sergeant.

5.423 Of the officers involved or mentioned in all of the above reports, including the September 1999 Report itself, the Inquiry has been able to trace and speak to: two of the Detective Constables; two Detective Inspectors; one Police Constable; one Police Sergeant; and one Police Inspector. It is of note that the Police Constable who authored the September 1999 Report declined to speak to the Inquiry, on the basis that the written documents would provide a better recollection than they could personally after the passage of time.

5.424 The Inquiry has also been unable to make contact with the Police Sergeant who ultimately received the September 1999 Report, and nor has it been possible to speak to the Sergeant who considered that "*no further action*" needed to be taken once he had reviewed the contents in October 1999. It is not clear to me that any action was therefore taken, at this point.

5.425 However, from those officers who did speak to the Inquiry in relation to this material, the Inquiry was told:

"*… if there were allegations there that underage sex was going on or exploitation was going on, I think it would definitely have ended up either with a crime squad dealing with it or a drug squad dealing with it… if it'd been identified as drugs…*

It wouldn't have been the uniform branch of staff that would've been dealing with it."[320]

5.426 It has been explained to me that the view of the officers responsible for putting in the intelligence was:

"*We'll have done our bit, we've been asked to do a bit of observations, a bit of walk pasts, a bit of frighten the punters away, whatever we've been asked to do…and we've sent it off, if there's nothing come back from that part of it, well, our job was done at that stage and the information and the intel was passed on.*"[321]

5.427 As to the Detective Inspectors noted to have received copies of the September 1999 and October 1999 reports referred to above, I am told that both were involved in major investigations for a large proportion of 1999, meaning that they were effectively taken out of their day-to-day roles. Neither recall having seen the above material. Neither officer

319 [redacted] pg 24
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could assist me as to who fulfilled their ordinary duties while they were abstracted, or indeed whether there was a system within WMP for ensuring adequate cover during absences or abstractions.

5.428 The Inquiry has ascertained, based on a review of later material, that of 24 victims/survivors known to the police for their involvement in CSE or for having associations with those suspected of CSE between 1999 and 2003, a significant proportion later appeared in subsequent operations, including within Chalice, Operation 'Alpha' ("Alpha"), Operation 'Beta' ("Beta") and Operation 'Epsilon' ("Epsilon"). Alpha, Beta and Epsilon are not real operational names, but represent pseudonyms for three other significant CSE operations which are discussed in more detail later in this chapter.

5.429 The result is that of these 24 victims/survivors:

- Nine victims were first visited by police in Chalice and one was first visited in Beta;
- Seven further victims featured in Chalice - five were identified as being unable to be traced, and there was a policy decision not to engage with the other two, meaning these seven victims were not visited by police until Epsilon; and
- Five victims were only identified and seen in Epsilon, and it is not clear whether the remaining two have been visited.

5.430 I deal later with those operations in more detail, but it is important to note that not all of these subsequent cases led to convictions in respect of offending against the victims/survivors; indeed only one of the victims/survivors out of the 24 named during this period has seen their case proceed to trial. It is impossible to know, had there been timely investigation, how differently matters may have unfolded.

The October 1999 Report

5.431 In October 1999 one of the Police Constables from Wellington wrote a report to a Detective Inspector in CID entitled 'Child Prostitution – Telford'.[322] The report was stated to have been initiated by a Detective Sergeant in the FPU "*to ascertain if there was a child prostitution problem in Telford*", and was prepared based upon the series of C44 reports compiled in relation to the issue. Based upon that paper trail of intelligence, and the names and associations of those involved, the author states on a summary front page:

"*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*

322 [redacted]

pilot project. This will undoubtedly be a long winded and drawn out affair that will take officers some time to collate and act upon the information."[323]

5.432 The officer then volunteers to continue to carry out enquiries in order to further the investigations into the problem.

5.433 Behind the front page, the file is split into sections which include a flow chart; pages of notes and lists naming 'child prostitutes' and 'pimps' and seeking to make connections between them. Within those notes, numerous premises and locations of concern are listed, as well as vehicle registration numbers. There is then a further section containing a total of 28 intelligence reports, ranging in date from February 1997 to September 1999.[324] Eight of these reports relate to associated offences of drugs, rather than CSE specifically, but are included due to the links between suspects.

5.434 One of the earliest of these reports, from February 1997 states that:

"*Info received that* [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* [missing persons]*. 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]… *was the I.P.* [Injured Person] *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 … daughter and friends are visiting* [premises] *daily, & often spending the night there."*[325]

5.435 Other reports give clear indications of underage sexual activity taking place – some examples being:

"[Adult Male C] *and* [Adult Male D] *both influential Asians from Wellington, Telford are currently involved in supplying girls for prostitution."*

"[Middle-aged Asian male] *driving* [car] *previous info suggests that this man may be a pimp. Front seat passenger (refused details) was a young child 16-17 years old… dropped* [her] *off… after claiming he had spent time with her in Wellington."*

"[child] *recently made a complaint of indecent assault against an Asian male named* [X]*. Since this complaint she has been terrified of reprisals from the Asian community and is afraid to leave the house without company."*

"[Address] *is a Council-owned property currently occupied by* [adult male] *and seen at* [this] *address was* [adult male]. *Also staying at the address are* [three children aged 13 and 14]. *All three are believed to be connected with prostitution."*

"[Named child] *was reported missing from home and was subsequently found to have gone to* [town] *with* [older male] *who had taken her there to be assessed for prostitution*.

323 [redacted]
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325 pg 21

[Named child] *was also … used as a drugs courier.* [The male] *regularly… associates* with [three children all of whom] *are single mothers aged 18/19."*

5.436 In relation to one report, it is clear that evidence was also emerging of children being trafficked to other towns to be exploited:

"Info [received] *that a 12 yr old female was being used as a prostitute in Wellington… She is in the hands of some Asians from Wellington. The leader* [name and description given]*... associates with three others and they keep her in their vehicle*. [She] *has allegedly said that she was raped… and so she ran away from them. She has since gone to Wolverhampton and is staying with* [named female]*. This young girl is said to* [be being given drugs] *by the persons holding her. She has alleged that* [the perpetrators] *have two 11 yr old girls working for them in Wellington as prostitutes. There is* [named man] *who also runs young girls. He and two others are alleged to have taught the young girls "things of the trade" at the back of a bus shelter... One of the young girls was forced to perform oral sex* [on one man] *after the other. When she has learnt to do this properly then she will be taken on as a prostitute".*

5.437 The reports were submitted by 18 different officers (some submit multiple reports), ranging in rank from Police Constable, Detective Constable, Police Sergeant, Detective Sergeant and, on two occasions, Detective Chief Inspector. Of those officers, the Inquiry identified eight key officers to speak to, but only three gave evidence; of the remaining five, one is deceased, one was untraceable, one was unable to engage due to ill-health, one failed to reply to any contact, and one refused to assist the Inquiry.

5.438 A number of the officers spoken to explained how the system of intelligence gathering worked, at that time, and that a lot of information would come either through voluntary sources – i.e. individuals who would come forward to provide information voluntarily – or via registered informants who were 'on the books' of officers within CID. Any officer could put in a C44 form – either handwritten or typed – and submit this to the intelligence unit for review. Intelligence would be 'graded' (in the manner explained above) in order to determine what, if any, follow up action would be taken.

5.439 Insofar as these particular C44s are concerned, they are understood to have come from a mixture of voluntary sources and registered informants from within the local community. The universal view of those officers who spoke to the Inquiry was that once those reports were submitted to the Intelligence Unit, the system was such that they would not know what happened as a result; any actions would be decided by senior officers and tasked out through the appropriate team – whether that be reactive CID or the CPU.

5.440 One of the Detective Constables explained their role in gathering and feeding through these intelligence reports as follows:

"I would have expected that the intelligence, had it just been more than my intelligence, you know there were different sources around the same thing, I would have just expected a bit of a package to go to a unit such as the COADs [Crime, Operations and Drugs] *to say right, we've got three or four different sources here, this is really serious, let's have a look*

at it, so and so is your target, set up some observations…so that's the next step from my level if you like."[326]

5.441 Another officer explained it in a similar fashion:

"… every time we came across something that sounded like a crime, not just was a crime, we would sit and write intelligence reports… it would be a question of me not wanting to miss providing something that might be a link… but from our point of view, unless someone in intelligence had said 'well look here [X] has put in a report about this today [Y] did one last week, [Z] did one two weeks before…' I'm not sure how that would have translated into any activity other than to acknowledge it."[327]

5.442 In other words – it needed someone to do the job of joining the dots and seeing the links between all of the individual intelligence reports that were being inputted, and recognising it as something that needed to be investigated further. This was, in my view, exactly what the Detective Sergeant in the FPU had started to do, when he instigated the review which led to the October 1999 Report. I have been unable to clarify what he knew and the action that he took at the time. Nor have I been able to speak to the author of the report, who declined to engage with the Inquiry.

5.443 The Detective Inspector[328] who ultimately received the October 1999 Report was unable to recollect receiving it. The Inquiry was told that this officer may have been posted to a divisional major incident room at the time the report was sent. The officer stated:

"If I had seen [this report] *I have no idea what I did as a result. I mean, clearly it's something you wouldn't just say 'yeh, that's interesting' and do nothing about it… it seems to me the obvious thing we would have done was to set up some form of operation…".*

5.444 The Inquiry was told that the subsequent expectation was that some form of surveillance would have been conducted, to verify the intelligence in a coordinated manner, but that that kind of response would have been driven by the intelligence unit and proactive CID – not reactive CID. The Inquiry has been unable to confirm whether any such action was taken. The Detective Inspector concluded:

"I don't know if any of those things were done or not but… had I seen something like that and I had just dismissed it out of hand without giving a thought in respect of any further inquiry or investigation, I would look back on that and view that as a grave mistake."[329]

5.445 WMP has explained, however, that it:

"… has not established any co-ordinated response to the CSE issues raised [in the October 1999 Report] *until the document resurfaced in Operation Chalice, where it was incorporated into D2276. Whilst the handwritten 'review' document raises a number of questions and suggested actions,* [WMP] *has not been able to locate any indication that*

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329 [redacted] pg 39

they were progressed at that time. The possibility that some action was taken but that records no longer exist or are not discoverable cannot be excluded."[330]

5.446 The Inquiry has ascertained, based on a review of later material, that of the suspects and victims/survivors 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 in the October 1999 Report, within three C44s from June 1999.[331] The three C44s were all in relation to concerns regarding children attending Premises A. As I have set out above, there were a number of reports made by officers regarding Premises A, with these three linking the premises to this same defendant. I consider Premises A further in the section below.

The November 1999 Intelligence

5.447 Shortly after the October 1999 Report was submitted, further intelligence reports were logged, this time by a different officer – a Detective Constable in the CPU. The officer submits two C44 reports in late October, followed by a third in November 1999.[332]

5.448 The first two intelligence reports are submitted on the same day, and relate to two children who are associating with one another, and who have apparently made 'false' allegations of having been victims of crime, including rape.

5.449 The first intelligence report follows concerns raised by the parents of a child who was involved with a man older than her. The parents attended a local police station to report that they feared their daughter "*may be getting involved in drugs and/or prostitution*" at the hands of this man. They explained that her behaviour had changed significantly since becoming involved with him, and another child, and that she was "*absolutely obsessed*" with him. The officer reports that the man is known to the police, having "*previous for indecent assault on females both under and over 16*", and that "*he may have other motives for the relationship i.e. involving girls in prostitution*". This intelligence log is stamped as received by the Intelligence Unit, and once logged, is copied to the LIO, another Detective Constable in CPU, and the same Detective Inspector in CID who was sent the October 1999 Report.

5.450 The second intelligence report relays the information obtained by the officer upon contacting a relative of the second child. The relative reiterated concerns for the child's associations and potential involvement in drugs and sexual activity, indicating that she has also been told that one of the men she is involved with "*has in his possession a list of young girls, including* [the child]" which is apparently offered out "*with the promise of a good time… for a price.*" The relative confirmed that the two children had "*admitted to having had sex in* [another town] *which* [they] *later reported to police as… rape*" – but in the report itself, such allegations appear to be referenced as 'false' allegations. It is not clear whether this is because the children later claimed the allegations to be false, or because they were not believed. This C44 is stamped as received by the Intelligence Unit, and once

330 [redacted] pg 164-165
331 [redacted]
332 [redacted]

logged, is copied to the same Detective Constable as the above report, and the same Detective Inspector in CID as was sent the October 1999 Report.

5.451 The third report, submitted in November 1999, was written following a visit to the home of another child who had been attending an older man's house after school. It noted that the child, together with others, was shown pornographic and other inappropriate material by the man, and she was coming home "*with clothes she hasn't got the money for, telling her mum her friends have given them to her.*" Information was also provided regarding other children, one of whom was only 12 and was thought to be "*working as a prostitute hanging around the phone box at the end of* [a named street]" The information also corroborated the earlier intelligence gathered and presented in the October 1999 Report of the 'brothel' being run by an Asian man in the area. The information source had stated that "*local kids are getting hold of homemade drink… made by* [a man] *who lives by the* [named location]" and that another premises "*has various rooms… with mattresses in them and they are being used by Asians to take young girls for sex*"; further, that the "*car park on top of the Wrekin… is also a favourite place for Asians to take young girls.*" Names of suspected men were provided.

5.452 This particular report is stamped as received three days later, and on this occasion is noted to have been copied to: two Inspectors in Wellington; a Detective Constable in the Intelligence Unit; a Detective Constable in the Drugs Unit; the Detective Inspector in CID as above; and another Detective Inspector, with the request "*for further instructions pls*".

5.453 The Inquiry was able to locate and speak to the officer responsible for submitting these intelligence reports. The officer recalled the parents attending the police station and seeming "*quite distraught*" and that they wanted the police to intervene to try to stop their daughter seeing the man. Due to the passage of time, the officer does not remember anything else other than as is written down in the logs – including whether or not the suspect was spoken to – but stated that the reports were disseminated to the Detective Inspector in CID as, at that time, there was not a separate Detective Inspector for CPU; the reactive Detective Inspector held responsibility for CPU as well as CID.

5.454 As mentioned above, in addition to the high profile Major Investigation Unit ("MIU") investigation in which this reactive Detective Inspector was involved at this time, I understand there was also a high profile child abuse and infanticide case which was under investigation, demanding the attention of a number of senior officers from CPU and CID[333] - including the Detective Inspector in proactive CID, who had also been copied into these reports.

5.455 Unfortunately, therefore, based on the evidence made available to me, it appears that, 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'.

333 [redacted]

The 2003 Report[334]

5.456 In September 2000, some ten months following the last intelligence reports submitted in relation to CSE activity, an incident occurs in Telford involving a 12 year old child who was reported to have had sexual intercourse with an adult male at an address in Wellington. The incident was reported by the family, and was referred to CID, with the FPU notified. However, the case was closed within the space of a month, as neither the child nor her family wished to pursue a complaint. Instead, WMP logs noted that the family had been put in touch "*with the social services children and family team to got [sic] [the girl] some counselling at the family's request.*"

5.457 However, the incident came back to light more than two years later, in 2003, in an A30 report and enclosures prepared by a Detective Constable in CPU, entitled 'Prostitution Wellington'.[335] The report was addressed to a Detective Sergeant, and enclosed minutes of a 'Sexual Exploitation Meeting' together with various C44 intelligence reports.

5.458 Behind the front sheet appears a C44 from early 2003,[336] entitled 'Prostitution – [a named street], Wellington', which goes on to detail information received 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 around* [a named street]*, when she was 12 years old. At this age she was raped by one of the 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.*"

5.459 The report goes on to explain that, following that incident, the child was subjected to a gang rape. She did not report the incident to police, but was stated to have "*gone into hiding*" as she was "*terrified*" of the males involved.

5.460 The information in this C44 was recounted to the officer by a reliable source who was clearly concerned for the welfare of the child, but would not divulge any personal details about her as they had "*only just gained* [the child's] *trust and feels that due to the fact she* [is] *terrified of this group, it wouldn't be right.*"

5.461 The source also reports that the child had discussed the murder of Lucy Lowe in August 2000 and the death of Becky Watson in 2002, alleging that both children were involved with the same group of men that she had been involved with.

5.462 The Sexual Exploitation Meeting referred to took place in May 2003, between Safeguarding and WMP; there were five attendees in total, two from Safeguarding, two from the police and a note taker. The meeting appears to have been held after concerns were raised by the Teenage Pregnancy Support Officer regarding the same child as detailed above. The notes of the meeting detail the same concerns regarding the child having been groomed

334 [redacted]
335
336 [redacted] pg 2 onwards

and subjected to rape, and that she was "*in fear of her life*". Reports are also given of other children being "*passed around the group of men.*"

5.463 It is of note that one of the officers in attendance at the meeting stated that "*this sort of situation has occurred before*", and demonstrated an awareness of the alleged perpetrators. The officer said that surveillance could be considered, but also indicated that "*because they have no real evidence it is difficult to take action*"; previous visits had been conducted to speak to children who were involved "*but they will only refer to the* [group of men] *as their boyfriends.*" 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 discussion turned to what could be done to support the child in other ways – and other children more widely – for example, through intervention in schools.

5.464 Within the paperwork appended to the 2003 Report, is a series of crime reports in relation to the child and one of the suspects, which includes a report of an earlier incident in 2002, involving an altercation between the child and a related male (who was considerably older) at the male's home address. There is a series of notes, tracking the attempts to take statements from both individuals in relation to the altercation. However the male refused to sign any statement or notebook entry about what happened "*until he knew what* [the child] *and her family were saying about him.*" The focus of the log appears to be on trying to secure a complaint in respect of the child's role in the altercation, rather than trying to ascertain what happened. The child was not interviewed and the incident was filed as NFA.

5.465 No further documentation appears to exist in relation to this particular case, and the Inquiry has been unable to contact and speak to the either the author of this report, or the receiving Detective Sergeant. However, some handwritten instructions appear on the face of the A30 – four months later – to state, in response to the author:

"*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/survivor] *is not currently at risk. If we now do a 'cold call' the risk is that an assault or other incident may occur on* [the victim/survivor]. *Please file.*"[337]

5.466 The authoring Detective Constable then passes the report to a colleague within CPU the following day, with the instruction: "*Please file in the misc file, thanks.*"

5.467 As far as the Inquiry has been able to ascertain, no further action appears to have been taken by WMP in respect of the incidents involving this child, despite the serious concerns raised in relation to offences committed against her, and the fears expressed for her safety.

"D2276" – The Chalice Review of the Early Intelligence

5.468 WMP explained that the file which became known as D2276 came to light when it was handed to a senior Chalice officer in 2010 by the same Detective who had previous

337 [redacted]

knowledge of intelligence reports in 1999, whilst a Detective Sergeant in the FPU.[338] It is not clear exactly when the file was handed over – but as noted above, the file was formally logged on the HOLMES system in July 2010. The Inquiry understands that the officer was told the folder contained intelligence going back to 1998, and that on speaking to the Detective Sergeant from FPU, he was informed that the file had been stored in the PPU office, since those intelligence logs had been gathered:

"I asked what had happened to the folder and what actions had been taken. He replied that it had been in the PPU office a while and he does not know of any action taking place. He wondered if it would be of use to the current Chalice work."[339]

5.469 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 officer reviewing this material 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.

5.470 Premises A was occupied by a suspect in Chalice, who went on to be convicted as one of the key perpetrators of CSE in Telford. This was the same man mentioned as one of the suspects in the 1999 reports detailed above. The inevitable conclusion therefore, is that Premises A had been used for the purposes of CSE for at least a decade, uninterrupted by any police action.

5.471 The Inquiry was told that D2276 was fully reviewed by the Chalice team and that where the intelligence was not relevant to the Chalice cases, this was to be placed on the unused disclosure file. As much of the material contained within D2276 was, now, "*an historic intelligence trawl*", much of it could not be corroborated on WMP's existing intelligence systems in 2010.[340]

5.472 The review of D2276 resulted in a report being written by one of the Chalice 'Actions Officers', a Constable who had been seconded onto the Chalice team. The report was written in September 2010, and it sought to review and summarise all of the evidence comprised within the October 1999 Report; the November 1999 Intelligence Reports; and the 2003 Report. Interestingly, and for some inexplicable reason, the September 1999 Report does not appear to have been referenced in this review.

5.473 The review goes through each of the above reports and intelligence material, setting out the chronology of information received by WMP in each case. Evidence from the documentation is quoted in much the same way as I have done so above, and efforts are made to link individuals on the police systems. The review goes on to identify a total of 13 potential victims/survivors, or "*child prostitutes*", and 14 alleged perpetrators, based on

338 [redacted] pg 164-165
339 [redacted] pg 1
340 [redacted] pg 2

the intelligence provided. Five individual premises/locations were identified as "*areas of concern*".

5.474 The author concluded:

"*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.*"[341]

5.475 The review is submitted into the Chalice incident room for actions to be considered by senior officers as a result.

5.476 The Inquiry was told that the author of the D2276 review was given a "*big thick pile of papers*" in no definable order, and that the officer sought to separate it into the distinct periods/reports as set out above.[342] Interestingly the report does not refer expressly to the September 1999 Report, but it does reference the intelligence contained within it. The officer included the same wording (such as "*child prostitution*") as was used in the earlier reports, in an effort to directly reflect the intelligence from the time. When made aware of the fact that no action appeared to have been taken in relation to the early intelligence, the author expressed surprise, stating that:

"*It would have seemed odd to me that it wasn't fully investigated, because if you've got a 12 year old who has been sleeping with a* [XX] *year old, then it should have been investigated further, and probably the officer's hands were tied because the family decided not to pursue a complaint.*"

5.477 The officer was not asked, however, to delve into why action might not have been taken as part of the review of D2276, or to recommend the specific steps that should be taken as a result; they were asked simply to make sense of what was in the file of papers, and to then present the information in a "*logical*" way. The author stated:

"I was quite shocked by the extent of it... I wasn't really probably aware of all of this that had gone on sort of in 1999, and… to sort of see… there was all this intelligence going back such a long, long time… it was quite shocking for me that there had been no actioning some of it, and whilst I do understand that some of it was because of parents that didn't want to report it or didn't want it dealt with… it was quite shocking to read all of this had been going on…".[343]

5.478 The Inquiry was told that an officer writing such a report would not necessarily expect to be updated or tasked with any follow-up actions as a result of the review, as there were so many other enquiry officers within the incident room – and that if there were to be any

341 [redacted]
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interviews taking place with any of the named individuals within the report, then these would be carried out by the skilled interviewing teams.

5.479 I deal with the Chalice investigation separately in this Report. I have, however, reviewed the position in relation to those individuals mentioned within D2276 and can confirm that of the 24 potential victims, 22 were visited as part of Chalice, Alpha, Beta or Epsilon. It is not clear, on the evidence I have been provided with, that the other two individuals were contacted. Only one of the victim's/survivor's cases proceeded to trial. The other victims/survivors either admitted they were a witness to CSE, but denied being a victim; denied being a victim of CSE; did not want to make a complaint; or did not support a prosecution. Only one of the suspects referred to in the D2276 material was later prosecuted, and convicted, in Chalice.

Case Studies

5.480 I explained at the outset of this section that I felt it important to consider this earliest body of intelligence in the context of three particular case studies, which the Inquiry identified 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.

5.481 These case studies have been reviewed and considered based on material disclosed to the Inquiry by both the Council and WMP. WMP has told the Inquiry that it has no records of the missing episodes in relation to these three cases, paper files having been destroyed. It has therefore been necessary to look at documentation provided by all stakeholders in the round, in order to determine what steps were or were not taken in each case.

5.482 All three cases bear striking similarities. I have referred to the children involved as Child A, B and G (to align with the naming conventions used for other case studies set out in Chapter 8: Case Studies).

Child A

Overview

5.483 Child A first came to the notice of authorities in 1997: to Safeguarding as a result of strained family relationships, following which Child A was made the subject of a police protection order. An initial assessment was completed by Safeguarding and she was temporarily taken into care. Shortly afterwards reports were made to the police that Child A was one of a number of children who had been subjected to USI offences by older males. Child A's family also raised concerns with the authorities that Child A was continually absconding, sometimes travelling out of Telford, and refusing to accept she was at risk. It is not clear whether WMP raised the USI offences with Safeguarding for discussion.

5.484 At a child protection conference the subsequent month, Child A was described as being "*in moral danger"*, due to concerns of her involvement in drugs and "*prostitution*"; and whilst it was acknowledged that Child A was at risk of "*suspected sexual abuse*", references were also then made to her 'behaviour', commenting that she was "*neglecting her own welfare*"

– suggesting an element of personal choice – albeit the notes make clear that Child A had disclosed the identity of one of her potential perpetrators.[344]

5.485 Discussions also took place at this time between Child A's family and a social worker, where concerns were raised about Child A being "*groomed*". There were noticeable physical signs of Child A's sexual activity and complaints to the social worker described the situation as if "*there is someone there who has a hold over her and it is like a magnet*".[345] The decision was nevertheless made for Child A to be placed on the Child Protection Register under the category of 'Neglect', although the Safeguarding contact sheet notes "*suspected sexual abuse*".[346]

5.486 The evidence shows that Child A continued to be treated as a child at risk, again being taken into police protection after she was removed from an address where she was considered to be at risk. This led to Child A being accommodated and placed on the 'At Risk' Register in late 1997, with conditions placed on premises from which she was to be excluded.

5.487 However, the risks posed to Child A did not cease when she was moved into local authority care. Safeguarding records show that she continued to abscond from her accommodation with increasing regularity, resulting in over 60 missing episodes in the space of a year – many of which led to her being found at the same address and in the company of "*adults outside of her family about whom there were concerns"*.[347]

5.488 Both the police and Safeguarding had continuing involvement in such episodes, albeit the majority of the engagement appears to be around managing Child A to return to the accommodation, or to find a new placement for her, rather than seeking to understand the reasons for her continual absconding. The assumption appears to be that Child A continued "*to abscond and place herself in dangerous and vulnerable situations[s]*" and that she was "*unable to grasp the seriousness of* [her] *situation*".[348] It appears connections are not made, at this point, with the previous concerns raised around Child A being at risk of grooming, and again, it was assumed by those involved in her care that she was acting out of choice. There does not appear to be any discussion of therapeutic support despite the missing episodes.

5.489 At this time, in late 1997, the evidence indicates that Safeguarding were seeking to allocate a new key worker within South Wrekin; it is not clear why, and what happened in respect of her existing social worker as a looked after child, or whether or not Child A had an allocated key worker in her residential placement.

5.490 Some months later, whilst still accommodated, a review took place with Safeguarding and Child A. Observations were made that Child A continued to act in an overtly sexual manner

344 [redacted] pg 267-269
345 pg 261-266
346 pg 38
347 pgs 24-32
348 pg 183-184

for her age (which was considerably below the age of consent), and there were clear signs of her using birth control, engaging in sexual activity and continuing to go missing.

5.491 However, a new key worker in South Wrekin was appointed, and after a very brief spell (less than a month) of improved behaviour and no missing episodes, the key worker presented Child A's case at a Child Protection Conference, stating that she (the key worker) "*had not had time to prepare a full report*" in respect of Child A, but that Child A "*is no longer behaving in way to put herself at risk*". Child A was therefore removed from the Child Protection Register the following month.[349] Within days of that decision, Child A is reported as missing to the police.[350]

5.492 A Core Assessment conducted at the same time acknowledged that whilst the missing episodes have subsided, there were still other issues that impacted upon Child A. The Core Assessment appears to be incomplete, yet plans continued to try to de-register Child A, and to return her to the care of her family, despite other concerns remaining as to issues within the family home.

5.493 At the same time, Child A had significant difficulties with attendance at school; it peaked at less than 10%. Out of school educational support packages appeared to have little impact on improving Child A's engagement in learning, and paperwork confirms that Child A had also been let down by her Education Welfare volunteer, who appeared to be busy to show up for Child A.[351]

5.494 As noted above, only a few months following Child A's removal from the Child Protection Register, her difficulties with attendance recommenced, and concerns were also raised over substance abuse. Child A was again found in the presence of multiple adult men together with other vulnerable children, leading to her being taken into police protection again and Safeguarding being informed.[352]

5.495 Child A was, at this point, without a social worker due to apparent resourcing issues, and the paperwork notes that when Child A "*needed a Social Worker she could trust and rely upon, there was no one there for her."* The notes stated that it was left to others *"to go and look for* [Child A] *and to show* [Child A] *how concerned we were for her safety*".[353]

5.496 In subsequent months, a Core Group meeting took place at which police and social workers expressed grave concerns about the company Child A was keeping with individuals in Telford, *"especially as she is mixing with a group of youngsters from the* [name removed] *area who are known to be involved with drug abuse and prostitution."*[354] Despite this apparent risk, no social worker was allocated to Child A (only an interim agency worker) and no action appears to have been identified in response by Safeguarding.[355]

349 [redacted] pg 256
350 pg 32 and [redacted] pg 61 and pg 138
351 pg 173-174
352 pg 22
353 pg 153-159
354 pg 151-152
355 pg 84

5.497 Within WMP, however, intelligence began to be collated by one particular police officer, who had received reports that Child A was "*involved in prostitution*" with two particular suspects, one of whom was "*acting as a 'pimp' and supplying … males for the girls to perform sex with*".[356]

5.498 Over just a few months, multiple separate intelligence reports were submitted to WMP's CPU, containing what the reporting officers describe as "*credible*" information that Child A was again involved in 'prostitution', with the same names of perpetrators and other victims/survivors cropping up in each report.[357] Safeguarding and Housing were also made aware of the concerns.[358]

5.499 During this time period, there were reports that Child A might be pregnant, at what was still a considerably young age. Connections also began to be made with other children in the same situation as Child A, and with links to possible exploitation in areas outside Telford, where concerns had been raised about wider gang exploitation. Despite these concerns - which were by now also being raised in respect of Child A by social workers for other children - the emphasis continued to revolve around Child A being held responsible for her own behaviour, with no therapeutic intervention considered.[359]

5.500 A strategy meeting took place with social workers, educational welfare officers and support workers – but with no attendance from the police. Child A made disclosures at the meeting of having a 'pimp', of being paid for sex, and having unprotected intercourse with multiple men; but she also admitted to being frightened of those she was in company with. The focus at this point appears to have been upon trying to relocate Child A, whilst referring her to a 'resource worker' who could help Child A to *"realise the dangers to herself when absconding and her current lifestyle".*[360]

5.501 At this crucial point in the timeline there appears to be breakdown in support from Safeguarding. South Wrekin Safeguarding appears to have taken over the care of Child A, however the paperwork indicates that there is a lack of liaison between the North and South Safeguarding teams, and a lack of representation from the South to offer information to the wider case management teams in respect of Child A. The notes of one Case Conference confirm that the Case and Team Manager had been invited from South Wrekin but had declined to attend, and as a result they were *"unable to comment as to how far their investigations have proceeded."*

5.502 The police continued to acknowledge the imminent risk to Child A, and to investigate one of the suspected perpetrators, and to raise ongoing concerns about Child A's ongoing missing episodes. One particularly concerned officer noted that if Child A is found to be pregnant, then "*serious implications arise*" – which I take to mean implications for those authorities involved in Child A's care, given their duty to protect her. [361]

356 [redacted] pg 70-71
357 [redacted] pg 50 and [redacted] pg 70-72 and pg 144-146
358 [redacted] pg 73-74 and pg 135-140
359 [redacted] pg 135-140

5.503 The police continued to share information of concern regarding a "*pimp and* [the] *risk he presents*" to Child A, and other suspects considered a threat.[362] However subsequent attempts to obtain updates from South Wrekin continued to go unanswered, simply stating that there are *"no immediate concerns for* [Child A's] *safety as the placement is exhibiting stability"*. A strategy meeting was abandoned as a number of participants did not attend. Liaison with WMP was also stated to have broken down (albeit the reason for this is unclear), resulting in there being no representation by the police. The police went to South Wrekin Case Management Team by way of follow up, only to be advised *"the Case Manager had been on holiday therefore had not been available to attend"*. The Case Manager failed to respond to police requests for information, resulting in the police having the wrong information as to where Child A was currently being accommodated. [363]

5.504 It also transpired that Child A had been allowed to travel back to a particular location of concern, with at least one other child who was also known to be at risk. This was despite Child A being barely a teenager and still in the care of the authorities. North Wrekin raised concerns at the lack of engagement from South Wrekin, stating they *"felt strongly that we should be dealing with these matters through a unilateral approach from both South and North Wrekin Teams, and this certainly does not appear to be the case".*[364] The continuing conflict between Safeguarding teams appears to have undermined any proactive joint working in the best interests of Child A.

5.505 Concerns nevertheless continued to be raised into the following year and beyond, with Child A breaking down in tears and making disclosures to carers and support workers that she found herself "*in situations that terrify her*", expressing a desire for "*someone to talk to*" as she "*needs help*".[365] Despite pleading for such help and social workers saying they will look at arranging support, there is no record of anyone from Safeguarding visiting Child A following this.

5.506 Subsequent records note that, not long after this, Child A returned home "*in a mess, blood everywhere, saying she had been raped*" by multiple men. Child A was taken for medical attention, the reported conclusion of which is that what had occurred was "*not forced sex*" despite Child A giving a clear and graphic account of the incident, and saying she recognised the perpetrators. It is not clear whether Child A was examined by a medical professional or whether these assessments were made purely by the social workers and residential carers.[366]

5.507 Child A agreed to report the rapes to the police, but at first refused to give details of the offenders; when she later agreed to give an ABE interview, Child A retracted the allegations. Safeguarding records suggest that the outcome of the investigation was that "*due to knowing her assailants",* Child A decided not to press charges "*as she feared for her own safety*".[367]

362 [redacted] pg 77-78; [redacted] pg 57-60
363 pg 191-196
364 pg 191-196
365 pg 74
366 pg 75
367 pg 76, pg 91, pg 95-97

5.508 The paperwork again notes little involvement from Child A's South Wrekin social worker, who was not in attendance at any of the above meetings relating to the rapes; these appear to have been dealt with by Child A's carer and representatives from the Housing, Health and Care teams. Shortly after this incident, Child A's social worker informs Child A's carer via letter that they "*have had no time to come and visit Child A*", and to "*contact the back-up officer if any problems occur*". Child A, at this point a high risk child, was left without a social worker for the best part of six months.[368]

5.509 The following year, Child A went missing on more than ten occasions within a matter of months, for multiple days at a time, and was found in the company of individuals who were, again, known to the police. She continued to be drawn into substance abuse, and was taken to the GP for concerns over her sexual health, where she was prescribed the contraceptive pill (whilst still below the age of consent).[369]

5.510 At around this time, Child A began to get into trouble with the police, at which point her social workers discussed whether they "*should either close the case or place* [Child A] *in an environment wherein she really can be protected from placing herself at risk*". The attitude expressed is that: *"there never is an easy answer with young people who are determined to go their own way. However, if we give up on them because they refuse to obey the rules aren't we in danger of mirroring their parents' inadequate parenting?"*.[370]Again, the assumption being that Child A is choosing to place herself at risk.

5.511 Child A's records end with her being re-accommodated and referred to Teencare for support. A strategy meeting noted that Child A "*has a history of absconding* [and] *uses that as a means to indicate that she does not want to be where she is and if she feels she is unable to resolve any conflicts with others*". It noted that her absence "*for days on end*" makes her particularly vulnerable and "*puts her at considerable risk*" – noting that she has been collected from an address of a man "*about whom there are concerns expressed in respect of a considerable number of other females in care*".[371]

5.512 It is not clear, by the time the records for Child A end, whether the authorities ever managed to effectively remove Child A from the clear risks to which she had been being exposed for some years.

Analysis – Child A

Safeguarding

5.513 Safeguarding became involved with Child A before she was a teenager. Even at that stage, concerns had been raised in a Child Protection Case Conference regarding Child A's experience of sexual abuse and 'child prostitution'. The police either were not invited or did not attend this conference. It is clear to me they should have been present.

368 [redacted] pg 81-82, pg 85-86
369 pg 55-69, pg 154
370 pgs 7, 65, 80, 88
371 pg 154-155

5.514 Two years later, similar concerns were expressed at a strategy meeting, where Child A was expressed not only to be sexually active but also paid to provide sex. Again, the police were not in attendance; I have seen documents which show an officer was expected to attend but was absent on leave. No provision appears to have been made for the absence, nor is there evidence of any insistence by Safeguarding that the police should attend.

5.515 It follows that Safeguarding were aware of Child A's vulnerability, continuous missing episodes, signs of sexual activity, reports of indecent assault and sexual assault before Child A had reached her teenage years; and indeed Child A asked the authorities for help and openly told them she was afraid.

5.516 None of these warning signs were followed up. During this time, all Safeguarding analysis appears to focus upon Child A as posing a risk to herself rather than upon protective steps that could be taken to shield her from harm. It is clear within the records that Child A is traumatised, but her distress is not recognised; there is a general lack of recognition of her being routinely abused; she is not seen, or treated, as a child.

5.517 Critically, Child A was left without a social worker during crucial periods (and at one point, for as long as six months) and accordingly had no active support or advocate at key child protection meetings. She was a child who was in the care of the state for much of the time under review, yet there is an astonishing absence of support and proactive intervention by some social workers. I have already expressed concern at the absence of police attendees at these meetings, but the absence of a child's social worker from such a meeting is astounding and entirely unacceptable. The state had a clear responsibility for Child A, yet for long periods of time she was left without any reliable support.

5.518 The evidence shows a failure by Safeguarding to ask questions as to why Child A is continually going missing, particularly given she is found in the company of much older peers, or as to the reasons for some of her other behaviour. The behaviour described was plainly age-inappropriate and extreme, and should have, in my view, signalled a child in need and should have triggered some professional curiosity as to cause; instead of which there is a focus on prevention of repetition.

5.519 Perhaps most importantly, no questions appear to have been asked nor steps taken to address the fact that Child A was clearly being coerced into sexual activity at an age when, first, she could not legally consent, and second, there was plain evidence to show she had not consented: she had complained of rape. This happened on multiple occasions. Not only did Child A complain, but people close to her also expressed overt concerns that she was being groomed for 'child prostitution'.

5.520 Given these concerns it is remarkable how few interventions and assessments there were by Safeguarding and astonishing how quickly the decision was taken to remove Child A from the Child Protection Register.

5.521 Taken as a whole, the response of Safeguarding demonstrates an overwhelming lack of care towards this child.

Police

5.522 Child A was the victim of a number of sexual offences at a very young age. In one incident, Child A claimed she had been raped by multiple adult men. There was also cogent information that Child A was being treated as a 'child prostitute', and that she was being trafficked out of Telford to be exploited.

5.523 One particularly concerned police officer did appreciate the urgency of Child A's situation. They filed numerous intelligence reports, and made attempts to speak with Safeguarding and to refer the matter internally to CPU. At no point however do WMP appear to have adequately investigated Child A's allegations, or followed up on the intelligence it had, or the concerns raised by its officer. Despite attempts to follow the thread of evidence within WMP, WMP have been unable to confirm to the Inquiry that any such action was taken in the case of Child A.

5.524 It is the view of the Inquiry's Policing Expert that given the police had known of Child A since she was very young; that there were continual reports of her being sexually active; being regarded as a 'prostitute' and being 'pimped', matters should have been progressed to, at least, a multi-agency case conference involving police, Safeguarding, Education, Health and a dedicated social worker.

5.525 It is clear to me that although WMP did make referrals to Safeguarding with a view to attempting to protect Child A, it took no other positive action; I regard that as a failure by WMP.

Education

5.526 Child A completely disengaged with school at an early age, and there appears to be little done to encourage her to return: paperwork suggests that the expectations of Child A are low.

5.527 Whilst her care plans consider other educational support packages, these do not appear to have encouraged further engagement, and ultimately efforts to reintegrate Child A into mainstream school appear to be unsuccessful. Child A was not helped by the fact that her Educational Welfare volunteer was unreliable or disinterested and made no efforts to assist her in attending school.

5.528 I note that one particular education support service did its best to recognise Child A's distress and advocated on her behalf, provided reports and at times challenged social workers – however this did little to address change Child A's difficulties with schooling.

5.529 This was a child who should have been in school every day; who was on the register, but who was almost continuously absent, and seemingly never missed. I regard this as an abrogation of responsibility by the school and supporting educational authorities.

Health Services

5.530 Insufficient records have been available to the Inquiry in relation to the health care provided to Child A in order to understand how far her GP and any other health support services were involved in her care.

5.531 It is not clear whether Child A was ever referred for any sexual health screening, given the concerns voiced about her premature sexual activity and her admissions regarding unprotected sex – and, importantly, following overt injuries after her sexual assault. The Inquiry has significant concerns as to why such referrals were not considered for such a young and vulnerable child, or, if they were, why the results were not being documented and shared with the authorities.

5.532 Noticeably absent from the records for Child A is any consideration of therapeutic or medical support or intervention from health services for the benefit of Child A; this just does not appear to be given any proper thought.

Overall conclusions – Child A

5.533 There is a consistent theme in Child A's timeline: little was done by any agency to understand her, or the reasons for her behaviour. She was simply treated as a problem, and not as a vulnerable child.

5.534 Child A's issues were often seen as her own 'choice'. Despite her very young age, she was treated as if she was able to make informed choices and give consent in situations that were entirely inappropriate for a child of her age.

5.535 In my view there is clear evidence of CSE, but Child A was on many occasions not treated as a victim/survivor, nor as a 'normal' child of her age. Despite contact with a number of the authorities and agencies, all missed the opportunity to intervene and further protect Child A from harm.

5.536 It is right that I note that there is evidence that WMP returned to speak to Child A many years later, as part of other CSE enquiries. Whilst Child A then maintained that she had been the victim of multiple sexual offences – repeating the allegations made when she was a child – she did not wish to engage with the authorities in order to pursue matters further. That is a decision which the Inquiry entirely respects and understands.

Child B

Overview

5.537 Child B became involved with the authorities in 1995, when concerns were raised by her school at her early sexualisation, with reports that she had disclosed being sexually active.[372] Safeguarding recommended Child B receive support within the school setting,

[372] [redacted] pg 27-29

but this early evidence of sexualised behaviour outside expected development for a child of Child B's age was not actively addressed by Safeguarding at this stage.

5.538 The police and Safeguarding visited the family following the disclosure, and whilst it was confirmed that Child B was 'sexually active' and that she would often run away to another location – Child B refused to talk about the allegations and the police interview was abandoned.[373]

5.539 Various episodes followed where Child B was picked up in vulnerable situations by the police, on occasions in other towns and cities a long way from Telford. Upon referral to Safeguarding, Child B made disclosures of sexual abuse, but in relation to a relative. During a joint interview between Safeguarding and police, Child B retracted the allegations. A case conference was not convened on the basis that "*no marks were found*" on Child B following a home visit. However, the records note that there is missing information surrounding the investigation of Child B's allegations and it was not possible to report the investigation outcome.[374]

5.540 Upon further investigation, Safeguarding confirmed that Child B had been known to the authorities for a number of years, and stated that "*Child B's behavioural problems were the cause of family discord*". Comments were also made in initial assessments by Safeguarding that Child B "*always liked the boys"* and it was openly acknowledged that despite her age, Child B was *"going out with"* men many years older than her.[375] No actions, or reactions, were considered – as if such behaviour is normal or acceptable for a child who is still some way under the age of consent.

5.541 During 1996, Child B continued to run away from Telford.[376] Issues in the home continued and at the same time, Child B made allegations about being "*touched up*" by a man known locally, which led to her lashing out, being given an emergency placement and being temporarily excluded from school. As a result, Child B attempted to commit suicide, whereupon she was referred to a psychiatrist, but did not engage: the psychiatrist noted that Child B's suicide attempt was premeditated "*but she couldn't specify why. She had run away to* [X]… *She would not, or could not, talk to me about why she had run away".*[377] It was also noted at this time that whilst Child B had previously been offered Teencare support, this had been terminated some months previously – it is not clear why.[378]

5.542 Contact with the psychiatrist and Safeguarding continued into the following year, but Child B still struggled to engage. Warnings were raised amongst Safeguarding in relation to an apparent relationship Child B had formed with a man a number of years her senior, who "*hangs around outside"* where she is living; staff challenged her about "*the consequences*

373 [redacted] pg 75-79
374 pg 73-79
375 pg 75 and [redacted] pg 15
376 pg 2
377 pg 39-40; [redacted] pg 7 and [redacted] pg 8-10
378 pg 7

of any kind of sexual relationship",[379] as reports had also surfaced that Child B thought she might be pregnant.[380]

5.543 The psychiatrist appeared to be at a loss as to how to assist Child B, stating that Child B:

"… has all the hallmarks of somebody who believes that she is unloved, unwanted and may have been abused … Her current behaviours … would all seem to fit with the picture of a girl with very low self-worth who periodically gets depressed and periodically attempts to harm herself in various ways, some of which bring her to the attention of people like myself, others of which … do not".[381]

5.544 However, the recommendation is that Child B should be accommodated somewhere "*to contain her behaviours so that the chances of her harming herself… are at least minimised*" and that this should be "*somewhere that has high staffing levels but not actually locked doors initially*". Almost as an aside, therapeutic input was recommended "*if* [Child B] *will accept it*".[382]

5.545 During early 1997, there were continuing incidents where Child B went missing and returned under the influence of drink or drugs. She appears overtly troubled, but continued to refuse to open up during sessions with the psychiatrist. There were also multiple incidents where Child B feared she might be pregnant, and sought emergency contraception and ongoing birth control.[383] She frequently reported these issues to staff members in her accommodation or to social workers. On one occasion, staff were made aware of Child B engaging in simultaneous sexual relationships with men "*from the Community*" (referring to Asian men), and seemingly relying on those men for transport. The response of the staff, however, was to encourage Child B to ensure that she practised safe sex and safeguarded herself.[384]

5.546 At this time, Child B was referred to Telford Family Centre by her social worker, with a view to supporting her with counselling, but no reference was made to concerns of her being at risk of sexual abuse or exploitation. This was despite Child B making more than one report to care home staff that she was being sexually assaulted at the time, and when she was continuing to be picked up from the home by older men in cars at night. Despite such disclosures, no formal child protection measures appear to have been taken by staff.[385]

5.547 Later that year, Child B admitted to social workers that (whilst still under the legal age of consent) she "*does a bit of business*"[386] – meaning 'prostitution'. Incidents also continued whereby Child B was sexually harassed, and she expressed to staff that she had "*nothing to offer or worth living for*".[387] Staff were also aware that Child B was continuing to make contact with a "*male friend in the community*", and appear to do nothing to stop this.[388]

379 [redacted] pg 37-38
380 [redacted] pg 27, 31
381 [redacted] pg 23-27
382 [redacted] pg 25
383 [redacted]
384 [redacted] pg 10, pg 21, pg 33-34
385 [redacted] pg 26 and [redacted] pg 13
386 [redacted]
387 [redacted] pg 18-20
388 [redacted] pg 11-12

Discussions took place at committee meetings as to whether Child B should be relocated in order to help her. Staff noted that, at this point, Child B had begun to open up on a number of occasions whilst intoxicated; she was emotional and seemed "*keen to communicate*" but it was recognised that she found this difficult, and maintained that things were *"so bad no-one could help"*.[389]

5.548 An alternative placement was found for Child B, however she continued to go missing with increasing regularity, often with multiple men in cars. In fact, the missing episodes increased to a staggering level, with Child B going missing on over 50 occasions in less than a year.[390]Despite this, there is an overwhelming lack of action on the part of Safeguarding or WMP.

5.549 In subsequent months, Child B was relocated after being "*thrown out of her placement*" due to her 'behaviour'[391]; despite there also being "*rumours*" at the same time that Child B had been raped.[392] Child B refused to make a complaint.[393] The only action appears to have been an application for a Teencare placement, noting that Child B is "*sexually active*".[394]

5.550 An educational report in the summer of 1997 identified that Child B had attended school for less than half of the academic year, and she was often "*tired*" and "*lethargic"*; it noted her underperformance as being due to events "*outside of tuition*".[395]

5.551 Further concerns followed that year, raised by social workers, that Child B was "*in a relationship*" with a man more than twice her age; that Child B "*may be prostituting herself*" and that she was struggling to look after herself.[396]

5.552 In a concentrated period of activity the following Autumn, Child B became pregnant; continued to go missing; was noted as having regular contact with much older men, and was recorded as being "*out of control*" and "*on a downward spiral, with no commitment to her care plan*".[397] Concerns were reiterated about Child B's ongoing 'involvement' in drugs and 'prostitution';[398] her missing episodes continued at an alarming rate, averaging approximately twice a week.[399]

5.553 A referral was made to the Initial Response Team following indications that Child B had begun another 'relationship' with an Asian male much older than her, and who was "*known*" to care home staff.[400] Core Group meeting notes acknowledge that attempts had been

389 [redacted] pg 18-20
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391 [redacted] pg 52-53
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394 [redacted] pg 35-51
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396 [redacted] pg 7 and [redacted] pg9
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398 [redacted] pg 9
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400 [redacted] pg 11 and [redacted] pg 29

made at adopting various therapeutic strategies to help Child B minimise the risk to herself, but these had all been unsuccessful.[401]

5.554 Towards the end of the year, discussions took place at a Safeguarding committee meeting where concerns were expressed at Child B's recent involvement with men, and reports about the ways in which they sought to exert control over Child B. Staff attempted to discuss the situation with Child B and express "*concern about the motives of this "boyfriend"*".[402]

5.555 Shortly afterwards, an incident was reported to police by staff following concerns that Child B had been raped by "*a group of Asian males*". Over the next two days following this incident Child B went missing, and was returned home having been at a location of concern until the early hours of the morning. The incident was reported to police but the following day Child B withdrew the complaint of rape, and no further action was taken. No apparent action was taken by Safeguarding in response.[403]

5.556 Following this, events escalated further over a number of months – with a cycle of repeated missing episodes and further reports of abuse by Asian men[404] - to a crucial point where staff at the home reported that Child B was "*running wild*" and expressed fear this "*could lead to tragic conclusions*"[405]; social workers considered whether a Secure Order was required in order to protect Child B from harm. In a report prepared by her link worker, Child B was noted as "*keeping company with several Asian gentlemen…*[aged between their twenties and forties]", and that their "*interest in* [Child B]" was "*of a sexual nature, which she appears to condone provided she is supplied with money for drink/ drugs or the product itself*".[406]

5.557 A link worker wrote to the case management team with the recommendation that Child B was "*at risk of significant harm*" and needed to be transferred to secure accommodation; the letter noted she "*is at risk from her own actions, which she has tried repeatedly to modify with little success … in light of her lack of self-control*".[407] Despite these descriptions and disclosures, the subsequent report for Case Conference described Child B as 'engaging' in these activities as a way of "*pursuing excitement*" and "*deliberately putting herself at risk*".[408] Against the recommendations, Child B was not put into secure accommodation. The only involvement of police during this period appears to have been whenever Child B went missing.[409]

5.558 During this same period, Child B continued to go missing at the same rate as before; was excluded from school; found herself in trouble with the police; and made another attempt at suicide. She was "*often found at* [an address] *which is used for abuse by others*" – notably the same location where she had disclosed she had been abused previously but

401 [redacted]
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403 and [redacted]
404 pg 4 and [redacted] pg 11
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406 pg 53
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408 pg 13-17
409 pg 1

refused to press charges. Despite this, some professionals continued to consider Child B as "*attracted to excitement and the lift it gives her*".[410] Increasing incidents took place where Child B was found in the company of males, or unknown males were calling the residence to speak with her, raising concern amongst staff.[411]

5.559 Incidents of a similar nature continued into 1998, with Child B continuing to make open disclosures about her sexual activity and substance abuse; however there seemed to be less engagement with Safeguarding during this year, with her 'Looked After Child' Plan focussing on therapeutic support to address "*emotional*" and "*financial*" issues – yet there is no evidence of whether such support was actually put in place.[412]

5.560 Later that year, Child B was found living at an address in Telford frequented by multiple Asian men and suspected CSE offenders. Over a number of months, police intelligence officers put in numerous reports of Child B and other young persons at risk of 'child prostitution' at this and other addresses in the area, and there were indications that Child B was being trafficked out of Telford for the purposes of 'prostitution'.[413] Minutes of a strategy meeting confirm that Child B had been without a social worker for a period, and that a new one needed to be allocated in order to consider whether to move Child B to another placement; it was noted at that meeting that "*there is no one here from social services to offer views* [on Child B] *and therefore no further information is available*". Discussions also took place with the police as to whether or not a 'Caution of Prostitution' should be issued for Child B's own protection. The meeting notes also record that Child B had, at that stage, been missing for a week, and that there were concerns that she was being housed by the men who were responsible for her 'prostitution'.[414]

5.561 In subsequent months, Child B continued to be the subject of police intelligence reports regarding 'child prostitution' taking place at known premises in Telford.[415] Further strategy meetings confirm that whilst another social worker had been allocated, that individual was unable to attend any meetings for a number of months. The Council Resource Team noted that whilst they could not provide a stable social worker for Child B, they were "*determined to impose the statutory input*" on Child B in order to safeguard her.[416]

5.562 Intelligence reports detailing information similar to the above, regarding concerns around 'prostitution', continued into the following year.[417] References within Council documentation also discussed when Child B was or was not 'working', with such 'work' known to be 'prostitution'. It is clear that Child B was continually going missing, travelling out of area, and efforts to keep up with her seem to have dwindled.

5.563 The records for Child B then go quiet, as it is suspected she has left the area. It is noted that Child B was never entered on the 'At Risk' Register.

410 [redacted] pg 19-21, pg 75-77
411 and [redacted] pg 34-36
412 and [redacted] pg 11-26
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414 [redacted] pg 15-25
415
416 [redacted] pg 191-196
417 [redacted] pg 10

5.564 As with Child A, when WMP followed up with Child B in later years, she accepted that a number of CSE offences had been committed against her, but she declined to file a complaint or support a prosecution.

Analysis – Child B

Safeguarding

5.565 Safeguarding had known about Child B's sexual activity with adult males from since she was very young. She was a frequent 'misper' (missing person) and had attempted suicide. She had come into frequent contact with the police and had been referred to Safeguarding.

5.566 The Safeguarding response included emergency placements, periods in a care home, and referrals to various support and psychiatric services. Yet professionals inappropriately describe Child B as someone who has *"always liked the boys",* and she was depicted as promiscuous and attention-seeking; like Child A there does not seem to have been any exercise in understanding the reasoning behind her behaviour, which was assumed to be either her choice, or as the result of a difficult home life.

5.567 By way of example, there were significant missing episodes, but little effort to assess the reasons for, or patterns demonstrated by those episodes. It is obvious Child B is extremely vulnerable but staff did not appear to ask more questions about who she is associating with and whether she may be being mistreated or abused by others.

5.568 As with Child A, Child B was treated as though she has full agency and is acting out of personal choice – for example the references to Child B "*liking the boys*" in the context of a child having sexual relationships with adult men. Again, like Child A, she was considered at risk of her own actions, and she is even described as pursuing "excitement" rather than those actions being seen as a sign of exploitation.

5.569 Notably, there was a failure to see what Child B describes as "*doing business*", or only dating men who "*have plenty of money*", as exploitation rather than consensual 'prostitution'. Her social worker even says that Child B *"may be prostituting herself",* yet there is no indication of the social worker raising or reporting those concerns. This is, of course, when Child B has a social worker; like Child A she went for a continuous period without any social worker support.

5.570 By 1998, social workers were aware of Child B's 'pimps' and whilst staff expressed concerns about the motives of certain males who are known to be associating with Child B, even noting down registration plates and receiving calls from unknown males to Child B, there seems to have been little proactive intervention or aims at preventing these incidents occurring.

5.571 The lack of proactive engagement was mirrored in a lack of formal representation and record keeping. Matters were openly discussed and recorded in a 'committee' book or 'contact sheet' however it is unclear whether this record was supervised or followed up. Child B's history is thus incomplete, with files and data missing regarding Safeguarding's

early involvement, and as with Child A there are periods where Child B is without representation at key strategy meetings.

5.572 Furthermore, I have seen evidence which shows that, even when strategy meetings were convened together with the police, Safeguarding had failed to inform the police of key incidents involving Child B.

5.573 In short, there is a catalogue of incidents and opportunities when Safeguarding should have been aware that Child B was being subjected to sexual activity that amounted to CSE. Safeguarding were aware that Child B was the victim of child sexual offences yet did not report these crimes to, nor seek to engage with the police; it did, in my view, fail in its safeguarding response.

5.574 It is the view of the Inquiry's Social Work Expert that this case shows a huge amount of drift and apathy on the part of Safeguarding; and that for the concerns raised not to have led to action and support when Child B was so clearly at risk of harm, is difficult to comprehend.

Police

5.575 Following some earlier engagement with the family, the police become involved more closely when Child B goes missing. Officers showed proper urgency in efforts to locate Child B, however, it is not clear what strategies (if any) were adopted by the police to try to deal with such a frequent misper, and to investigate the reasons for her going missing.

5.576 It is the view of the Inquiry's Policing Expert that while the police were involved with Child B in respect of various incidents and missing episodes, there is no evidence of enquiry as to the root causes of her behaviour or of consequential referral to Safeguarding. While the police had expressed urgency in their dealings with Child B's missing episodes, there is no evidence of any action being taken in response – by way of investigation or disruption - to the reports that Child B was involved in prostitution. WMP maintains that missing persons records for this period no longer exist, although it is plain that some other historic police records existed given the intelligence included within D2276.The point is, if no action was taken, then I consider this was a serious failing by WMP.

5.577 There are further reports of 'prostitution' when Child B is under the age of 18, and is frequently found residing with adult males, including in premises where Asian men are known by WMP to have sex with children. Indeed Child B is found with known perpetrators at a point when she is evicted from her accommodation. The Inquiry's Police Expert concludes that the authorities should have pulled all this information together to mount an operation against those committing sexual offences against children, including Child B.

5.578 I have noted that there is reference within Child B's case to the police considering whether to issue her a 'Caution of Prostitution'. On the face of it this may look like a stark response to a child who was in fact a victim/survivor; however a close reading of the evidence shows that it was hoped that once taken to a police station, Child B would feel "*empowered*" to

make disclosures about her abusers.[418] My view is that this demonstrates that individual officers were showing concern and some imagination in their response. Whilst I do not regard the suggestion of a Caution as an appropriate response in the circumstances, and indeed it was not followed up, it seems to me that this case demanded a robust organisational response that was never forthcoming.

Education

5.579 The educational records show Child B had very poor attendance at school but there is no evidence that this resulted in any referral to Safeguarding or engagement with Educational Welfare Services. The documents simply remark that her underperformance was due to events "*outside of tuition*" – which I read to mean that the school regarded the reasons for her absence as 'not its responsibility'.

5.580 Education agencies make assumptions that Child B's truancy and failure to engage are down to personal choice, rather than being indications that Child B is vulnerable and at risk. Again, as with Child A, this is in my view an abrogation of responsibility by those agencies for the safeguarding of pupils.

Health Services

5.581 There is inconsistent and incomplete health records data and thus limited evidence of action from Health Services in supporting Child B. There are records of contact with a psychiatrist, who, starkly, declares that Child B has "*all the hallmarks*" of someone who has been abused, but whose ultimate recommendation was that Child B be sent to some form of residential unit with high staffing levels in order to protect her; this reads to me as an indication that the psychiatrist regarded Child B's problems as intractable.

5.582 It is not part of my function to second-guess medical intervention, however I am not convinced that this would be the same today. I think this response may be very much 'of its time'. If so, it speaks to prevailing attitudes, which I discuss more fully in Chapter 9: Attitudes and Impact.

5.583 I have seen no other information of any other medical intervention; including, despite evidence of multiple pregnancy scares as well as confirmed pregnancy, any attempts to ensure Child B had access to appropriate medical and sexual health support. Again, I view this as an inadequate response of those involved in Child B's care.

Overall conclusions – Child B

5.584 The narrative of Child B's experience, like that of Child A, is of appalling experiences at the hands of older men; but also of shocking inaction by those institutions charged with her protection.

[418] [redacted] pg 23

5.585 Child B was revisited in recent years as part of later investigations by WMP into historic CSE, and whilst she verified she was a victim/survivor of USI and rape, she declined to pursue any allegations with the police. No further action is recorded.

5.586 I am driven to wonder what the result would have been, had a proactive multi-agency approach been taken contemporaneously in relation to Child B – both for Child B and for the perpetrators who exploited her.

Child G

Overview

5.587 Child G had been supported by the Children and Families Team whilst at primary school, and had been in and out of care from an early age. Concerns were raised by Safeguarding about Child G having money by unknown means and associating with other children about whom there were concerns of vulnerability and underage sexual activity, even in primary school years.[419]

5.588 The Inquiry has seen a number of reports of social workers raising concerns about Child G's lack of inhibition and 'sexualised behaviour' at such a young age, including that she reportedly "*had unprotected sex with about* [multiple] *boys*", including sex taking place "*in front of others*". Concerns were also expressed about the possibility that Child G could be pregnant when still well below the age of consent.

5.589 While these incidents are noted in committee reports, there is a lack of information about whether Child G was dealt with formally as a 'looked after child', or whether any child protection action was considered or taken as a result.[420]

5.590 In early 1997 the police became involved when Child G was attacked by young males known to her, but Safeguarding records indicate she declined to pursue a complaint "*for fear of reprisals*" by the perpetrators. There is no evidence that this led to a child protection response either.[421]

5.591 Throughout the course of that year, referral notes and contact sheets detail reports of Child G's ongoing sexual activity and risks to her health at what was still a considerably young age. The school also raised concerns about Child G's frequent absence.[422]

5.592 Reports later surface that Child G had undergone a termination, which resulted in a social worker visit. Records suggest that Child G's family did not welcome the attention from Safeguarding, and ultimately no section 47 child protection measures were sought. The matter was, however, reported to the police, although it did not appear to lead to any formal complaint in respect of the sexual intercourse.[423]

419 [redacted] pg 21-25
420 pg 41-48, pg 63, pg 113
421 pg 101
422 pg 60, [redacted] pg 42, [redacted] pg 74
423 pg 54-56

5.593 The Education Authorities became involved at this time: Child G had by this point moved between a number of schools but had failed to attend any of them. At one stage her attendance was so low that there was talk of enforcement action against the family, and imposing an Educational Supervision Order, although it is not clear whether this action was ever actually taken.[424]

5.594 At around this time, Safeguarding records note that Child G was seen outside Telford engaging in sexual activity whilst in a car with multiple older men. The records state that Child G was confronted about this by social workers, in front of her family, at which point she "*curled into a ball, hiding her face*" and refused to talk about what had happened.[425] This still did not elicit a child protection response.

5.595 Evidence seen by the Inquiry shows that concerns were raised anonymously with Safeguarding by more than one person, indicating that Child G had been subjected to 'child prostitution' in Telford, before she was a teenager. It is not clear whether those reports were passed on to the police; however the police were not present at a strategy meeting which followed, and where it was admitted that Safeguarding "*do not have a clear report*" on Child G. The reasons for the police absence are unclear, and it is noted there is no representative on behalf of the school either. Those who were present discuss section 47 proceedings, but the meeting focussed on the absence of 'evidence' of Child G's sexual activity – this is regardless of the material referred to above being on Child G's file. An Education Welfare representative appeared to encourage the attendees at the meeting to look at the "*wider picture… together with the known problems involving young people in the vicinity*" – which I take to mean the emerging knowledge in Telford around 'child prostitution'. It appears that Child G's GP also attempted to make contact with her to provide advice to Child G on how to protect herself (it is assumed, from a sexual health perspective).[426]

5.596 Shortly after this meeting, Child G's name appeared in separate police paperwork relating to concerns about 'child prostitution' and associations with other vulnerable children and known suspects. This information appears to have been shared with Safeguarding.[427]

5.597 The Council made a referral for Child G to be accommodated some distance away, "*due to risks and grave danger it is currently felt she is in*", and it does appear that, at this point, she was quickly moved out of Telford.[428] However, the evidence shows that WMP were not informed about Child G's whereabouts. As with Child A, there is also an apparent lack of information sharing even within Safeguarding between North and South divisions.[429]

5.598 Despite this, Child G continued to be in contact with individuals of concern in Telford – and the authorities were aware of this. This eventually led to Child G absconding from her

[424] [redacted] pg 280, [redacted], pg 75, [redacted] pg 255
[425] pg 58-60
[426] pg 61-62, pg 262-267
[427] pg 43, pg 49-50
[428] pg 74
[429] [redacted] pg 220

accommodation and returning to Telford; despite being under a Care Order, there were insufficient efforts to take her back to her placement.[430]

5.599 As noted earlier in this section, at this time police were already in receipt of intelligence relating to certain suspects, who were also linked to Child G; however records state there was insufficient evidence to confirm that Child G was being 'prostituted' by the perpetrators, and therefore no action could be taken.[431] WMP did interview Child G about the concerns raised, whereupon she confirmed her involvement in 'prostitution' giving details about the 'pimps' and admitting that "*girls get paid £*[X] *a bloke*".[432]

5.600 However, just a few months later, further reports emerged that Child G was once again being prostituted by the same suspects as before, still being considerably under age.[433]

5.601 This situation continued for some months before a core assessment takes place and Safeguarding contact police to ascertain whether there is any proof of Child G being subjected to 'prostitution'. No multi-agency meetings follow, but Safeguarding do appear to have considered a section 50 order for the recovery of abducted children. However, I have seen no evidence that such an order was actually made.[434]

5.602 The concerns around Child G's sexual exploitation continued for another six months, before a senior social worker prepared a Risk Assessment in respect of Child G, which considered that "*CSE is a harm that* [Child G] *is likely to have suffered*".[435] Nevertheless there were considerable gaps in Child G's file and there is no evidence of what happened next in following up on the Risk Assessment, and no Care Plan on file. Child G was allocated a new case manager many months after the Risk Assessment and almost a year after the assessment a manager noted, rather repetitively, "*considerable concern… for* [Child G's] *sexual promiscuity and possible prostitution*".[436]

5.603 The same concerns continued to be repeated in subsequent months, by this time into mid-2000, when Child G went missing and refused to engage with police questioning regarding the 'prostitution'. Reports surfaced that Child G was pregnant as a result of a rape by a much older man. Child G does not engage with the police investigation of USI against that man.[437] Medical practitioners became involved to discuss concerns for Child G and the unborn child, whilst members of the Community Support Team also attended a Strategy Meeting to discuss the concerns around 'prostitution' and risks to the baby. Subsequent child protection meetings focused on Child G's pregnancy, and there is some engagement with Child G's GP practice and a teenage pregnancy support worker.[438] Interestingly, however, there is reference to the services of the teenage pregnancy support worker

430 [redacted] pg 105, [redacted] pg 62
431 [redacted] pg 191-196, pg 220
432 [redacted] pg 205
433 [redacted] pg 62, [redacted] pg 120, pg 123, pg 125
434 [redacted] pg 13, [redacted] pg 122-124
435 [redacted] pg 45
436 [redacted] pg 15
437 [redacted] pg 95-98, [redacted] pg 36-50, pg 52
438 [redacted] pg 17, pg 104

stopping, as soon as Child G is old enough to leave school as "*there is no provision in place for this*".[439]

5.604 The following year, an Initial Child Protection Conference and a strategy meeting take place to consider the risks to Child G, and section 47 proceedings – previously discussed three years before, but never actioned. The meeting minutes note that *"there is a problem in Wellington with older men… engaging in sexual activity with young females",* however *"there would seem to have been placed a code of silence around this and without a complaint, no action can be taken."* The police expressed the view that if Child G were to identify her perpetrator(s), then "*enforcement action*" for USI would be considered. The decision was made that there was no basis for section 47 proceedings, but both Child G and the baby should be entered onto the Child Protection Register. It was noted some months later, that there had not been an up to date Care Plan for Child G for over a year.[440]

5.605 The police continued to investigate Child G's suspected perpetrator, which led to further connections being made with other suspected perpetrators and victims/survivors of CSE in Telford. Meanwhile, video evidence is reported to have been obtained corroborating sexual offences committed against Child G – but because *"the men in the video are Asian,* [those reporting it] *fear repercussions*".[441]

5.606 Despite all of the above, the decision was made to remove Child G from the Child Protection Register - a matter of months after the section 47 proceedings were discussed and following receipt of video evidence confirming Child G's sexual exploitation whilst still under 16.[442] Almost immediately afterwards, Child G was again found in the company of other vulnerable children and males known to the police,[443] although no further action appears to have been taken. The records for Child G go quiet in terms of intervention after late 2001.

5.607 In 2002, an internal inspection within the Council raised concerns about the handling of Child G's case – but it is not clear what internal action was considered or taken as a result.[444]

5.608 Child G is named within other CSE investigations a decade later. Police investigated the historic offences committed against her, and, as with Child A and Child B, whilst Child G confirmed the offences against her, she decided she did not wish to pursue a criminal justice outcome.

439 [redacted] pg 122
440 pg 518-522, pg 243-244, pg 392-397, [redacted] pg 38
441 pg 525, pg 134-138, [redacted] pg 38
442 pg 425-429
443 [redacted]
444 pg 22

Analysis – Child G

Safeguarding

5.609 Safeguarding knew that Child G was vulnerable and was exhibiting inappropriate sexualised behaviour even before she went to secondary school.

5.610 Although Child G's sexual activity was discussed by authorities in multi-agency meetings, no action plans were formulated. The evidence I have seen demonstrates that Safeguarding faced challenges with Child G's family, and the result of this appears to have been that strategy meetings focus on perceived lack of parental control and a desire to separate Child G from the family, rather than upon any action to address underlying issues. For example, although social workers appear to have been aware that Child G was subjected to abuse by a male, there was no follow up or police report once Child G indicated she did not want to pursue it "*for fear of reprisals*".

5.611 The language used in material relating to Child G rarely appears to consider her as a victim, despite her considerably young age. There is talk of 'prostitution' and promiscuity, rather than exploitation and victimhood. Further, there is a stark illustration of an authoritarian approach in challenging Child G in front of her family while she hides her face from them. It is difficult to imagine that professionals could genuinely have thought that would be a useful tactic; it seems guaranteed to alienate the child and breed resentment.

5.612 Child G was a child in and out of care; and at one point she is subjected to a Care Order – a legal obligation is therefore placed upon the Council to remove Child G from the home. Yet she is later allowed to return to a situation known to be harmful to her. The oversight of Child G's case was ineffective and she did not meet the criteria for a 'looked after child'; care planning meetings take place without her; and section 47 proceedings were considered but never implemented.

5.613 Overwhelmingly, there appears to me to have been a sense on the part of Safeguarding that they saw themselves as powerless and resigned to Child G's fate. She was a child who had been pregnant at a very young age and who had been sold for sex; yet it was decided there were no grounds for section 47 intervention, i.e. that there was no reasonable cause to believe that she was suffering or was likely to suffer serious harm. I regard that conclusion as bewildering. Child G's records show almost six years of concern surrounding sexual exploitation.

5.614 I have noted that there was a dispute between Safeguarding areas; it led to the southern area, which was dealing with a case closely linked to that of Child G, failing to attend strategy meetings or engaging with the police.[445] To have allowed silo thinking or turf war to interfere with the proper management of a case of this seriousness was in my view a gross failure. The failure to share information with the police is inexplicable; the failure to share within different safeguarding areas of Telford speaks inevitably either of negligence or of a service unable to perform its basic functions.

[445] [redacted] pg 191

5.615 Furthermore, Safeguarding's failure to update its Action Plan for Child G over 12 months, the gaps in her file and the lack of continuity of management of her case show the same lack of engagement and astonishing gaps in provision as with Child A and Child B; I am driven to the view that Child G's case was simply not given the urgent and close attention it demanded.

Police

5.616 Child G was brought to the attention of WMP when she was assaulted, although she later indicated to Safeguarding that she did not wish to pursue the complaint, for fear of reprisals. At that time there was already significant Safeguarding material which, if it had been shared and properly considered, should have led to grave concern and, it seems to me, further investigation of the underlying causes of Child G's assault and associations.

5.617 That was just the beginning; the police were to have information about underage sexual activity, and they received information which indicated that she was being subjected to 'child prostitution'. That Child G was troubled was quite obvious, but still strategy meetings took place without police presence.[446] While I do not know why officers were unable to attend (the reasons for apologies were not noted), it is difficult to think of a child more in need of an effective multi-agency response; the police failed to give the meeting the priority it deserved.

5.618 As to investigation of offences of which Child G was the victim, the police did take some steps to try to confirm the identity of Child G's perpetrator, apparently to consider USI offences, but this does not appear to have come to fruition. I note that the decision to limit the investigation to USI – as opposed to indecent assault or even rape - before identification and interview – seems to me to have been premature and an indication of the reduced priority Child G's case was given. Throughout, any potential offences revealed appear to have been discounted quickly on the grounds of her apparent consent or lack of co-operation, even when there was – in the case of the video – independent evidence that could potentially have been used, even absent complaint, to found a prosecution.

5.619 Based upon the material disclosed to the Inquiry, so far as missing episodes are concerned the police involvement appears primarily to have been focussed upon returning Child G to her residence, rather than any investigation of the root causes for the missing episodes in the first place.

5.620 It is the view of the Inquiry's Policing Expert that the police failed to use the information they collected about Child G's 'prostitution', including the information given to them by Child G, either to consider disruption tactics or to gather further information about those exploiting her; and in so doing, they failed Child G.

Education

5.621 Child G was exhibiting disturbing signs of exploitation from the time she was in primary school. This should in my view have alerted Education Services to Child G's obvious

[446] [redacted] pg 262

vulnerabilities and the need to keep a close eye on her; and yet, as with the other children I have considered in this section, Child G's ongoing relationship with school was notably and obviously poor. I have seen no evidence of any Educational Services response to her poor attendance beyond talk of enforcement orders; and rather than seeking to monitor her, Child G was instead excluded.

5.622 While it is clear that Child G had critically low attendance at school the response appears to have been to focus on the family; it is not clear what actual efforts were made to persuade Child G to attend school or what alternative provision, if any, was made for her education. It seems to me the proper emphasis should have been on ensuring that some form of support was offered, and it is not clear there was any.

5.623 I have noted that strategy meetings took place in the absence of education representatives. I conclude in respect of education as I did in respect of the police - that there could not have been a case in which it was more urgent that all agencies be represented to share information and discuss the appropriate response. I have seen strategy meeting minutes which do not show education representatives even as expected attendees: I do not know if this evidences a washing of the hands by Education in respect of a child who it was felt had abandoned school, or if they were simply not invited; whichever was the case it is wholly inadequate.

5.624 The overwhelming impression from the papers in Child G's case is that wider problems with Child G's family led the Education Authorities to writing her off, from an educational point of view.

Health Services

5.625 There are serious concerns regarding both Child G's access to health services, and the actions taken by those services in response to the risks and patterns exhibited by Child G's behaviour at an early age. There was an early reference to psychiatry services but no indication of continued engagement or involvement.

5.626 There is a general lack of information on record regarding Child G's access to or engagement with a GP, nor any support and advice given regarding contraception and sexual health; there is no detail within the documents regarding references to her pregnancy, nor is there any clarification regarding what Child G received in terms of any maternity support. Whilst there is some reference within the paperwork to seeking engagement of Child G's GP, this never appears to amount to anything substantive by way of support. This is concerning given the amount of information within Child G's Safeguarding records which clearly evidences her exposure to regular sexual exploitation at a very young age.

5.627 Further there is no evidence that any information was shared with Safeguarding by the GP practice that apparently arranged the termination of Child G's pregnancy. Given that she was not yet a teenager at the time, I consider this remarkable.

Overall conclusions – Child G

5.628 Child G was a very vulnerable child, known as such to Safeguarding and Education before she reached secondary school. There is obvious history surrounding Child G and her family, and the approach of every authority suggests this led to exasperation rather than concern: for example, the account of social workers questioning Child G in front of her family until her embarrassment and shame was palpable is extremely distasteful, as was the response of Education Services to Child G's lack of attendance at school by seeking enforcement action. In my view each service should have tried harder to understand and assist, not simply to criticise and punish.

5.629 That Child G's multi-agency meetings took place in the absence of representation by crucial agencies is a shocking indictment of the system. That Safeguarding's representation within those meetings was inadequate because of a dispute between geographical areas within Telford defies belief, and shows that the essential focus of the child had been lost.

5.630 There is an inescapable conclusion in the professional responses here that Child G was simply regarded as an impossible child from a difficult family; and that active intervention would yield no result, so was not pursued. Instead, responses and meetings have become a box-ticking exercise designed to satisfy process rather than to improve real outcomes.

5.631 The paperwork shows that Child G came to the attention of police again, many years later, whereupon the historic allegations and intelligence were considered – however Child G maintained that she would not support a criminal complaint; a choice that I can entirely understand, given her appalling treatment in the past.

Conclusions – Case Studies

5.632 As noted in Chapter 3: The Council Response to CSE in Telford, the Inquiry's Social Work Expert, Jane Wiffin, has considered these case studies and has suggested that taken together they justify the following overarching conclusions, which, although they relate primarily to the Council rather than to the police response, I consider sit usefully here, proximate to the factual backgrounds; the first two points also apply with equal force to WMP:

5.632.1 Looking at common themes from the three cases, it is clear that in each case, even though under the age of consent, the language used in documents demonstrates that these children were being treated as though they had full agency and there was a general opinion that they were acting out of personal choice.

5.632.2 There is a repeated element of victim blaming, with the children considered at risk by virtue of their own actions. There is a failure to see what is happening as exploitation rather than consensual, and little intervention or attempts are made to prevent the behaviour.

5.632.3 Support provided by social care was erratic in each case. One child was removed from the Child Protection Register by her new social worker after less than a

month of improved behaviour with no missing episodes. Once the missing episodes recommenced and the police became involved once more, there were apparent resourcing issues in social care which meant there was no support forthcoming, even after disclosures and admissions were then made by the child. Subsequent support was thwarted because of social workers failing to attend meetings or not liaising appropriately, and when further rapes were reported by the child, the social worker did not attend the interview. The child was without a social worker for a number of months.

5.632.4 There were clear incidences of significant harm across all of the children's timelines and a number of incidents which should have led to child protection action, but these were simply not responded to.

5.632.5 The reaction by social care in each case appears to have been reactive only, for example returning a child to her accommodation as opposed to seeking to understand the reason for going missing, or 'acting out' (as it was often perceived) in the first place.

5.632.6 Despite the Council's duty to act as corporate parents, there is evidence that the children were to a great extent abandoned by the Council.

5.632.7 There was a complete failure of the looked after children's system in respect of all three children. To provide one example, there appears to have been no Care Plans put in place for one child, despite the existence of a Care Order. There is no evidence that the child's circumstances were reviewed every six months, overseen by a senior manager, as required by the looked after children's system.

5.632.8 This is mirrored in a lack of formal representation at meetings and in record keeping, meaning that files and data are missing regarding Safeguarding's involvement; routine paperwork was not filled in; assessments and action plans were not completed or did not exist; and care planning was sparse.

5.632.9 There is evidence of continual drift and delay.

5.633 I take the view that all of these conclusions are well-founded and I adopt them.

5.634 Insofar as WMP is concerned, I have noted that in each case there are also features that repeat, and which should have acted as red flags to the police:

5.634.1 All of the children persistently went missing and were found often in locations of obvious concern for a child their age; yet on the records disclosed to the Inquiry (which I recognise may not be complete) it appears that no further enquiries were made to understand either the reasons for their absconding, or for why they were frequenting the same locations where they were found.

5.634.2 WMP officers were often involved when the children were 'picked up' after getting into trouble, or following substance abuse, yet insufficient efforts appear

to be made to refer them to Safeguarding or share information which might help understand the reasons behind the behaviour of the children.

5.634.3 In every case, disclosures are made at some point indicating serious sexual offences, whether of USI or rape. Whilst those disclosures may have been later retracted, in a number of instances there was nevertheless sufficient evidence for the police to consider further investigation of the fact that these children were being coerced, controlled and exploited by men many years their senior. Yet no such action was taken – even when it was being flagged by individual officers. This, as I have said, is a serious failing.

5.635 It is my view, and that of the Inquiry's Police Expert, that WMP had the opportunity in all of these cases to enquire further and ascertain the causes of these children's behaviour, which should have been considered unusual given their age, and should have led to multi-agency engagement; and equally to have sought more evidence to support the obvious indications of underage sexual intercourse and exploitation offences against three children who were all, in my assessment, obviously extremely vulnerable.

2000 to 2006

5.636 The above cases represent stark examples of how three cases of CSE were dealt with by the authorities in the late 1990s, into the early 2000s. Around this same time, two other high profile cases are dealt with by WMP, which have been widely reported on and have revealed links with CSE in Telford: first, the murder of Lucy Lowe and her mother and sister in an arson attack on the family home in August 2000; and secondly, the death of Rebecca (Becky) Watson in a road traffic accident in March 2002. I have chosen to deal with both Lucy and Becky as specific case studies within this Inquiry, and their stories and experiences – and how they were handled by the authorities – are dealt with separately in Chapter 8: Case Studies.

5.637 It is clear on any assessment of the timeline, however, that at the time of both Lucy and Becky's deaths, there was knowledge within WMP of 'child prostitution' and exploitation of children of a similar age by a number of Asian men. As noted from the cases above and the earlier section of this chapter dealing with multi-agency working, meetings on sexual exploitation began to take place between WMP and Safeguarding between 2000 and 2003, where the issue of 'child prostitution'/sexual exploitation was discussed in relation to specific children, and with concerns being raised by one school in particular.

5.638 Despite this, there appears to be an identifiable gap in information in the years that followed, 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', and in light of the initial multi-agency meetings that took place in the early 2000s.

5.639 Given that the national understanding around CSE was also growing at this stage, and given 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.

Conclusions – Early Intelligence Regarding CSE

5.640 As I have set out, the earliest intelligence report that I have seen revealing 'child prostitution' in Wellington is dated February 1997; and between that time and September 1999 there were a total of 28 such intelligence reports submitted by 18 officers at ranks from Police Constable to Detective Chief Inspector. The only evidence of proactive action in that time is of surveillance of a property in July 1999.

5.641 This alone shows two things – first, that there was an obvious problem of CSE in Wellington at the time, commonly known among police officers and police civilian employees; and secondly, that the intelligence system was working as intended, at least to the extent of harvesting these reports.

5.642 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.

5.643 In my view, taking into account the evidence I have heard about dissemination of intelligence reports and about the size of the police station at Wellington itself, it defies belief that senior officers within Wellington and within Telford as a whole would not have been aware of these reports.

5.644 The inevitable conclusion from those two findings is that a culture had developed 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.

5.645 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.

5.646 It is clear to me that there were officers in 1999 who were unprepared to accept the culture of turning a blind eye to CSE. I have in mind the Sergeant who commissioned the September 1999 Report and the Police Constable who compiled it, not least because it was likely his original surveillance that drew the Sergeant's eye to the problem. As I have noted, that report was unfortunately marked *"This is now filed no action".* I have not heard evidence as to why that was so; but I am not able to conclude that the September 1999 Report was actively suppressed. Indeed, although marked 'no action' it was passed to the

officer who completed the October 1999 Report, a much more comprehensive document. It seems to me that the September 1999 Report was simply superseded by what came next.

5.647 The October 1999 Report, commissioned by then-Detective Sergeant in the FPU, was comprehensive. It named victims, perpetrators, and locations of concern. It was founded factually on 28 intelligence reports. It set out a process for disruption and prosecution, included an early victim strategy, and concluded with the author volunteering to pursue the investigation. It is marked as passed to a Detective Inspector in CID; that officer had no recollection of it, though he would have expected to, given the content. The Inquiry heard that he had been abstracted to a major enquiry at the time.

5.648 He was not the only officer who struggled with his memory of these events. It was to prove a common theme among those who spoke to the Inquiry from this time.

5.649 I do not need to determine whether that officer has helped the Inquiry to the best of his recollection, because regardless of whether he saw the October 1999 Report at the time, it is inconceivable that someone of like or greater rank would not have seen it; and, as the officer himself said, once seen:

"… you wouldn't just say 'yeh, that's interesting' and do nothing about it … it seems to me the obvious thing we would have done was to set up some form of operation."[447]

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

5.650.1 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

5.650.2 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.

5.651 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.

5.652 I recognise, of course, that CSE offences are difficult to investigate and difficult to prosecute. Victims/survivors are very often reluctant to engage with the police. This is illustrated by the 2003 Report and by the case studies, however those case studies also show that in each case there was a failure to follow up, ask further questions or make any real attempt to investigate – even when, in respect of Child G, there was solid evidence

[447] [redacted] pg 36

which might have founded a prosecution of the perpetrators. In parallel, and as I have stated above, the case studies show a lack of awareness on the part of the police of missing episodes and criminal behaviour as an indication of exploitation.

5.653 It is my view that this material, taken as a whole, illustrates that notwithstanding the obvious urgent concerns of individual officers through the ranks, WMP as an organisation simply did not give these cases the sufficient attention and priority they deserved.

5.654 I have set out my findings as to WMP's approach to the early evidence of CSE but it is necessary to point out the consequences of that approach. While it chose not to investigate multiple detailed and apparently credible reports of children being exploited, those children continued to be exploited; and a new generation of children was exploited, as Chalice was to show, over a decade by at least some of the same men and even in the same place - Premises A.

5.655 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 judgement at the time - there would have been successful prosecutions in the late 1990s. It is 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.

5.656 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

Introduction

5.657 Chalice was WMP's first major investigation into CSE in Telford. It commenced in early 2008, and concluded in 2012. Given the length of time the investigation ran, the chronology of events can be difficult to follow, and I have therefore added the key dates and events into the following table for reference:

Date	Key event
Late 2007	First incident arising relating to two children.
Early 2008 – May 2009	Intelligence gathering phase of the investigation commenced. A small team of SOIT officers began to investigate incidents of CSE, parttime, in addition to their existing SOIT caseload.
May 2009	Full investigation commenced. First SIO, deputy SIO and OIC (Officer in the Case) appointed.
June 2009	Gold Group status requested for Chalice, but refused.
31 July 2009	Further officers from SOIT joined the investigation team part-time.
September 2009	Second SIO appointed. First SIO became second Deputy SIO.
8 December 2009	Phase 1 arrests.
9 March 2010	Phase 2 arrests.
15 April 2010	Gold Group status awarded in around December 2009 and a Gold Group meeting took place on 15 April 2010.
29 June 2010	Phase 3 arrests.
17 September 2010	Third SIO appointed.
As at 10 January 2011	The Deputy SIO had been replaced by the former OIC.
16 May 2011	The first Chalice trial commenced.
5 September 2011	The trial judge discharged the jury in the first Chalice trial.
December 2011	The trial of one Phase 3 arrestee concluded. The Defendant was convicted of rape offences and sentenced in December 2011.
Summer 2012	The trial of two Phase 1 defendants took place and resulted in the conviction of both men. Afterwards 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 convicted between 2011 and 2012.

Chalice – the Beginning

5.658 Chalice was WMP's first major investigation into CSE in Telford. It led to indictments and pleaded offences taking place from 2008 onwards.[448] It is plain from the evidence given to the Inquiry, including that which was uncovered by Chalice, that the problem now known as CSE was long standing in Telford. I deal elsewhere in this report (Chapter 2: Nature, Patterns and Prevalence of CSE in Telford) with the question of the scale and duration of CSE historically in Telford, and the evidence this Inquiry has heard about the current position in relation to its prevalence within the town. This section is intended to look at Chalice as the "*earliest co-ordinated operation*"[449] conducted by WMP, which sought to uncover and address CSE offences known to have taken place.

5.659 WMP explained to the Inquiry that Chalice "*had initially commenced in early 2008 in response to incidents occurring in 2007*"[450], which led to WMP "*working closely with the recently formed Telford Local Authority CATE Team.*" [451] As a result of intelligence gathered by WMP and by working together with the CATE Team, the full-scale investigation known as Chalice was eventually established in September 2009.

Acknowledging the Problem

5.660 The Inquiry was told that the trigger which prompted the beginning of Chalice was an episode involving two children in late 2007 (hereafter referred to as the 'Two Mispers'). The Two Mispers went missing for a number of days and were eventually found in vulnerable circumstances in another town, many hours away from Telford. They were suspected of having been abused by a number of men, and initially co-operated with the police investigation, providing information to the police which confirmed those suspicions. However, as the investigation proceeded, both children withdrew their support for any further enforcement action and the CPS declined to prosecute citing "*insufficient evidence to provide a realistic prospect of conviction*".[452]

5.661 A Detective involved in the Two Mispers enquiry was, at the same time, also involved in another case involving a 13 year old child who had been videoed whilst being subjected to sexual activity with two different men. The men concerned were identified and charged, but acquitted at trial; a decision which an officer in the case commented as one they "*will never understand, ever*".[453]

5.662 Also at the time of the Two Mispers enquiry, concerns were becoming more widespread amongst officers. In October 2007 an intelligence report addressed to the FPU stated:

"It has been noticed by the reporting uniform officer that there is an alarming number of teenage females being reported missing to police who share friends. This despite the females not coming from the same area. When being looked for, and contacted by

448 [redacted] pg 193
449 pg 193
450 , pg 101
451 pg 6
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453

telephone, the females will often repeat a story of being held in houses. Or of being in a building some place, usually London or Birmingham, from which they are unable to leave. These are almost scripted. There is a common thread to their stories once found, usually involving being taken by males to the West Midlands and sexually abused. These stories never seem to lead to investigation". [454]

5.663 Other reports that typified the sort of exploitation incidents, which, since the Two Mispers enquiry, were[455] being scrutinised, included an intelligence report[456] also from October 2007, which noted that:

"It is … believed that [a child] *and other girls are visited by Asian males at the address and taken from the address by the males to other location unknown, it is believed that* [two named children] *and other girls are now pimped out to a prostitution ring covering a large area of England".*

5.664 The Inquiry has also seen a number of further intelligence reports logged throughout the next 12 months, describing similar incidents taking place to the above.[457]

5.665 An FPU Detective reflected on the Two Mispers case and that involving the 13 year old mentioned above, commenting that:

"I'd become so frustrated with the fact that the victims or the people who were believed to be victims were not engaging with ourselves and Children's Services. I felt that the girls [and] *their parents needed support from us. And from an evidential point of view in terms of trying to build evidence up, we needed to have that relationship wider than just what essentially we'd been doing up to that time which is ourselves or Children's Services approaching victims, asking them to provide evidence and for reasons that are now much better understood, those victims declining, and essentially the investigation and any prosecution not being able to just get past that point."*[458]

5.666 This Detective explained that these reflections *"demonstrated the difficulty of trying to achieve success: if success is defined by prosecution"*[459] and that this caused them to rethink the approach that the FPU/CID should take to such cases.

5.667 Previously, as explained to me and as noted earlier in this chapter, the system had been such that Safeguarding would contact the FPU with a referral and a decision would be made as to whether the case merited single or joint agency investigation. If it was a case for joint investigation, a Detective Constable would be allocated to work with an opposite number in Safeguarding. Joint visits would be carried out, and information shared between the departments– but this almost did not appear to be considered 'police work', in the sense that I was told that a lot of this joint working activity "*was very much kept in-house; it didn't find its way onto police systems*".[460] This meant, in my assessment and based on

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the evidence I have seen, that information about child sexual offences was being acknowledged and collated, but was not being fed through the required channels within WMP in order to prompt police action. This reflects what I found in my review of the early evidence of child exploitation, as set out in the previous section.

5.668 For example, a police officer told the Inquiry 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*".[461] I have also seen an email from 2006, headed 'Grooming of white girls by the Asian Community', showing that at that time concerns were being raised with Safeguarding by a local school in Telford; and this was reported to an officer in FPU by Safeguarding.[462]

5.669 It has been suggested to me by numerous witnesses that the concerns may not have been acted upon due to the fact that the allegations had a racial element to them. The Inquiry was told:

"*… it was unpopular work to investigate some of the Asian men and criminals in Telford; I don't think it was specific to CSE, if there were two investigations on the table and one* [involved the Asian community] *and one was something else, the majority of people in the police station would have picked the something else; it comes with problems, it comes with grief, it comes with difficulties*".[463]

5.670 Prior to 2007, as explained earlier, the position was also that FPU would not investigate non-familial sexual offending (which at that stage would be dealt with by reactive CID). In 2007, the approach changed, and the change was two-fold. First, the decision was made that the FPU would (at least initially) retain CSE work referred to the FPU – on the basis that the FPU had an existing co-working relationship with the Safeguarding department which involved daily interaction, and it therefore made sense that this should stay with the FPU. Officers from the FPU also indicated that they did not always feel confident that detectives in reactive CID would have the required knowledge and experience to deal with the particularities of CSE cases. Secondly, a system was introduced whereby officers attached a log number to each enquiry, so that all relevant information could be captured, recorded and traced on WMP's systems – which as noted above had not been happening previously.[464]

5.671 The next step towards Chalice being initiated came when, having seen the cases coming through and reflecting upon the working practices of FPU, a senior officer approached a Sergeant in reactive CID, telling him: "*I think we've got a problem with child sexual exploitation*".[465] A small team was then formed to investigate these concerns.

5.672 I understand there was some initial reluctance on the part of certain officers to become involved; an officer told the Inquiry they refused to be part of the team at first, as had others, on the basis that they felt "*because of the Asian element, you know, we're going*

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to be onto a loser". Their experience was that there was, at that time, "*a culture of bending over backwards to ensure that we weren't seen as racist*".[466]

5.673 An intelligence gathering operation was then set up using the newly-formed team. It was felt that a formal operational name was required in order to ensure that a proper, coordinated investigation could be conducted. The operational name ultimately settled upon was Chalice.

The Intelligence Gathering Phase

5.674 The Inquiry was told that, for the duration of 2008 and into 2009, this team worked to coordinate the gathering of intelligence, much of which initially focussed on the Two Mispers who had gone missing in late 2007. At that stage, three members of the SOIT were engaged in the gathering of CSE intelligence. The SOIT officers also began interacting with the recently-created CATE Team; this was the first time the multi-agency engagement had stepped outside the usual FPU-Safeguarding gateway.

5.675 It was explained to me that the evidence gathering included working with the Two Mispers and their families to try and build up trust. Each young person was allocated a SOIT officer as their Specially Trained Officer ("STO"), and a CATE worker, who would visit the children and try to get them to open up about what had been – and still was – happening to them. Initially the children refused to engage and seemed reticent to speak openly in front of anyone from Safeguarding (which they saw as including the CATE workers) – which officers reflected was out of a fear of their families being scrutinised. However, both the CATE and STO teams felt strongly that they needed to continue working together as both children were still regularly going missing at this stage.

5.676 There was no formal way of working between CATE and the STOs at this point; it was clear from the evidence given to me that officers were trying to come up with any strategies that would encourage disclosures from the children, which the police could then act upon. This included officers working with parents to seize items of clothing after the children had gone missing, in order to try and obtain DNA evidence; an imaginative approach which was defeated by perpetrators later, obviously having been told what was happening, insisting victims wash underwear before returning home.[467]

5.677 I have seen evidence that the Two Mispers presented as very quiet and guarded initially, but that over time they began to open up to their STOs, when they felt comfortable that they could "*share information in a manner that was led by them*".[468] Officers felt this was an inevitable consequence of the control being exercised over them by the perpetrators. The STOs would record any information given to them by the children in a Family Liaison log, and any intelligence gathered was formally logged on NIRs and submitted for review and grading by the intelligence unit. The information was also logged against the child's own personal nominal (or 'GENIE') record on WMP's systems, so that response - i.e.

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uniformed - officers had access to this, should the children be found in vulnerable circumstances.

5.678 As the Two Mispers 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 their friends and associates. As a result, the police investigation grew, with each STO taking on more victims/survivors to work with, commencing the same process of trying to build trust and encourage disclosures, whilst at the same time continuing to work with the CATE Team to try and assess and manage the safeguarding risks to each child.

5.679 As mentioned above, initially the two STOs and other members of the team were managing these investigations alongside their existing SOIT workload, which included a heavy caseload of rapes and other serious sexual offences (both child and adult). It was clear that the volume of CSE related enquiries was now growing, and demanded further resourcing. As one officer put it to me:

"… 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".[469]

5.680 I have seen evidence that in fact concerns about the scale of the growing issue of CSE in Telford were discussed earlier, at Senior Officer Coordination Meetings between the Council and WMP in late 2007[470], following the case of the Two Mispers. Further evidence leads me to believe that these concerns were also taken to senior officers throughout the course of 2008, as the intelligence gathering exercise was ongoing, with a view to transforming the operation into a prosecution-focused investigation, assisted by targeted operational support. Such concerns were considered and discussed by senior officers in tandem with a report that had been commissioned and produced separately, entitled '*Young and Vulnerable People who may be subject to Sexual Exploitation*'[471](the "YVPSE Report"). It represented an important turning point in the establishment of Chalice.

The "YVPSE Report" - 2008

5.681 The YVPSE Report[472] was commissioned by a Detective Chief Inspector in late 2007 to "*look at the problem of sexual exploitation of young and vulnerable people in the Telford area, particularly instances that relate to young females who frequently are reported as missing…* [and who] *are subject to sexual exploitation and are being groomed for or lured into prostitution*".

5.682 The Inquiry was told that the YVPSE Report's author, a Detective Constable, was given a "*loose brief*". One of the first steps they were asked to take, was to meet with an individual from the Telford community, who wanted to speak to WMP about "*a problem with Asian men taking girls away for sex*" – but the individual would not give names, or provide a formal statement. The author was given access to the Council's Safeguarding premises at

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The Mount in Wellington, where they were given a "*big pile*" of Safeguarding paperwork to go through, and this revealed the following:

"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".[473]

5.683 Those Safeguarding files were both paper and computer based, and related to contemporaneous notes made by Safeguarding staff in relation a number of children, some of whom were also the subject of WMP intelligence profiles. It was considered that the files provided "*a valuable source of evidence*" [474] and required a more detailed examination.

5.684 The YVPSE Report summarised the position as follows:

"The problem highlighted itself in Telford due to the frequency that certain young females were being reported missing and the fact that they were identified as leaving the locality and were being found in Wolverhampton, Birmingham and in some cases… Yorkshire. It was clear that they did not have the means or know how to get to these areas and were being assisted to do so. They were seen in the company of young Asian males and it became apparent that they were exhibiting sexualised behaviour both at home and at school".[475]

5.685 The YVPSE Report commented upon the failed prosecutions in relation to the Two Mispers and the 13-year old child, and 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*".[476]

5.686 The approach recommended in the YVPSE Report essentially mirrored that which was adopted by the investigating team – i.e. that STOs should team up with CATE workers 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 young person so that they felt comfortable and confident to open up.

5.687 The YVPSE Report also noted that whilst prosecution of offenders should always be the aim, it may not always be the final outcome, and the welfare of the child should always be paramount. Equally, it considered that:

"This particular type of offending determines that disruption of the abusers activity or acknowledgement by the offender of robust investigation by the police that places them under close scrutiny can be considered a success."

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5.688 This approach seems particularly sensible to me where a prosecution may be stymied by the lack of a complainant. Indeed, I have noted that one of the failings in WMP's dealings with early intelligence was that no disruption seems to have been considered in reply to intelligence reports.

5.689 The YVPSE Report further noted that:

"In relation to [a Telford] *school I have obtained copy of files in relation to the females that attended this school. These form original notes and the point of contact* […] *is a valuable source of information who will robustly collate the information that comes within her domain. Copies of these files are attached. Similarly as with the Social Services notes these can be converted into statement form.*

The third source of information is the missing person logs that are compiled on the COMPACT (force Intranet) system.

Finally all intelligence logs relating to individual victims contain a wealth of information."

5.690 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."

5.691 All these concerns, couched as possibilities, did of course materialise in the following years. 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.

5.692 It is worthy of note that the author of the YVPSE Report was, again, an officer of constable rank addressing the CSE problem – just as it was relatively low-ranking officers who developed the Chalice response and ground-level youth workers who, in the Council sphere, developed the CATE process. I would have expected institutional responses to an obvious problem of this seriousness.

Senior Officer Decision-Making

5.693 On 18 January 2008 the YVPSE Report was forwarded by its commissioning Detective Chief Inspector to the Divisional Commander (Chief Superintendent) at Telford at the time, with the following covering note:

"I do not intend to discuss the investigative options at any great detail at this stage. However it is in my view appropriate for a team of officers to be dedicated to the investigation with access to a full range of investigative options i.e. Reactive investigation/covert and witness support (together with support from partner agencies)… our partners and in particular Telford and Wrekin Child Services have met in this respect

on a confidential basis and are fully aware of the research being carried out. It is in my view essential that the way forward is discussed as a matter of urgency and investigative direction and resources are identified."[477]

5.694 This is the first suggestion that Chalice might move to a full investigation rather than simply remain an intelligence gathering operation. However, although senior officers on division attempted to engage HQ CID, the response was cautious. At the end of January 2008 the YVPSE Report was forwarded to other senior officers with the message:

"At a Command level we are very concerned about this exploitation and I wanted you to see the report so that you could have a view on how we should proceed; [the YVPSE report] *outlines a number of options for developing a "success" and that is everything from prosecution to "warning people off". He is realistic and I concur with his views but before we embark on any course of investigation, I want to consider the full range of West Mercia resources, particularly HQ CID to see if there are opportunities to enhance our prosecution option.*

You will get a flavour of what is going on from [the] *report but I think we need a further discussion with you to "flesh out" the information and intelligence and to seek your views on the right way forward…".*[478]

5.695 After six months, the Chalice team emailed the Telford Division as a whole to push awareness of the Chalice intelligence gathering exercise, and to raise with senior officers the fact that SOIT officers were managing the increasing caseload part-time (in addition to their usual caseload) – and indicating that the investigation needed more resource:

"At this early stage, officers have not been written off to this enquiry and the investigations are being conducted by officers from the various divisional CID departments."[479]

5.696 I heard evidence that officers were, throughout this time, also taking their individual concerns to senior officers, seeking support for a 'full-blown' investigation and additional staff to manage it. I have seen paperwork which shows that the CATE Team and the SOIT officers were continuing to work with families which was generating more disclosures, and more evidence upon which WMP could build an investigation. One officer described that:

"*… there had previously been intelligence reports but the snowballing effect was establishing an evidential base for the problem: specific information about who the offenders were"* and it was following this that "*conversations started to happen between Telford as a police division and West Mercia's headquarters."*[480]

5.697 However, it appears that the cautionary approach adopted by senior officers prevailed for some time even after the YVPSE Report, and well into 2009. I was made aware of attempts by officers to obtain the support of surveillance teams via the SOCU, in order to track individuals of concern, in order to "*find out where they're going and who they're*

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meeting".[481] However requests for such surveillance support in Telford were rejected by SOCU, I understand, for two stated reasons: first, as WMP priorities at this time were around other criminal enterprises such as robbery and car theft, and therefore the "*criteria*" for SOCU support "*were focused in different directions*"; and secondly, on the basis that there were concerns for the potential liability of WMP, if it was seen to be "*condoning the offence*" by following individuals and "*allowing*" offences to take place during the observations.[482]

5.698 This was clearly a source of great frustration to the Chalice officers at that time, who felt that evidence was essentially there for the taking, but that support was needed to obtain it, and senior officers within the intelligence unit and SOCU "*just didn't get it".*[483]

5.699 Other officers also individually recalled to me that, as the evidence in Chalice continued to mount, they became increasingly concerned. In the words of one officer:

> "*During the intelligence gathering I can remember* [X] *coming to me one day and said, "I'm not sleeping at night." I said, "You and me both."* [X] *said "If* [this child] *is found dead in a ditch, the only people who are going to take the fall for this are you and me". So I had been nagging the bosses over it. I was trying to get it off the ground; I would go to DCIs, Divisional Commanders, and I would say we've got this problem and we need to do something more than being sat here with a team of five, six or so, trying to do something while at the same time investigating your rapes, your stabbings, your frauds."*[484]

The Investigation Phase

The First SIO

5.700 An experienced Detective Chief Inspector was appointed to Telford CID in May 2009.

5.701 The Inquiry heard that after approximately one week into his role, the Detective Chief Inspector was approached by two officers with a box labelled 'Operation Chalice' which contained *"a number of allegations of rapes of young girls in the area … Many of the allegations related to young females who had gone missing on a regular basis or had made allegations which had subsequently been retracted."*[485]

5.702 The information in the box related to that which had been gathered by the STOs and CATE workers, as set out above, during the Chalice intelligence gathering investigation. The Inquiry heard that it "*identified the growing problem and its hidden nature*". Within the box, I understand, 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 was then briefed on the work that had been done as part of the intelligence gathering phase of Chalice – including the difficulties perceived by professionals with sharing information in fear of breaching data protection

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and confidentiality laws, and that officers had been struggling to "*get someone to take on the investigation.*"[486]

5.703 I heard that a decision was made at senior level to direct the operation towards the goal of prosecution, rather than simply intelligence gathering. It was to retain the name Chalice. From documentation made available to the Inquiry, it appears this decision was taken in around May/June 2009 – some 15 months after the submission of the YVPSE Report.

5.704 The perception was, I heard, that action had not been taken previously due to the lack of official complaints, and because, "*at the time policing was risk averse".*[487] I explore elsewhere in this Report my findings in relation to why policing within the West Mercia region had been risk averse, and the impact this had (see Chapter 9: Attitude and Impact).

5.705 I heard that at the beginning of a police operation, a SIO would be appointed to lead the investigation. They would begin a SIO logbook to record policy decisions made throughout the operation. The Inquiry has seen the Chalice SIO logbooks. Initial discussions at the time the formal investigative phase of Chalice was commenced, focused around resourcing of the investigation team – given the growing nature of the evidence being gathered – and whether or not the operation should be coordinated via a 'Gold Group'.

5.706 A Gold Group is, as I understand it, designed to ensure effectiveness of a police response by bringing together appropriately skilled internal or external stakeholders; to ensure appropriate provision of force or national resources; and to provide senior oversight and scrutiny of decisions. I have seen evidence that Gold Group status for Chalice was initially requested in June 2009, because Chalice would focus on "*vulnerable persons and members of a minority ethnic community* [and] *there* [was] *potential to generate a high profile in the media at the prosecution stage".* Senior officers also considered that "*the effectiveness of* [WMP's] *response will have a significant impact upon the confidence of the victims, families and community".*[488]

5.707 The request for Gold Group status was rejected. It is in my view difficult to understand the objection to awarding this status as anything other than further evidence, along with the initial response to the YVPSE Report, of underestimation of the seriousness of the problem.

5.708 It was further recommended that covert resources and tactics should be considered, because of concerns that traditional 'overt' disruption tactics would simply drive the offending underground. The suggestion was, according to the SIO decision log, rebuffed and overt disruption was favoured over covert surveillance on the basis that the vulnerable children at risk "*do not perceive they are victims*".[489] It is not clear to me how victim perception affects tactics; and having reviewed and considered the material that had been collated and disclosed to senior officers by the SOIT and CATE Team at this stage, it is clear that for whatever reason covert tactics were not authorised by HQ at this stage, despite the clear communications being sent from senior officers at a Divisional Level. It is difficult to see the insistence on using tactics of the past as anything other than, again, a

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lack of understanding of the seriousness of the problem and a denial of the recent intelligence gathering.

5.709 Telford's Detective Chief Inspector was then appointed as the SIO (the "First SIO") for Chalice, with the Detective Inspector and the Detective Sergeant from the intelligence gathering phase of Chalice acting as Deputy SIO and Officer in the Case ("OIC"). The remaining members of the management team for Chalice were a Divisional intelligence Inspector and an officer serving as a UK Human Trafficking Centre ("UKHTC") advisor. The objectives of the investigation were stated as follows:

- *"Rescue the victims of these criminals through multi-agency intervention and police investigation;*
- *Secure and preserve evidence leading to identification arrest and prosecution of offenders; and*
- *Put in place processes to ensure that this criminality is stamped out in Telford and victims are reintegrated with care back into the community."*[490]

5.710 The First SIO's initial policy decisions show that it was acknowledged that the investigation would involve challenging decisions, but that the investigative team remained of the view that overt methods such as issuing harbouring notices and seeking sexual offences prevention orders would not tackle the root of the problem. However, it was appreciated that by following a covert investigation route, this also risked allowing the activity to continue whilst sufficient evidence was gathered to support a prosecution. The decision was made that approaches would be decided on a case-by-case basis, with risk assessments carried out in relation to each child considered to be at risk, and a "*short list of nominals*" in respect of each young person would be decided upon. I understand a 'nominal' to be a person in respect of whom the police hold a record of any description.

5.711 Insofar as further intelligence gathering was concerned, the decision was taken to focus on those perpetrators 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:

"A shortlist of nominals will be decided upon; the investigation has to be focussed. There will be major and minor players in any criminal enterprise. I intend to focus intelligence gathering on those nominals who are central to the criminality".[491]

5.712 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/survivors:

"*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'*

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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".[492]

5.713 At this stage, based on a report prepared by a WMP analyst in May 2009, the First SIO noted that a total of 21 individuals were suspected of "*involvement in the sexual exploitation of young females*" and that, at that time, there was a list of 34 females who were considered to have been subjected to such exploitation. The decision was subsequently taken to focus on two main suspects. Links had been established between these two main suspects and a number of victims/survivors, and there was initial evidence that these suspects were involved in the facilitation of prostitution of the children.[493]

5.714 Another policy decision taken at this stage was that, because the name Chalice had now become well-known in Telford policing circles, a secondary operation would be established for any covert operational tactics, with a different operational name. This was considered necessary in order to protect the integrity of evidence and in light of Telford having "*experienced operational security issues in the past".*[494]

5.715 Such 'operational security issues' had been raised in the YVPSE Report, which suggested a general difficulty in keeping investigations confidential within WMP. Additionally, the Inquiry heard evidence from one officer:

"I'm absolutely convinced that some of the major players in Telford had officers who would let them know if the spotlight was shining on them at a given time. There's certainly investigations that we were involved with that we tried to keep as close as possible… let fewer officers know what was going on than… was necessary. We were scared that internally the information was getting out, and I think that was a very real risk. The bottom line with that is that I'm aware that certain members of the Asian community were speaking to police officers and as I say we were aware that information was leaking out of the police station towards them".[495]

5.716 Had this concern about information security been mentioned once, I should have found it difficult to come to a firm conclusion about whether it was a real one. The fact of its repetition, though, and inclusion in contemporaneous documents, leads me to accept that there were real concerns about the ability to keep sensitive operational information sufficiently secure. I have seen no material elaborating upon the "*operational security issues in the past*" and no evidence that any action was taken in respect of these concerns save the decision to keep information tightly held.

5.717 I have seen evidence confirming that covert tactics were adopted in Chalice, and that these were successful in providing WMP with further evidence on which to base their ongoing intelligence and evidence gathering.

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5.718 Insofar as resource for Chalice was concerned, at a meeting on 31 July 2009 with a WMP headquarters-based Superintendent, it was recognised that Chalice required a full time team but the SIO was told this was not possible because "*ward resources are stretched*". Chalice was instead instructed to use further officers from the SOIT.[496]

The Second SIO

5.719 In September 2009, the First SIO was replaced by a Detective Superintendent (the "Second SIO"), as it was noted that Chalice "*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*".[497] I understand this to mean that rank carries clout.

5.720 The First SIO became Deputy SIO and an "*enhanced investigation team*" was set up. I heard evidence that it was felt that "*CID at Headquarters… were pressing for arrests*". Upon taking over the investigation, the Second SIO contacted the SIO for Retriever in Derbyshire for 'guidance and advice' on how to run Chalice, because "*awareness nationally around CSE was comparatively limited at the time".*[498]

5.721 Based on that guidance, the Second SIO redrew the Chalice terms of reference into four objectives[499]:

- "*Minimise the risk of immediate harm to child victims or witnesses under the age of 18 years in conjunction with West Mercia safeguarding children procedures;*
- *Minimise the risk of harm to any other victim or witness over the age of 18 years;*
- *Secure and preserve intelligence and evidence leading to the identification, arrest and prosecution of any offender; and*
- *Develop an intelligence picture of CSE taking place in Telford & Wrekin, West Mercia and beyond."*[500]

5.722 On 14 September 2009 the Second SIO made immediate decisions that the previously assessed highest risk targets (i.e. potential victims) of CSE were to be profiled with partner agencies and subject to ongoing risk assessment,[501] and all the material that WMP and its partners had amassed should be collated and reviewed. A victim engagement strategy was determined to engage with the following groups:

- "*Victims already engaged with the local authority and the police;*

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- *Children or young people coming to notice as missing persons or through other police contact; and*

- *Those that had no engagement with the local authority or police and had not come to notice but their names had been mentioned by others in the previous two categories".*

5.723 The Second SIO further determined to instigate a meeting with Staffordshire and West Midlands police forces to share Chalice related information (i.e. information relating to CSE), as well as to refer the operation to the Regional Intelligence group.[502]

5.724 The difficulties obtaining evidence - as anticipated by the YVPSE Report and by others - were manifest, as was exemplified in an email from October 2009:

"[A child] *was on side and gave me an ABE interview. On the flip side, she will not attend court so a decision has been made to leave her out of Chalice totally …".*[503]

5.725 An Operation Chalice Regional Meeting ("OCR Meeting") then took place on 12 October 2009.[504] This seems to have been the meeting contemplated a month before, with attendees from Staffordshire and West Midlands police forces, as well as the RIU and UKHTC. The purpose was to "*scope the regional issues in respect of internal trafficking of girls for sexual purposes*" between the three police forces. Representatives of each force described ongoing similar CSE investigations within their areas.

5.726 By this stage, the nominals under investigation in Chalice had grown, with 40 open investigations within the CATE Team, 20 of which were active, 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*".[505]

5.727 The OCR Meeting was told of similar issues relating to CSE being encountered and investigated in other areas, recognising that in East Midlands, care homes were being targeted initially before other children were "*brought into the network*", and the children were all of a similar age, primarily between 12 and 16. It was noted that Derbyshire Police had shared the same challenge with victims/survivors refusing to come forward and complain, and that proactive tactics and victim-focused strategies had also been adopted as part of Retriever.

5.728 The Deputy SIO at the time was of the view that Chalice should mirror Retriever, and it was noted at the OCR Meeting that – unlike Chalice so far – Derbyshire had set up a Gold Group for Retriever, which included Heads of Service from Education, Children's Services

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and Social Services, supported by a Silver Group run by a Detective Inspector, and which included all of the social workers involved with the vulnerable children.

5.729 On 16 October 2009 there was a CATE Heads of Service meeting,[506] comprising WMP representatives (the Deputy SIO and the OIC), Safeguarding (an Assistant Director and senior safeguarding officers), and others. The purpose of the meeting was said to be to reach agreement about how to progress the CATE process and it was noted 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.*"

5.730 The Council representatives were to make representations to the Chief Executive at the Council that there should be a Gold Group to give "*commitment and resources*" to the work. The meeting heard that UKHTC had recommended that the 'Derby model' (i.e. Retriever) was the way forward, this including "*victimless prosecution*"; a prosecution without a complaint.

First Operational Orders and Phase 1 Arrests

5.731 Following the Heads of Service meeting in October 2009 the Second SIO gave operational orders.[507] The covert aspect of the enquiry was to continue as a separate operation. It is clear – by the Second SIO asking for SOIT to be "*written off*" for an initial "*strike*" (arrest) week in December – that the SOIT had still not been fully assigned to Chalice at this stage. It was also the case that the Second SIO was not assigned to Chalice on a full time basis, as he retained his full time role within reactive CID simultaneously. SOCA was to be approached with regard to victim support and the Second SIO noted "*I will look to support you from HQ CID during this key week*". There was an instruction to confirm that the risk model being applied was a nationally recognised one, and an instruction that once the subjects of the strike were identified that there would be:

5.731.1 Liaison with UKHTC to obtain "*Palermo*" (trafficked) status: the Second SIO had information which indicated that this would afford the victims a status in the eyes of the CPS and the wider criminal justice system "*which in turn will enable wider options to be explored in terms of bringing offenders to justice*";[508]

5.731.2 Search of COMPACT and CRIMES for the preceding 12 months to identify any critical intelligence;

5.731.3 Liaison with the CATE Team to establish if there is anything evidentially that could be used as a result of any disclosures made over the last 12 months or over the subsequent weeks; and

5.731.4 Debrief by SOIT.

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5.732 The orders also noted that a CPS lawyer should be identified as "*we need to be alive to any new suspects emerging prior to 7 December* [2009]" – the nominated 'strike day' for the first phase of arrests ("Phase 1 Arrests").

5.733 On 22 October 2009 a policy file update tasked the OIC with reviewing the intelligence assessment against the two main suspects identified as representing most risk to children, on the basis that "*it is imperative that with finite resources police and partner agencies prioritise and concentrate their efforts on these suspects*". The Second SIO noted that:

"*… whilst other Asian males are identified as being involved in child exploitation in Telford, the* [two] *are consistently identified as co-ordinating the sexual exploitation by a number of victims*." [509]

5.734 A further policy file update the same day instructed that the investigation should:

"*… remain open minded to a range of offences that could be considered against the 2 … these include section 58 Sexual Offences Act 2003; risk of sexual harm order; sexual offences prevention order; child abduction*".

5.735 It further noted that the "*CPS will be closely engaged. It is imperative all legal options are considered*".[510]

5.736 As regards the approach to victims/survivors and evidence collation, a policy decision was also made by the Second SIO that WMP would not proactively approach or involve any of the identified children *"unless exceptional circumstances prevail",* due to concerns that *"suspects would become suspicious and future policing activity may be compromise*d". It went on:

"*Any approach to the victims needs to be carried out in a careful, considered and co-ordinated way utilising officers who are appropriately trained and have sufficient experience*".[511]

5.737 In November 2009, two missing Telford children were found in Birmingham having been subjected to CSE. Officers engaged with them, and more potential victims/survivors began to be identified as result. Officers also continued to engage with the CATE Team in order to seek assurance that (a) they were continuing to share intelligence with WMP, and (b) a CATE Group Pathway would be formed to ensure there was an ongoing risk and aftercare plan for all victims/survivors, in the run up to the Phase 1 Arrests.[512]

5.738 WMP also, at this stage, sought early advice from the CPS in relation to the two main suspects and the approach being taken in engaging in an 'indoctrinated' operation whereby no formal criminal complaints had been made by any of the victims/survivors. The CPS was told that, by this point in early December 2009, the CATE Team now had 46 children on file for CSE activity, 24 of which had been linked to the suspects under investigation in

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Chalice. Those 24 children had been split into four groups, according to high to low risk/priority. The highest risk group comprised six children, who it was proposed would form the basis of the Phase 1 Arrests, whilst the remaining 18 children would "*remain flexible to emerging risk".*[513]

5.739 The Second SIO also ordered[514] that '*Palermo'* status letters should be prepared, as earlier anticipated, and that Automatic Number Plate Recognition ("ANPR") systems should be checked for the previous 12 months in order to track suspect vehicle movements.

5.740 Ongoing investigations also 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 the three new suspects in the Phase 1 Arrests.[515]

5.741 CPS early investigative advice received on 4 December 2009 suggested:

"When building the full file, please consider obtaining expert psychology evidence regarding the way in which the victims become dependent upon offenders in such a scenario and do not see themselves as victims in a manner that is possibly similar to the Stockholm Hostage Syndrome Please try to obtain an expert's overview (possibly from the UK Human Trafficking Authority) of the system that has been used by the offenders in this case."[516]

5.742 I deal in greater detail with CPS involvement in Chapter 6: Other Organisations.

5.743 On 7 December 2009 the Chalice Operational Order[517](the "Operational Order") was drawn up in respect of an arrest phase involving five suspects. Premises A, to which I have previously referred, was noted as an "*identified premises suspected of being used in this criminality*". There was specific reference within the Operational Order to an application for Risk of Sexual Harm Orders ("ROSHOs") in the event of subjects being bailed. I deal with ROSHOs below in a section entitled "Civil Orders".

5.744 A strike day was confirmed for 8 December 2009 taking into account "*ongoing risk, resourcing requirements, competing operations..."*[518] Five arrests took place as scheduled.

5.745 The decision was made to make the Phase 1 Arrests despite the absence of supporting victim/survivor complaint. I have seen evidence explaining that the approach taken by the Second SIO was that the suspects should initially be brought in on drug offences, with the hope that this would lead to disclosures being made by the victims in relation to CSE. The Inquiry was told:

"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

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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.'"[519]

5.746 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 to speak, 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..."*[520]

First Charges Laid and Victim Strategy

5.747 Following the Phase 1 Arrests, a decision was made to engage with CEOP who "*may be in a position to compare images recovered with national database.*"[521]

5.748 On 10 December 2009 charges of conspiracy to traffic (section 58 2003 Act) and conspiracy to engage in sexual behaviour with a child (section 10 2003 Act) were brought variously against the five men arrested. The Second SIO took the decision to serve section 2 Child Abduction Act harbouring notices (also known as "CAWNs" – Child Abduction Warning Notices) on all five suspects "*where association with any of the 9 victims can be evidenced.*"[522]

5.749 A Victim Therapy Strategy dated 11 December 2009 noted that:

"*The decision as to whether a child will receive therapy before the criminal trial is not a decision for the police or the Crown Prosecution Service. Such decisions will be taken by the Care Pathway Group set up in partnership with the Local Authority. This group is comprised of those professionals from a number of agencies who are responsible for the welfare of the child, in consultation with the carers of the child and the child herself…*".

5.750 However, it further noted that there *"must be an audit trail which is disclosable before cross examination. Preferred method of therapy is not to rehearse abusive events".* [523]

5.751 In tandem with that went a Guardian Strategy[524] which set out different approaches according to assessed risk:

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"***High risk:***

- *Strategy meeting with each girl. This will be multi agency and involve the parents in providing a care package*
- *Warnings on the home address*
- *Targeted patrol instigated at the address (frequency to be based on the intelligence available)*
- *Each girl to be given a mobile phone by which they can be contacted and to distance themselves from previous contacts.*
- *Creation of persons record on COMPACT in case they go missing due to external pressure.*
- *Where a direct threat is received then personal welfare visits by the Local Policing Team*

Medium Risk:

- *Strategy meeting with each girl. This will be multi agency and involve the parents in providing a care package*
- *Warnings on the home address*
- *Each girl to be given a mobile phone by which they can be contacted and to distance themselves from previous contacts*
- *Creation of persons record on COMPACT in case they go missing due to external pressure*
- *Each girl will have a dedicated police officer who is liaison between the investigation team and the family. Due to the numbers involved STOs will be utilised alongside the CID Sexual Offences Investigation Team. The intelligence gleaned by these officers and the information coming from the CAI team will inform who is currently at risk and what measures need to be put in place*".

5.752 I note here the recognition that liaison was beyond the capacity of the SOIT and with it the use of STOs.

5.753 The police also took practical steps to support the victims, for example, the Second SIO approved the distribution of clean pay as you go phones to designated high risk children in exchange for their personal phones.[525] The Inquiry was told by one witness:

"We bought them phones. It was something that [was] *trialled on the SOIT team - somebody pours their heart out to you, telling they've been raped, they've got the worst*

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thing in their life and we take away their mobile phone and they've got nobody to talk to. It's ridiculous. It's still happening now…"[526]

Phase 2 Investigations and Arrests

5.754 On 22 December 2009 discussions began around expanding the scope of the investigation, proposing 'Phase 2' investigations[527] in relation to ten potential CSE victims, all but two of whom were open to CATE. It was recognised that Phase 2 would be more challenging, as the engagement of the victims/survivors and the intelligence gathered was limited.

5.755 At the same time, an operational Memorandum of Understanding[528] was entered into between WMP and WMiP. 27 potential suspects and 24 victims of CSE were listed in the WMP area and it was noted that WMiP was investigating a rape prosecution which involved two of the WMP named children. There were, it was noted, no other links between the two investigations but it was nevertheless agreed that material would be "*properly shared*", the respective forces agreeing to:

"*… disseminate appropriate intelligence according to the 'Code of Practice for the Recording and Dissemination of Intelligence Material' (current version 2002/3) agreed by NCS, NCIS, and HMRC. Each will ensure their subjects and appropriate associates are flagged where necessary, and intelligence in support of the flags is submitted correctly…*".

5.756 Designated points of contact were identified. It was further ordered by the Second SIO[529] that Chalice officers needed to seek disclosure of information from WMiP, in order to use that force's evidence in Chalice, noting that it was "*imperative at strategic and tactical level* [that] *intelligence is shared between the* [regional] *forces.*"[530]

5.757 The SOIT officers were ordered to continue to liaise with the CATE Team, into the following year, with the instruction that "*they should identify no more than 9* [victims/survivors] *for approach in February* [2010]*. If any of* [the] *girls* [are] *at significant risk of harm we will need to act at the time.*"[531]

5.758 A CATE risk evaluation dated 20 January 2010[532] listed 35 children in four tiers representing levels of risk. 19 of the children were working with CATE; however the following day, a Phase 2 list identified six target children[533] and 37 nominals, or potential suspects.[534]

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5.759 During Phase 2:

5.759.1 Evidence gathering continued and involved, variously: contact between the investigative team and the UKHTC;

5.759.2 There was liaison with Sanktuary, a charitable operation providing late night support to revellers around Wellington;

5.759.3 There was review of information and intelligence shared by both School A and School C;[535]

5.759.4 Local policing teams were tasked to stop-check the Phase 2 suspects, particularly around night clubs;[536] and

5.759.5 WMP reviewed COMPACT missing persons records, liaised with the Covert Authorities Bureau ("CAB") telecoms department and reviewed forensic investigations linking nominals to defendant cars.

5.760 On 18 January 2010, a decision was taken by the Second SIO, based on internal advice, to use the HOLMES 'lite' system - a scaled-down version of the HOLMES database system usually used for major enquiries, for Chalice. His policy note read "[the] *resourcing is appropriate to demand*".[537] Later documents suggest, however, that this iteration of HOLMES had "*limited indexing which as the case progressed caused significant issues*".[538] One such issue was the management of the vast amount of intelligence that was beginning to be gathered by investigating officers. The decision to use the HOLMES lite system was explored in the review of Chalice by the Major Crime Review Team ("MCRT"), which I discuss later in this chapter.

5.761 9 March 2010 was the nominated strike day for Phase 2[539] (leading to the "Phase 2 Arrests"). A total of nine suspects[540] and 11 potential targets (i.e. victims) of CSE were identified. It was noted that three identified victims/survivors from Phase 1 who had not wanted to cooperate initially were to be re-approached if "*this arrest has consequences for their co-operation*". All the children were to be visited by WMP and where appropriate Safeguarding. It was stated that the "*… Intention is to formulise* [sic] *any potential disclosure which substantiates … abuse*". On 1 April 2010 the CPS approved charges for six Phase 2 arrestees.[541]

5.762 On 13 April 2010 the Deputy SIO made a call to all staff by email:

"A number of you have already provided copies of pocket books and information in relation to stop checks when these girls have gone missing or where they have been found in suspicious circumstances. This email is a request to any officers who have not been

[535] as previously defined in Chapter 3: The Council Response to CSE in Telford. [redacted]
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approached and provided information that could assist with the enquiry. If the above relates to something you have dealt with please contact me. I have a full list of suspects and victims with addresses which I do not intend to send out due to the sensitivity of the investigation and fears of intimidation. However if you have stop checked a young girl in a car, seen a girl at a premises or believe you have information/evidence which could assist the investigation which fits with the grooming process above then contact me at my office by mobile/email…".[542]

5.763 Finally it appears that officers were being encouraged to report their suspicions, rather than lone officers battling to get investigations off the ground.

Phase 3 Arrests and Review

5.764 By 25 March 2010 the investigation was already working to identify Phase 3 suspects[543]. A review of Chalice on 30 March 2010 identified an omission in the lack of a 'Bichard' officer "*to ensure the appropriate dissemination of intelligence captured in the Operation Chalice database in order to support and protect vulnerable persons."*[544] This was a surprising omission: the Bichard recommendations around intelligence sharing were no longer new thinking, to put it mildly.

5.765 By 15 April 2010 WMP had relented in its decision not to form a Gold Group and such a meeting took place in respect of Chalice. The minutes note the ongoing liaison with other regional police forces, and the sharing of intelligence that was taking place with Staffordshire and West Midlands police forces in relation to their own large-scale CSE enquiries.[545] Whilst neither of those inquiries appeared to be as advanced as Chalice, it was noted that:

"The RIU have linked the intelligence and identified that the profile of the victims and offenders in each investigation is similar. Clear 'hubs' of activity have been identified and include Stoke on Trent and [a location] *in Birmingham…*

There is daily sharing of intelligence between the three investigations but due to the immaturity of the Staffordshire and West Midlands investigations they have not been formally linked up…

The activities of Phase 1 and 2 are believed to have significantly reduced the criminal activity of this nature although it is acknowledged it may have displaced it or driven it further underground".[546]

5.766 In what may have been a note of caution, the SIO was asked by a more senior officer if the CPS had a view on the Phase 3 investigation; his enquiry was rather deflected. There was discussion as to whether Chalice should form part of the overarching intelligence

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systems for tracking regional Organised Crime Group ("OCG") related investigations[547]; however it was suggested that this would be likely to delay progress in Chalice as "*the other regional investigations were well behind and significantly less mature*".[548]

5.767 The Gold Group meeting heard that Chalice had been run hitherto on a "*skeleton staff*" - essentially the designated SOIT officers – and that the "*large scale of the investigation had not been reflected with the volume of staff currently allocated to it".* Further:

"The 'actions' on HOLMES do not truly indicate the scale of the work required. The investigation is complex and time consuming due to the vulnerable nature of the victims and witnesses. There are 25 victims in total of which 9 are core victims. The use of the divisional SOIT alone cannot be maintained for the work generated from the enquiry and from the division… Currently each of the STOs involved with Op Chalice are from Telford Division and have about 4 victims each to look after. This is putting a strain on the Divisional STO cadre".[549]

5.768 The minutes record that it was resolved that divisional STO coordinators would be spoken to in order to lessen the pressure on Chalice; so far as extra officers were concerned this would mean going to 'precept' – which I understand to mean a request to the Headquarters for officers from other divisions to be 'written off' solely to Chalice – and that the size of the precept "*would need careful consideration as* [an ACPO level officer] *did not want to affect the operational/investigative resilience of the divisions providing officers.*" This decision was adjourned pending preparation of a business case.

5.769 A meeting with the CPS on 28 May 2010[550] was cautionary as to the manageability of the trials, with advice being given that while it was desirable that children not give evidence more than once, eight or nine defendants was a realistic maximum. This warning was sounded as follows:

"Phase 3 arrests: police to consider, please: the prosecutors' view is that whether to make Phase 3 arrests is recognised as a police operational decision, but 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".

5.770 The Phase 3 arrests proceeded on 29 June 2010 notwithstanding the warnings. I have seen material in the form of a slide briefing for the Chalice Phase 3 strike day officers (leading to the "Phase 3 Arrests") which suggests there may have been a corporate desire at WMP to pursue large cases, the note being:

"*Upon completion of phase 3 UKHTC will confirm that Chalice will be one of the largest investigations into human trafficking of this type in the UK*".[551]

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5.771 Of course, arrest is also an effective warning and an (at least temporary) disruption tactic.

5.772 CPS advice in respect of seven suspects arrested in Phase 3, whereby WMP were advised two suspects should not be charged and the remainder put off for further enquiry, further counselled caution in respect of the forthcoming trial, with advice for "*long bail dates and standalone cases*" on the basis that:

"*A fresh wave of arrests (with court appearances and early file building if they are charged at this stage) at what is a critical period for the investigation will divert finite police resources away from building the case against defendants who are already charged, against whom much evidence is still awaited*".[552]

5.773 Formal advice from CPS in respect of Phase 3 followed on 30 June 2010, and raised the following strategic issues for consideration:

"(a) The strengths and weaknesses of seeking to try as many defendants together as we would for a conspiracy… (b) The implications in terms of potential trial dates and the impact on the victims (including the number of times they have to give evidence) should any of the Phase 3 suspects be ultimately charged".[553]

5.774 The CPS consulted with Prosecuting Counsel, and the view expressed to WMP in that same advice note was as follows:

"Our views are:

(a) The key to a successful prosecution is the quality of the evidence rather than the volume of defendants.

(b) Please note that the draft indictment is now much more specific (regarding individual substantive offences) than the overall conspiracy with which we started.

(c) Making the trial any bigger in terms of the number of defendants before the court at one time is likely to be counter-productive. The case will become too unwieldy for a jury to follow. The jury will not be able to concentrate on some of the lesser defendants, whose defence team would have nothing to do at trial for weeks, other than to ask whether their client is of good character. We stand a better chance of success against the lesser defendants if they are dealt with separately later on.

(d) We would have preferred it if the Phase 3 arrests had been delayed until the autumn of 2010 but accept that the decisions whether and when to arrest are operational matters for the police. Prosecuting counsel and I are firmly of the opinion that the great priority for the police at present must be to focus on improving the case against the defendants already charged, please. The police arrested the first phase defendants on 10/12/2009 but the case against them is still not complete."

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5.775 A Gold Group meeting on 7 July 2010 reviewed progress prior to a plea and case management hearing that month, involving 11 suspects from Phases 1 and 2. Phase 3 Arrests had taken place a week before, and there were nine suspects in this phase. All arrestees had been bailed, and it was forecast that "*the vast majority of these are likely to be charged with serious sexual offences*".[554] Another 30 males were identified who may be involved in CSE, though at that stage their roles were not clear. Over 50 victims/survivors had been identified in total; another 20 remained to be seen.[555]

5.776 The Gold Group meeting heard that the Chalice team was now 60 strong including staff from Telford Division, the Major Investigation Unit STOs and SOCU. The Second SIO indicated that Phase 3 required a separate investigative team.

5.777 A senior officer present at the meeting took the view that in the light of investigative developments, the strategy should be reviewed, and also:

"Highlighted the current economic climate where funding will become even more of an issue for large investigations. A short briefing on the enquiry, resources and funding together with an estimate of how long the investigation would carry on for was requested."

5.778 The concerns about growth in Chalice's scope are illustrated by the fact that on 19 July 2010 the Chalice team received information suggesting that the death of Becky Watson in 2002 was "*linked to Operation Chalice*" – bringing historic cases to the fore. I deal with the death of Becky Watson separately in Chapter 8: Case Studies.[556]

5.779 CPS gave further charging advice on Phase 3 in August 2010, which recommended no further action in respect of six arrestees. Of the remaining, "*the case against each is in significant difficulties at present*"; long bail dates (to year end) and further investigation was recommended.[557] In response to a question as to whether it was appropriate to warn suspects bailed pending further investigation, the CPS advised:

"My initial view is that it will be in order to give a warning to certain men [where the evidence is weak or where you will not visit for at least a year] *to say you have intelligence that they may have been involved in this type of activity, and then say that if you get more intelligence of current activity you will take positive action. You have correctly identified that it is important that the officers giving this warning do not ask questions.*

The officers giving these warnings should make PNB entries/reports that they have done so. In case these warnings are later used in evidence or are scheduled as unused material. In case the Integrity of what they say is later challenged, it would be advisable for two or more officers to be present when such a warning is given. It might be a good idea if the warning was in the form of a letter, so that there can be no doubt as to what the men were told. A copy of that letter should then be preserved and if necessary, it can later be produced as an exhibit.

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In this way, you will have taken steps to protect the public by being able to demonstrate that you have done something in the interim period."[558]

5.780 I deal with my view of the efficacy of such warnings later in this chapter in the section on the use of civil orders.

5.781 This sums up the essential difficulty with Chalice's virtually exponential growth: it was unable practically to pursue the new lines of enquiry (including non-recent cases) alongside the existing cases being prepared for prosecution, but such were the nature of the offences being uncovered that it could neither stop nor ignore what had been found.

Victim Strategy Review

5.782 On 27 July 2010 the Victim Strategy was set out.[559] It was written by the STO co-ordinator. It read:

"Following extensive work by Telford CID officers, prior to Operation Chalice, and a close inter agency working practice with the local Child Abuse through Sexual Exploitation Team (CATE), a list of persons (mostly female) has been compiled by the CATE working group which details persons who have disclosed some form of involvement. This list also contains persons who whilst not disclosing offences are suspected of involvement. This list is to be taken as a starting point to identify persons involved however other persons who come to notice of the investigation and following assessment by the Victim Lead are deemed to display some SE [Sexual Exploitation] *behavioural indicators will be approached."*

5.783 Notably, this list of people to be approached includes those who were suspected of being victims/survivors of CSE.

5.784 The role of the STO was described in detail in the strategy:

"Where a person is deemed to be a potential victim of SE, that person will be allocated to a dedicated STO who will be tasked with making personal contact. The STO will explain the nature of the Operation and seek to gain the trust of the person. In order that they feel able to disclose any offences that have occurred against them or any witness evidence that they hold in respect of offences against other people. It is recognised that a lot of potential victims will be unlikely to disclose information to Police at an early stage, due to the failure to recognise themselves as victims, embarrassment, fear of reprisals etc.

It is therefore the policy that the STO will maintain a level of contact with each person in order that when and if that person feels comfortable to talk to Police they will have a dedicated officer with whom they are comfortable. It is recognised the building of trust in the Police may be affected by the wish not to meet with the STO's at a Police Station, family home, school etc. Therefore neutral locations will have to be used in order that the person is put at ease. In view of this it is acceptable to the investigation that neutral locations can be used and are likely to be coffee shops, takeaways etc. It is deemed that

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the purchase by the Police of a drink or normal meal (i.e. McDonalds) will not be seen as an incentive but as a method of placing the witness at ease and assisting in conversation".

5.785 It is clear that this followed the CATE model of intervention by befriending victims to obtain intelligence. It led one experienced Detective Constable on the Chalice team to reflect to the Inquiry:

"*I think one of the big problems with Chalice was officers knowing where their role stopped. You know, we're police officers, we're not social workers*".[560]

5.786 As to support for victims/survivors, the Victim Strategy continued:

"It is the intention of the Police to provide an enhanced level of support to persons identified in Chalice as potentially a victim of SE. However it is equally recognised that this support may not be sufficient to meet the needs of the said person. In view of this, close working practices will be maintained with CATE to enable them to provide support and assistance to persons who fall within their remit (up to 18) In addition to this the services of WRSASC has been purchased [by] *Telford and Wrekin.*

The permission of all potential victims approached by Police is being sort [sic] *to allow personal details to be released to WRSASC, so that independent support can be offered whether the person has disclosed to Police or not."*

5.787 Worcestershire Rape and Sexual Abuse Support Centre ("WRSASC") was the provider of Independent Sexual Violence Advisor – "ISVA" Services. However, WRSASC provided a service for adult female victims/survivors of sexual abuse, whether or not those individuals choose to report to WMP. It was described to me as a fledgling service, and it was unable to assist under 16s.

5.788 The Victim Strategy went on to note that where a person was identified as being a potential victim/survivor of CSE, not within the remit of Chalice – which I take to mean not identified from the lists referred to in the opening paragraph - then that person will be risk assessed, and "*following assessment an approach will be made to the relevant agency best placed to deal with the situation at that time.*"[561]

5.789 As at 28 June 2010 the potential victims/survivors numbered 72 and the expenditure on Chalice had reached £60,000.[562]

5.790 On 9 August 2010, in light of progress and the three phases of the investigation, the Second SIO invited a Detective Inspector to conduct a review of the Victim Strategy for "*reassurance that the victims/ STOs are being appropriately managed in accordance with recognised Police practice and / or provide an opportunity for any learning to be included within the investigation*".[563]

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5.791 The report produced following that review (the "Victim Strategy Report") is dated 25 August 2010.[564] It noted that there were 11 STOs allocated to Chalice, although not all had been deployed on a full time basis. The victim care team had two additional officers appointed to act as a link with family members of victims/survivors, and to scrutinise third party material in relation to disclosure. All officers involved in this capacity were noted to be 'experienced' STOs, and all those who had been identified as victims/survivors within the investigation had been offered the support of a named STO.

5.792 The Victim Strategy Report explained the STO arrangements were provided as follows:

"Initial police contact with an individual who has been identified as a potential victim of offences is made by a specially trained officer. Support is offered and a clear decision made on a case by case basis regarding any further police contact or any ongoing support. The decision with regards to ongoing contact is made in consultation with [a] *DS* [Detective Sergeant].

The STO is the main police point of contact for partner agencies in relation to individual victims. STOs are updating police systems with relevant intelligence to support risk management and also the investigation. STOs maintain a record of contact with each victim within major incident books. The books are disclosable documents and relate to each victim, rather than each STO.

The STOs provide the victims with a mobile phone contact number and a contact agreement is established. With the victim's consent they are provided with a mobile phone so that they are assured an opportunity to contact the police. STOs will always return messages or be available for the victim. Should the victim contact them out of hours, they are advised to text or leave an answer-phone message for the STO to return the call, otherwise call 999 in an emergency."

5.793 As to victim support via the CATE Team or an ISVA, the Victim Strategy Report explained that in the case of victims/survivors over 16 years old, referrals are made to ISVAs with the consent of the children concerned, and victims/survivors either under 18 years or 16 years and younger are managed through the CATE Team. It acknowledged that the CATE services consisted of a Manager and two Social Workers who "*facilitate and provide support for families and those identified as potential victims of exploitation*"; whilst the ISVA service had been funded by the Council's Community Safety Partnership ("CSP"), and was, at that time "*the only specialist 3rd sector provider of support for victims of sexual abuse within West Mercia".* It was also limited to a maximum of five clients for a period of six months, although this was under review by the CSP. The Victim Strategy Report noted that the short term nature of the ISVA funding needed to be addressed outside Chalice by WMP as a whole to meet the wider needs of victims/survivors in Telford.

5.794 The Victim Strategy Report also remarked on the pressures on the investigative team, including multi-agency working in line with the Working Together strategy, which it noted

564 [redacted]

was "*a considerable area of work in its own right*". The Victim Strategy Report raised concerns for STO welfare, noting that:

"The role of STO is relatively new to West Mercia, having been introduced in March 2009. The deployment and management processes in relation to this role within a large scale operational setting have no precedent within West Mercia, and within an investigation of this nature, within the majority of police forces. Learning from this operation in relation to officer welfare is crucial."

5.795 The date of creation of the STO role within WMP – March 2009 - does rather limit the previous assertion that all STOs were 'experienced'. None could have been performing the role for more than 16 months. However, the concept of the STO had existed in other forces for a number of years previously.[565]

5.796 In terms of recommendations, the Victim Strategy Report suggested that management of partnership working should be separate from the operational management of the investigation, and that while CATE cooperation was embedded within Chalice:

"*… in order to meet future demand, there needs to be some work carried out at a more strategic level to address this issue. This is outside the remit of the Chalice investigation and needs to be met separately*".

5.797 I understand this to mean that there needed to be a degree of formality and structure in information sharing, which hitherto had been based entirely on the relationships formed between the CATE Team and the Chalice investigators. This seems to me to be an entirely sensible recognition that the working practices developed during Chalice needed to be formalised and embedded, so they could endure beyond the currency of the investigation itself.

5.798 The Victim Strategy Report further concluded that there needed to be "*consideration given to the management structure in place to support a team of this size within this investigation".* I regard this as a tacit recognition that Chalice had outgrown its beginnings but that resources had not matched its growth.

The Third SIO

5.799 A policy file update on 17 September 2010[566] recorded a change in SIO with a Detective Chief Inspector taking the reins (the "Third SIO"). 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 which led to the Second SIO's replacement; that the Third SIO had been asked to take control of Chalice because it had become a "*massive entity*" and was regarded as "*unmanageable*".[567] It was expressed to the Inquiry that Chalice had been intended to be confined to the investigation leading to the first Chalice trial (the "First Trial"), but it became an 'umbrella' investigation for any CSE generally in Telford, and it was "*exploding*" as a result. Whilst I have not seen evidence that there was any specific operational order

[565] HMCPSI Report 2006 – *'Without Consent'* - 15642_Report (justiceinspectorates.gov.uk)
[566] [redacted]
[567] [redacted] pg 61

or direction 'from above' to reduce Chalice's scale, I accept that this was the rationale behind the change in SIO at this point of the investigation.

5.800 Despite this, there was no formal handover between outgoing and incoming SIO. The Third SIO recorded that his priority was to ensure that WMP was ready for the First Trial, 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.*

I intend to manage this case in the following way:

- *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.*

REASON - This a priority as we have a number of time limits to submit the papers to the CPS and to ensure that all available evidence is served. This line of enquiry will be the main priority of the next month.

- *The management of all victims, in the short, medium and long term.*

REASON - It is vital that those victims who are going to attend Court are feeling supported, that measures are put in place to reduce the risk of witness intimidation and that any persons identified as intimidating witnesses are dealt with effectively and brought to justice.

- *Review the current situation in relation to those suspects currently on police bail and identify further lines of enquiry to support the Phase 3 case.*

REASON - Time limits are now in place to further this enquiry and decide on what action to take against those on police bail.

- *Effective Action Management and review all current live actions.*

REASON - A review of the actions is required due to the number of allocated actions, (500 plus) and then those actions are relevant to the current main lines of enquiry.

- Administration and Finances.

REASON - Due to the scale of this investigation it is imperative to ensure it is cost effective."[568]

568 [redacted]

5.801 At a Gold Group meeting on 22 September 2010, the Third SIO suggested that a specific victim care divisional team may need to be considered as a way of looking after witnesses, some of whom were "*wobbling*".[569] The trial of Phases 1 and 2 of the investigation, the First Trial, now comprised of ten defendants and five victims; it was resolved that Phase 3 would not be added to the existing trial – given that no one had yet been charged, this was perhaps an easy decision. The costs of the operation were now £139,000 of which approximately £30,000 was forensics. A senior officer involved in Chalice told the Inquiry that he thought the previous faith in forensic evidence had been optimistic, and the results had not been useful.[570]

5.802 At this same meeting, the business case for more resources submitted after the last Gold Group meeting had been accepted and Chalice – as opposed to Telford - was awarded a "*ring fenced*" sum of £270,000. Some disquiet was expressed about the ability to maintain STO and FPU capacity on the Telford Division, outside Chalice. The Third SIO also 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*"; he felt that there should be such a formal direction consolidated into a plan.

Revised Victim, Suspect and Witness Strategies

5.803 On 27 September 2010, the Third SIO decided that further visits to victims/survivors by police officers would only be made in exceptional circumstances. Future witnesses would receive one visit to obtain an account and a single follow up.[571] The purpose of the decision was said to be so as not to lead witnesses inadvertently who may have had multiple visits. It is notable, though, that this represents a distinct moderation of the police's role in witness support, and that the decision was made just five days after the concerns expressed about FPU and STO capacity outside Chalice.

5.804 The Third SIO made this policy decision to limit the number of times a witness would be seen based on the prior experience of the team, whereby the use of the Achieving Best Evidence ("ABE") process involving a lengthy free-narrative stage meant the interviews often lasted days, following which an officer would obtain the interview transcripts, and read them to pick out all the follow up actions for the team, which may then result in further interviews. Additionally, by making this decision, he bypassed the standard ABE transcription process, which was lengthy, and used the more rapid in-house process generally used in major incidents.

5.805 Around this same time, following an action raised after the earlier notification raising concerns about her exposure to CSE (referred to above), a report was submitted to the Chalice team in respect of Becky Watson on 4 March 2002.[572]

5.806 The Third SIO took the view that it was:

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"… *vital to the investigation that* [the Division's future disruption] *strategy also identifies the issues to victims and witnesses in this case and identifies tactical officers in order to manage the risk over this period leading up to trial*".

5.807 The Deputy SIO was tasked with managing this strategy.[573]

5.808 On 3 November 2010 the Third SIO decreed that there would be no further arrests of those currently charged, prior to their trial, for any further offences which came to light unless these had been committed whilst those individuals were on bail, or were of such a serious nature that it was in the public interest to add them to the charge sheet. He rationalised:

"*At this stage of the investigation there are around 100 victims and around 70 suspects not counting those already charged. In order to effectively manage the victims & the case & ensure that the entire investigation is dealt with expeditiously this decision has been made*"[574]

5.809 It was explained to me by another officer that this rationale was necessary, as each arrest was generating further disclosure obligations in respect of the upcoming Phase 1 and 2 trials and the CPS risked becoming 'swamped' with this responsibility and had asked that WMP stop making arrests in order to concentrate on making the trial ready. The Chalice team had also been told by colleagues in Lancashire, that they had experienced a similar "*deluge of historical rapes*", and that they had "*dealt with this by way of 150 section 2* notices [harbouring notices] *to get back onto an even keel.*"[575]

5.810 I do not understand this material to suggest that there was a halt to investigation of further suspects, merely a halt to arrests; the forthcoming updated investigative strategy, with which I deal in the following paragraphs, makes that clear.

5.811 At the same time, a change of approach was mandated by the Third SIO in relation to suspects.[576] Directions were given that "*all known details of every suspect mentioned by every victim*" would be recorded, together with details of the offences disclosed. The Third SIO would then review how each suspect should be dealt with, setting out whether or not offences would be investigated, together with reasons, and for which approval would be sought from the Assistant Chief Constable ("ACC"). The Third SIO saw this strategy as "*the future driving force as to the investigation. It will shape what we will be doing and what we won't*". By this stage, the investigation had the names of 110 nominals, "*all but 11 of* [which were of] *Asian background*".[577]

5.812 Also at this time, at the end of 2010, the Deputy SIO was replaced by the former OIC[578]. Raw data was as follows:[579]

573 [redacted]
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577 [redacted] pg 140
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579 [redacted] pg 4

Number of victims to be seen	Figures to be updated
Defendant charged	10 Phase 1 & 2
Victims	10 Phase 1 & 2
Others due to be charged	2 Phase 3
Other known suspects	53
Other unknown suspects	56

5.813 An updated Investigative Strategy was released in February 2011,[580] and was agreed with the ACC.[581] In the month since the figures were last updated, almost 40 more complainants had been seen (131 in total) and 40 had made disclosures, indicating the incredibly fast-growing nature of the investigation. As a result, the Third SIO reflected upon the previous view under past SIOs, which had been to visit all children who had been mentioned by others during interview as having potentially been subjected to CSE – and considered that this needed to change. Under the revised strategy, anyone mentioned by another complainant would have their details run against an intelligence search to determine if they may still be at risk of CSE; it was noted:

"*… this will include some of the precursor indicators which may highlight their current status and risk, i.e. regular missing person, reasons for going missing, stop checks with potential offenders, other intelligence and any information held by third parties such as social services*".

5.814 In the absence of evidence to suggest that a child was currently being exploited or no risk was identified, that child would not be visited by Chalice officers.

5.815 The reasoning for the change in policy was set out in the Investigative Strategy thus:

"This investigation is a high profile case. It is well documented within the area. The vast majority of the young women we have seen have been as a result of a friend or associate, who is involved, disclosing this information during interview but with little or no evidence.

It is inappropriate for Police to be approach [sic] *these young women who may or may not have been subjected to this type of abuse if they are not ready to come forward themselves to report the matter. There is expert opinion given in that to enable person to deal with such trauma they need time to reflect and come to terms with the situation, rather than Police directly questioning them to establish if they were part of this exploitation when they may not be ready to discuss this matter. This may prevent them from actually coming forward again should they wish to report the matter when they are ready to do so. Work is currently taking place with the local authority to ensure that there are routes for individuals to obtain access to services/support easily when they feel they are ready to report any incidents."*[582]

580 [redacted]
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582 pg 2

5.816 In a similar vein, men identified by witnesses in Phase 1 (other than the defendants) were not to be seen until the First Trial had run its course. This was justified on the basis that to arrest further men on the basis of these witnesses' accounts would put further pressure upon, and increase the possibility of intimidation of the witnesses. Instead, it was decided that those perpetrators would be dealt with and offences investigated by a team of officers under the supervision of a Detective Sergeant, who would produce a separate file of evidence for review of which charges should be sought via CPS advice. Under the revised Investigative Strategy the (new) Deputy SIO, was to "*act as the gatekeeper*: *if the case does not pass the threshold test then it will be disposed of by means of an undetected offence or a no crime, depending on the individual circumstances and evidence in each case.*"[583]

5.817 Unidentified potential suspects were to be searched against local and WMP intelligence systems, national databases and third party agencies – probation, the UK Border Agency, Social Services and the Prison Service – in an effort to identify them. Any identified would become a known suspect and be dealt with accordingly.

5.818 The Third SIO noted that many recordable crimes had been reported, and would be recorded in accordance with HOCR. However:

"Each crime will be reviewed and a decision will be made regarding the level of investigation the report will receive. There are examples where the information is so limited, although there is enough to record the crime, there is a lack of information on which to base an enquiry. In these circumstances it will be the decision of the SIO/DSIO as to what, if any, further enquiries are to be carried out. This will be the final decision and those offences which have not been investigated based on that decision will not be subjected to any Major Crime Review."[584]

5.819 The reason for the decision was "*to effectively manage the high volume of reported crimes*". As at 11 February 2011, 114 crimes had been recorded[585] of which only 23 were detected.

5.820 There were further decisions in respect of care of witnesses in the trial, with each witness to be assessed by the Investigations Support Unit of Merseyside Social Services, presumably to ensure that support was seen to be independent from either WMP or the Council. That would then generate profiles to be disclosed to the court and the parties in the trial. In the meantime there was to be double deployment of STOs to ensure constant coverage for witnesses and pre-trial counselling as required. There would be 'ghost' COMPACT profiles created and updated regularly by the Chalice team with contact details so as to effectively manage the situation in case one of the witnesses went missing.

5.821 Decisions were also made to spin-off two complainants' cases into standalone investigations, called Alpha and Beta (not the real operational names), which I discuss in more detail below. Each of those operations was to be managed on the full HOLMES system and linked to Chalice to ensure the ability to cross-search the material.[586] The Third SIO

583 [redacted] pg 9
584 pg 10
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on Chalice would act as SIO for both spin-off investigations, but each would have a dedicated deputy SIO.

5.822 The updated Investigative Strategy dated February 2011 was approved at Superintendent level - including the decision to exclude a Major Crime review:

"*As this has been a proactive investigation where we have actively sought out these offences, I am of the view that this sits outside the remit of the MCRT and will be seeking to have this minuted in the next gold meeting.*"[587]

5.823 While it was, at that time, for individual forces to decide which cases were subject to review I am surprised that a review was not pursued given that relevant guidance states that serious undetected crimes should be reviewed, "*particularly where the gravity of the offences suggests it is prudent.*"[588] It tends to suggest the gravity of the offending was still not fully appreciated.

Intelligence Arising During Chalice

RIU

5.824 Intelligence received during the Chalice investigation included information supplied by the West Midlands RIU. A policy file report of 9 April 2010 shows Chalice receiving a regional intelligence analysis summary from the RIU.[589] The summary acknowledged the similarity in offender and victim/survivor profiles, as well as the 'MO' (modus operandi) of the offences across the region; and that offenders were not confined to police force boundaries, and travelled across borders to commit offences.[590] It also found that "*the perceived threat and scale of this Offending (to date) is not representative of regional OCG Mapping*" – i.e. my understanding of this is that the RIU was suggesting that as CSE offending did not match regional OCG mapping, the CSE offending groups within Chalice should be recorded as OCGs.

5.825 I heard that the process for designation of a group of offenders as an OCG was that:

"*We have to make an application via the ROCA, ROCTA, to form an OCG, and then that comes back as a "yes" and then that OCG is managed by the divisional crime manager*".[591]

5.826 I have seen material which suggests that this technique was in its relative infancy, and though WMP had made some progress by 2008, the impact of OCG activity was "*partially understood*".[592] As to the purpose of designation as an OCG, WMP told the Inquiry:

[587] [redacted]
[588] Murder Investigation Manual ACPO/NPIA 2006, pg 83 para 4.4 (murder-investigation-manual-redacted.pdf (college.police.uk)
[589] [redacted]
[590] [redacted]
[591] [redacted] pg 29
[592] [redacted] pg 12

"Once ratified the relevant OCG are allocated to an appropriate Lead Responsible Officer ("LRO") and managed according to national standards and guidance, including the creation and maintenance of a 4P's plan specific to individual risk. Partnership working is a key feature of this process with information and intelligence sharing taking place via a wide range of mechanisms".[593]

5.827 On 6 May 2010 an Intelligence Strategy for Chalice was drawn up.[594] It noted that an 'Open Intelligence Cell' had been commenced at Malinsgate Police Station, and that intelligence was, from that point, to be submitted by way of NIRs via a nominated Bichard officer, to ensure that information was also being reviewed by the Intelligence Unit and not just Chalice analysts.

5.828 Regional liaison continued with neighbouring police forces, and it was agreed that regular meetings should take place. WMP put forward a Specified Point of Contact ("SPOC") for Chalice and various recommendations were put forward to suggest how and what information should be shared between police forces. This included not just the sharing of intelligence and specific data regarding locations, vehicles and contact details; but also, for example, any information regarding the placement of victims. Suggestions were also made regarding agreed turnaround times for acting on requests or information shared; and that monthly situation reports ("Sitreps") should be submitted for sharing.

5.829 A regional SIO intelligence meeting took place within the month,[595] at which intelligence sharing arrangements were agreed. This included the establishment of a dedicated unit within each police force to co-ordinate information from partner agencies and internal systems, and to assess and analyse information and carry out risk assessments in relation to victims/survivors. COMPACT procedures were also to be reviewed in order to address intelligence sharing protocols of vulnerable missing persons who travelled across regional police force boundaries.

5.830 Consideration was also to be given to recording offenders as part of an OCG, and sharing knowledge where those individuals were believed to be operating across force boundaries. The meeting between regional SIOs suggested that *"there is a substantiated regional/national OCG operating".*

5.831 WMP's Corporate Submission suggests that Chalice suspects were recorded as an OCG on 2 November 2010.[596]

Licensing Information

5.832 In an illustration of information being disseminated by WMP, the Council's Licensing Department wrote to WMP in June 2010[597] with regard to a Chalice suspect's taxi licence, previously suspended at WMP's request on his arrest and which now, following discontinuance of the criminal proceedings, inevitably (in the view of the Licensing

593 [redacted] pg 124
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596 pg 73
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Authority) needed to be restored. The email is marked "[a Detective Chief Inspector] *to speak personally*".

5.833 It is not clear from the papers I have seen what the content of that conversation was, but it appears that the taxi driver was operating on a licence from Shropshire until 2013 when his licence was revoked (albeit based on non-CSE related concerns).[598] The episode does show sensible informal information sharing between WMP and the Council during Chalice.

5.834 Some months after this, there was a call for evidence[599] sent to Telford's taxi drivers in the form of a joint letter from a Telford Detective Chief Inspector and a member of the Council's Licensing Department as follows:

"The police are currently carrying out an investigation into serious sexual offences which have taken place in the Telford area. It has come to light during the investigation that on a small number of occasions taxis have been used to facilitate the commission of the offences. Of course in the main the taxi drivers will have unknowingly been involved in moving these young girls between addresses. However there is intelligence that on occasions some taxi drivers are believed to have been aware of the purpose of the journey and have requested, and received, sexual favours instead of paying a fare.

As a result the Licensing Authority and the police are working together closely to ensure that all allegations are effectively investigated. Where these allegations are found to have a basis suitable action will be taken. This action could include arrest, review of private hire/Hackney Carriage driver licence and forfeiture of the taxi.

We would reiterate that the allegations are isolated and may involve a very few drivers. We would ask you to assist the police and the licensing authority in this enquiry, and if you have any information that can assist them on this or any other matter please call Crimestoppers."

5.835 I have not seen material that suggests the call for evidence was fruitful, but I consider that it is an example of a sensible approach and of useful joint working between the police and Licensing Authority.

5.836 As I have previously noted, in the section relating to 'Early Intelligence' above, in September 2010 a Chalice Detective Constable produced a report in relation to file D2276, with a view to "*bring forward any links with Operation Chalice*".[600] This was the first time that this significant body of intelligence had come to light, after many years.

5.837 As I have noted above, the D2276 review concluded that:

"*… the information contained in 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*

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information initially may now, ten years down the line, be willing to speak to the police in relation to Operation CHALICE".

5.838 The following month, in October 2010, a report was produced by another Chalice Detective Constable following another review of historic evidence in respect of Premises A, in which he noted that "*several intelligence logs and O.I.S. messages in relation the address"* had been identified, and he recommended that further evidence should be sought from sources of the information.[601] A bundle of logs was collated relating to the address; the earliest report citing concerns around 'child prostitution' in 1999; the latest reporting concerns about "*a girl screaming and crying… this has been going on for ten minutes now*" in 2007. The Detective Constable recommended the logs be passed to the Intelligence Unit, "*for the attention of the D/Inspector who can authorise to find out the sources of the information and assess whether they can be approached to make a statement".*[602]

5.839 An action was then raised to speak to a Detective Inspector who had been of long standing within Telford, for comment on the logs and for any further information within his recollection in relation to Premises A; the action was completed as follows: "*due to length of time* [the Detective Inspector] *cannot add any additional details".*[603] It has not been possible for the Inquiry to establish what, if anything, then followed in relation to Premises A.

5.840 The collective lack of memory of police officers of the events of the 1990s has been a common feature of this Inquiry. It is, as I have noted in the section dealing with D2276, beyond credibility that so many officers would fail to have any recollection of such dramatic reports.

5.841 It is to the credit of the Chalice team that these matters were investigated. There is no doubt, however, that the historic reports of CSE materially broadened the scope of the Chalice investigation and increased the potential burden upon it. This burden no doubt contributed to the view in WMP that Chalice was growing uncontrollably and to the desire to close it down. A regrettable feature of that close-down is that some of the historic matters were, once again, inadequately investigated.

The First Chalice Trial

5.842 I have found the figures in respect of the Chalice investigations difficult to reconcile. WMP has provided me with a number of documents, including spreadsheets, reports and reviews, which were written during, and after, Chalice. The figures are often conflicting. I have used the figures from documents such as indictments, and overarching reviews from the SIOs on Chalice, in this section.

5.843 The first Chalice indictment I have seen dated 28 May 2010 charged eight men with 30 counts[604] including rape; sexual activity with a child; inciting; facilitating and controlling

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'child prostitution'; trafficking for sexual exploitation and related conspiracies. The earliest date of alleged offending was 1 January 2008.[605]

5.844 A policy file entry on 18 March 2011[606] notes the existence of a covert operation to observe and protect a Chalice trial complainant during the course of the trial; information had been received that she was being threatened or coerced into CSE-type activity. There were also reports of further active attempts to derail the impending trial[607]; the 'no further contact by police' rule was therefore broken to record the complainant's account.

5.845 Two of the men initially indicted were severed from the original case due to ill health.[608] The First Trial – now comprising seven defendants[609] - began on 16 May 2011.[610] There were seven complainants.

5.846 On 5 September 2011, the judge decided to discharge the jury in the First Trial. This was for evidential reasons; by that time the trial had already run for 16 weeks. One of the complainants was cross-examined for over three weeks.[611]

5.847 This resulted in a policy decision to scale back the STO support offered by WMP to the complainants,[612] limiting this to support during working hours only and that for any support outside those hours the usual police emergency number should be used. This was based on the fact that STOs had come under increasing pressure, with complainants calling them at all times of the day or night for "*a general chat about insignificant events rather than requesting or needing support at any time, especially during the early hours",*[613] and this was taking its toll on the officers concerned. This also led to a further update to the Victim/STO Strategy to ensure that STOs maintained "*proportionate and appropriate contact with the victims/witnesses*" (my underlining).[614] STOs would however continue to attend Safeguarding and other meetings in relation to their individual victims/witnesses, to ensure that any ongoing risk to them was managed appropriately – the updated Victim Strategy concluded:

"*Should a victim/witness be contacted by persons that are "unknown" to them or are contacted by defendants, their families or friends, then they should be advised to make contact as soon as possible with their specially trained officer so the contact can be assessed and risk managed."*

5.848 It is unclear whether "*as soon as possible*" must be read as "*as soon as possible within STO working hours*" given the other provisions of the Victim Strategy – and whether there was a risk that disclosures might be missed as a result.

605 [redacted]
606 [redacted]
607 [redacted]
608 pg 2
609 pg 2
610 pg 2, [redacted], pg 1, [redacted]
611 [redacted], pg 7, [redacted]
612 [redacted]
613 [redacted]
614 [redacted]

Post-First Trial - Review of Complaints

5.849 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.

[In respect of] those persons who do not wish to pursue their cases, or I decide not to pursue them, should the suspect be known, [an officer] *will review each of these individuals and complete a risk assessment for each to establish if any of these individuals continue to pose a risk to other members of the public. If they do then decisions will be made to ensure the risk is reduced/managed*".[615]

5.850 The reason for the decision was recorded as:

"*Due to the fact that there is likely to be another trial,* [and] *this will not be for many months. I feel it is now appropriate to revisit my initial decision, to reassess the impact this action will take* [in order] *to maintain some momentum in the enquiry, to obtain the views of the victims and to maintain victim focus*".

5.851 The Inquiry was told that following this review of the complaints and consultation with victims/survivors, 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'.

5.852 During November 2011 the process of scoring Chalice nominals on a formal risk assessment began.[616] So far as measures to mitigate the risk presented by those not proceeded against, a decision was made by the Third SIO to task an officer to research ROSHOs and to liaise with local and force PPU managers to discuss the orders' use in the context of a means of 'mass disposal' for "*some individuals who will not be dealt with by way of arrest.*"

5.853 In this regard, the Inquiry was told that advice was given by the WMP legal department that preventative civil orders (in this case, ROSHOs) demanded proof that there was a current risk of the suspect offending (my emphasis) – i.e. there needed to be evidence of an ongoing risk of sexual harm, and that there was no such evidence at that time. The Third SIO therefore did not regard it as tenable to pursue such orders in cases where the CPS had refused charge.

5.854 Later material suggests[617] 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*

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616 [redacted] pg 118-135
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Operation Chalice are actively managed by the Intelligence Department and the CSE team, by way of a 'marker'".[618]

5.855 I deal with the question of action taken by WMP in respect of ROSHOs and other civil orders in more detail later in this chapter.

Chalice – The Results

5.856 The first 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.[619]

5.857 The shape of the first, aborted Chalice trial was heavily revised; defendants were by and large tried separately or in smaller groups. 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. 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.

5.858 It is notable that the successful prosecution of the two men in the summer of 2012 was exactly the shape of trial originally contemplated by the First SIO.

5.859 In advance of a meeting on 8 June 2012, the Third SIO wrote to the Deputy Chief Constable, setting out that the application of the Investigative Strategy had led to "*in excess of 50 offences with no further investigation…"* and he indicated that he was *"concerned about being able to confidently justify not dealing with possibly 60-70 serious sexual offences".* The Third SIO raised this with his superior officers as he felt they *"have the potential to impact on the credibility of the organisation in the future, if not handled well now… There is no doubt it will impact on Force performance and, if we do decide to investigate these outstanding cases, it will have staffing implications*".[620]

5.860 On 8 June 2012 the Third SIO submitted his decisions regarding management of offences not then subject to proceedings to the Deputy Chief Constable ("DCC") "*for information and consideration*". The DCC replied:

"*The extent of the investigation is a matter for the police, ultimately in these cases it is your decision as SIO. It is important to articulate why we are not investigating further, for example by stating that there is "insufficient evidence to pursue a prosecution" the challenge could be "how do you know until you have carried out an investigation?" In each case we need to apply a proportionality test balancing the needs of the victim, risk posed by the alleged offender and a judgement of the likelihood of a successful investigation*

618 [redacted] pg 13
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taking into account elapsed time, forensic opportunities, realistic chances of a confession etc. Subject to the above, I fully support your decisions and your documented rationale".[621]

5.861 This seems to me to be a textbook example of a request for approval dodged. I regard it as a matter of such obvious seriousness to WMP as a whole that I am surprised no guidance was given.

5.862 In the course of the Chalice investigation (not including those investigations which became Operations Alpha and Beta), 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, including the 'spun-off' Alpha and Beta operations, a total of 94 suspects were identified, 27 of whom were not arrested.[622]

5.863 There are conflicting figures regarding the total number of crimes recorded across the whole Chalice investigation; some documents suggest it was 114[623] and another suggests a total of 119 crimes[624] 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.

Chalice – Reflections and Learning

5.864 The Inquiry heard from officers involved in Chalice who expressed the view that, by the end of the second Chalice trials in 2012, Chalice had "*run its course*".[625] The investigative team focussed on Alpha and Beta; the STOs were reduced "*massively*" and the wider team began to be disbanded. I read evidence that the SOIT, which as explained earlier in this chapter had been absorbed by Chalice, was not reinstated, following a report that suggested there was "*no role for it*".[626] I have not seen this report, which cannot be found by WMP, but I have no reason not to accept the account given. This decision in respect of SOIT was crucial, in my judgment, and was one that impacted upon the subsequent handling of CSE cases by WMP.

5.865 A senior officer involved in Chalice told the Inquiry that it was their belief that CSE had been ongoing in Telford for a number of years prior to Chalice, basing that view on their knowledge of older intelligence reports and complaints from victims/survivors that went back 20 years. The officer noted that an address had featured in intelligence reports indicating suspicious presence of schoolchildren in 1998, over ten years before the same address was searched as part of Chalice.[627] This accords with the documentation I have reviewed and referred to in the section entitled Early Intelligence above.

5.866 After the first, aborted, Chalice trial, the Third SIO and one of the STOs debriefed the Home Secretary and the Attorney-General, and had also expressed their concerns internally as

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623 [redacted]
624 [redacted] calculated from pages 6 to 10
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626 [redacted] pg 34-35
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to their reflections on Chalice, and in particular the distress occasioned by cross-examination during the First Trial. They explained:

"*In May 2011, seven … men stood trial at Stafford Crown Court, they were charged with a total of 47 indictments … There were seven complainants in this case. The trial ran for 16 weeks at which point the jury was discharged … I have to say, I was amazed about the amount of questioning these young, vulnerable women were subjected to by the defence barristers … The main complainant in the case who has been subjected to abuse for four years, spent 3½ weeks being cross-examined. In my opinion this was completely unacceptable*". [628]

5.867 They went on:

"*There were significant issues in the first trial in dealing with so many defendants at one time. This obviously opened the victims up to significant and varied lines of cross-examination by several defence counsels. The victims were questioned by all of the defence teams over a point, which could last for hours, again I find this unacceptable.*"

5.868 I regard the officers' uncompromisingly couched closing words on this point, as set out below, to be accurate and their comments appropriate:

"*Something must be done to ensure these vulnerable complainants get the protection they deserve from the criminal justice system. There is significant comment about putting the victims at the heart of the criminal justice system. In this case, that comment could not be further from the truth. For a young vulnerable victim to have to endure cross-examination for over three and a half weeks, covering the most personal and sensitive matters, cannot be in the interests of the victim or the interests of justice. There must be a degree of protection given, from being bombarded by cross-examining QCs.*"

5.869 In March 2014, the Ministry of Justice was to publish a report in review of ways to reduce the distress of victims in trials of sexual violence. The report referenced Chalice and other cases including Retriever, noting:

"Any distress and trauma that victims might endure in trials of sexual violence offences by virtue of the very nature of the allegations under consideration, would be exacerbated in trials where there are multiple defendants, when cross-examination is protracted (lasting many hours and sometimes days) and repetitive (with several counsel covering the same issues with victims)."[629]

5.870 On 29 April 2013 the Third SIO drafted and circulated a document headed '*Operation Chalice – Debrief and Points of Learning'*.[630] The document set out the background to Chalice and noted missteps in preparation (such as overlong 'free recall' ABE interviews) and approach (e.g. victims/survivors becoming reliant on STOs; STOs being seen as

[628] [redacted]
[629] '*Report on review of ways to reduce distress of victims in trials of sexual violence*', March 2014 - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299341/report-on-review-of-ways-to-reduce-distress-of-victims-in-trials-of-sexual-violence.pdf.
[630] [redacted]

offering inducements by buying meals). A number of recommendations were made, such as:

5.870.1 The use of covert tactics including victim surveillance and monitoring of suspect mobile phones in the early stages of an investigation;

5.870.2 Seeking forensic evidence from underwear/clothing and other possessions, in the event of contemporaneous reporting;

5.870.3 Stop-searches revealing children in cars with older men should generate challenge; and

5.870.4 "*Effective*" use of harbouring notices and preventative civil orders should be considered.

5.871 This document was not intended to be a formal operational debriefing or a comprehensive review of Chalice.[631] Some of the recommendations cover ground which had been considered in the very early stages of Chalice, of which a number – notably, certain types of surveillance – had been actively refused; however, there were practical recommendations regarding interview co-ordination, STO briefing and welfare, and use of the COMPACT missing system.

5.872 The Inquiry was told, surprisingly, that no formal operational debriefing took place at all in relation to Chalice[632], despite the length of time it ran for; the resources and funding it demanded; the (eventual) Gold Group oversight; and – most crucially – the horrific nature of the underlying offences themselves and the vast number of victims/survivors and perpetrators uncovered as a result. This is, in my view, not a failing of the Third SIO, who as I have noted, produced briefing documents and provided briefings to government figures, but it was a failing of WMP; the force did not take the necessary ownership to ensure the fundamental learnings from Chalice were disseminated throughout the organisation, and whilst I have not seen overt evidence that this was the case, I am left to wonder whether this was perhaps symptomatic of an internal view that, with the conclusion of Chalice, CSE in Telford was already 'in hand'.

5.873 Reflecting on Chalice to the Inquiry, officers said that the team initially only expected the first nine men that were arrested to be involved. They did not realise the investigation would grow to the extent it did, and it was only at this point that the strategy towards the number of cases and prosecutions became an issue.[633]

Conclusions – Operation Chalice

5.874 WMP is proud of Chalice. It claims that these were the first prosecutions for trafficking offences under the 2003 Act; that may well be right.

631 [redacted] pg 40
632 pg 12.
633 pg 10

5.875 It is important to remember, though, that the Chalice convictions came many years after the enactment of the 2003 Act. WMP did not react to the new legislation by transforming its response to a CSE problem which, as I have shown, had been ongoing for a great many years involving the same men and the same places. As had been the case in the 1990s, individual police officers were noting their concerns about CSE but there was no force-led investigative response. Such response as there was, came by FPU referral to Safeguarding.

5.876 It seems to me that the prevalent view was that CSE was a societal, and not a police problem.

5.877 The roots of the Chalice investigation came 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 edict that FPU should only take charge of familial abuse cases. 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 such cases involving children.

5.878 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 Mispers, 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.

5.879 Within a short space of time, the scope of the intelligence gathering grew beyond the Two Mispers but there was no commensurate change in staffing or funding. The members of the SOIT working on this project were not working on it exclusively, although the operation was progressing – slowly and without any great enthusiasm at senior levels within WMP - from intelligence gathering to a full-blown investigation.

5.880 It is important to stress just how slowly that progression in purpose was being made. The YVPSE Report was in the hands of senior officers in January 2008 and yet it was not until 15 months later that the full investigation began. Furthermore, that was not as a result of a top-down directive, as one might have expected in reply to an important report on a sensitive topic; but rather as a result of the original officers who instigated Chalice approaching their new Detective Chief Inspector, who pushed for progress.

5.881 That senior officers were reluctant to engage with CSE issues is further shown, in my judgment, by the otherwise mystifying reluctance to convene a Gold Group, which could have brought much needed focus to, and set the direction of and limits for the investigation. I have noted previously and repeat that this was a gross underestimation of the seriousness and extent of the CSE problem; an attitude that was further displayed in the reluctance to allow covert tactics to be employed.

5.882 Despite what I have concluded was a rather studied disinterest at senior levels, the First SIO's approach to Chalice was engaged and strategic. The police decisions show a desire to focus the investigation on a small number of suspects thought to be central to CSE in

Wellington. While I have no doubt that this was borne from practical considerations, not least the fact that the investigation was not generously resourced, I also consider it to have been based in a desire to ensure that the investigation and any subsequent trial remained manageable. It is an eternal truth that the only beneficiaries of long trials are lawyers: the longer the trial, the worse the experience for victims, witnesses, and (not least) jurors. That the initial strategy was narrowly drawn, was in my view entirely sensible.

5.883 The Second SIO was significantly more senior in rank, appointed as the scope of the investigation grew wider than the original Two Mispers and two main perpetrators. Chalice's terms of reference were now drawn widely, referring to minimising the risk of harm to unnamed but plural "*child victims and witnesses*", to securing and preserving intelligence leading to the identification, arrest and prosecution of any offender and to developing an intelligence picture of CSE in Telford, West Mercia, and beyond.

5.884 All those objectives were laudable. Each was a necessary focus for WMP. The question is whether Chalice, an active investigation into particular criminal activity, was a suitable vehicle to deliver those aspirations and goals.

5.885 Under the reign of the Second SIO, increased resources were made available; for example, the SOIT team was tasked full-time to the investigation and there were studies of a year's worth of ANPR data on suspects. 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; by the arrest day, the evidence speaks of nine victims/survivors and five arrests. There was a recognition even then that dealing with the victims/survivors was beyond the capacity of the SOIT officers and the STOs.

5.886 In that context, it seems to me that the decisions to press ahead with a second and then a third arrest phase were mis-steps. I have seen evidence that – for different reasons - both senior officers within WMP and the CPS regarded Chalice as growing too quickly. Indeed, in July 2010 over 50 victims/survivors had been identified and the Victim Strategy now included approaching anybody suspected of being a victim of CSE.

5.887 Chalice was not, now, in any real sense an investigation focused on preparing a trial – rather, it had become an investigation into not only current but also historic offending, as well as retaining its original intelligence-gathering function. I have no doubt that this was why the Third SIO was appointed to take charge: to bring Chalice under control. While the Third SIO plainly did address concerns about Chalice's impact on other cases – for example by reducing witness support – he also remained concerned that there was no direction in respect of the "*Chalice issue*".[634]

5.888 Those concerns were in my view justified. 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 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 debrief after the convictions; such an exercise would surely have revealed the obvious gap in provision for investigation

[634] [redacted] pg 5

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.

5.889 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. This marked a return to the unhelpful structure within CID, to which I have previously referred many times, in which CSE cases fell uncomfortably between reactive CID and FPU.

5.890 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.

CSE Investigations Post-Chalice

5.891 In this section I deal with a number of CSE investigations post Chalice. This is not a comprehensive list of all the subsequent CSE investigations; that features at Appendix J. These investigations have been selected as illustrating the direction of travel of CSE investigation by WMP post Chalice, and the steps taken to resolve threads left hanging when Chalice ended.

Operations Alpha and Beta

5.892 Both these operations were 'spun off' from Chalice because of their size. There was a separate investigation team in each though the Third SIO acted as SIO on both. The Inquiry heard that the two teams shared physical space with the Chalice team, for the time the operations overlapped. Operations Alpha and Beta had both used a full HOLMES database.[635]

Operation Alpha

5.893 Alpha arose[636] when a victim/survivor of CSE was identified during the Chalice investigation in October 2010. The individual concerned was in her 20s at the time 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. Actions were assigned to officers in the middle of March, the first being to visit witnesses who might be able to corroborate or offer additional evidence to that provided by the victim/survivor; and to carry out further interviews with the woman herself, in order to build a file to support arrests of the multiple offenders identified.[637]

5.894 In May 2011 a decision was taken by a Detective Sergeant to *"visit and obtain evidence from women (who at the time were girls) who* [the victim/survivor] *knew or suspected to*

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have been exploited similar to [herself]*"* – i.e. attempts would be made to identify further victims/survivors revealed by the Alpha investigation.[638] The Detective Sergeant noted:

"*It is accepted that this is almost in contradiction of Decision 1 of* [the Chalice SIO's] *investigative strategy …* [however] *These possible victims may be able to provide evidence which is valuable to this investigation. The reasons identified in* [the] *strategy are acknowledged, but in order to effectively investigate the allegations made by* [the victim] *these women are considered a necessary line of enquiry, as they may be able to provide corroborative evidence which is likely to be required … Also the purpose of our contact with them will be focus on the actual event under investigation and not to explore their own involvement in such sexual exploitation*".

5.895 On 1 June 2011 the Third SIO approved this strategy providing that the witnesses were specifically not asked if they had any sexual 'relationship' with the suspect, on the basis this was "*leading*".[639] I disagree with that assessment. This is plainly not a leading question in the context of examination of a witness, and one which in my view would be appropriate in the circumstances. I understand that advice was sought by the Third SIO on the approach to be taken to such interviews, but my interpretation of this is that, by failing to ask known victims/survivors such questions, this clearly reduced the potential for disclosures to be made.

5.896 Also in May 2011, a decision had been made to:

"*Pend the arrests of the younger males and any suspects for offences considered less serious than those committed by … the individuals responsible for the gang rape. The Punters are an exception to this as they are an important part of the trafficking offences*".[640]

5.897 As part of the strategy under consideration therefore, officers planned to interview those 'punters' who had paid the perpetrators – traffickers – for sexual services from the victim/survivor, in order to seek to substantiate trafficking charges as a priority, alongside charges of rape.

5.898 At the same time, the decision was made to narrow the focus of the victim/survivor's interviews and concentrate on only developing the evidence in relation to those offences disclosed to date, rather than to seek further evidence from the victim/survivor in relation to 'other nominals' she mentioned during her initial interviews. This was on the basis that:

"*The investigation of these other offences have been pended… It seems a sensible decision then given this, that the further interview in respect of these offences can be pended. This will enable the interviewing officers to focus the victim's mind on those offences we have decided to investigate further at this time. This will assist in retaining the victims concentration by reducing the duration of the interview*".[641]

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5.899 It was clear during the course of Alpha that officers were being abstracted for duties relating to Chalice, and that "*there* [was] *limited staff available given commitments of the Force*".[642] Of the original seven officers, three (including the SIO) had commitments to other investigations.[643] The idea of a dedicated team is, of course, less real than notional when half the team is in fact working on something else.

5.900 The decision was taken to close Alpha in the summer of 2011. The further interviews had begun, but the victim/survivor told the police she no longer wished to pursue her complaints; she said she "*found the second interview very difficult*" and that there were other, unspecified "*personal*" reasons why she did not wish to proceed. It is perhaps worthy of note that the Chalice trial was ongoing at the time. The SIO noted:

"I have made it very clear … that if, at any time she wishes to resurrect this investigation she only needs to make contact. I have also explained my intention to ensure that although we will not be in a position to arrest these men for the offences against her due to her wishes, I will do all I can to ensure that should these men still pose a risk to young women then we will do what we can to remove the risk they pose. A number of the main offenders in this case also feature in Operation Beta which is a similar ongoing case with another complainant". [644]

5.901 The victim/survivor was content with the decision to close the case, and also expressed a desire to see the outcome of the Chalice trials before reconsidering her own complaints.

5.902 However, the consequential policy file decision stated that efforts would nevertheless continue to "*try and identify all those men who have offended against* [the victim/survivor] *before this case is closed".*[645] 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".

5.903 No detail is given as to what disruptive tactics would be considered, in the event that an ongoing risk is identified, but the policy decision confirms that despite the victim/survivor failing to support any further arrests, WMP recognised it has an ongoing responsibility to protect others.

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5.904 During the course of the operation, Alpha investigated 19 recorded offences. There were six suspects in total, two of whom were arrested during Alpha; two were arrested as part of Beta; whilst the remaining two were not arrested.[646]

Operation Beta

5.905 Beta was another case which developed from Chalice. The victim/survivor was first identified when mentioned by others in interview, and she was visited by the police. At the time she was interviewed, officers had significant concerns for her safety and put a number of protective measures in place[647]; whilst her accounts involved historic disclosures, it became clear to officers that the victim still had ongoing contact with perpetrators which put her at risk.

5.906 The victim/survivor went on to give an account in an initial ABE interview which disclosed close to 100 possible offences committed by over 100 potential suspects.[648]

5.907 In May 2011 a review of the suspects and offences resulted in reducing the number to 41 suspects covering 52 offences.[649] 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/survivor] *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*".[650]

5.908 The pre-charge advice notes the 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 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…*
>
> *One would comment that the strategy as it reads makes sense whilst creating some disclosure issues in relation to the offences not being pursued and why, and a risk that* [the victim/survivor] *will be accused of picking and choosing her suspects".*[651]

5.909 An example was given where telephone numbers or contact details for other potential victims/survivors were provided but not investigated, and that clear reasons would have to be shown if the plan was not to investigate those lines of enquiry – given they have the potential to lead to incriminating evidence.

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5.910 So far as visiting potential victims/survivors mentioned by the complainant in Beta, the then-current Chalice approach was adopted – not to visit anyone who appeared no longer to be involved in CSE, on the basis "*this is to ensure that they were not approached before they were ready to come forward themselves*".[652]

5.911 The case progressed further than Alpha; more than ten men were arrested.[653] However, progress revealed further practical difficulties. The victim/survivor was also a witness in another CSE case. The pre-charge advice lamented:

"*… the potential absence of a SPOC at both the police and consequently the CPS because different matters and offences were referred to different lawyers and officers provides an obvious potential for the absence of a united approach, especially with regard to disclosure*".[654]

5.912 The CPS gave its decision on Beta in January 2014 – some three years after the investigation commenced – and concluded that there "*was no realistic chance of any prosecution* [sic]*, or of passing the CPS full code test*".[655] The case was to be closed. The difficulty in this case was evidential: potential witnesses did not offer expected support, and in some cases undermined the victim/survivor; there was no independent supporting evidence; independent evidence that had been obtained such as telecoms material contradicted the victim/survivor's account. I have seen evidence from a police officer involved in the investigation, who informed the Inquiry that the victim/survivor (who had attended with a counsellor) indicated she was relieved at the decision not to continue, and that she would not be required to give evidence.[656] Officers visited the victim/survivor and her family in order to share the CPS decision with her personally.

5.913 Over its duration, Beta had investigated 35 offences; and close to 30 men were identified as suspects.[657] As I have noted, more than ten men were arrested; but none was pursued to trial following the CPS review and charging advice.[658]

5.914 This case illustrates again the difficulties that had been faced in Chalice – when a team is focussed 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 focussed 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.

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656 pg 31
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658 pg 13-14

Operations Gamma and Delta

Operation Gamma

5.915 Operation Gamma ("Gamma") was an investigation which took place from 2013 to 2016 into the exploitation of a 12 year old child. The child had been referred initially to CATE in 2011; in 2013 there was a pregnancy as a result of a CSE incident and this led to further CATE involvement.

5.916 The case was initially investigated by reactive CID[659] before being given an assigned team. Contrary to initial expectations, it bore significant differences from the Chalice model of exploitation – there was no evidence that the victim/survivor was subject to a 'grooming gang'. Rather, the model was of multiple exploitative relationships with adult males who had individually made contact and developed links with the victim/survivor. One analysis showed that she had received thousands of missed calls in a matter of months.[660] The victim/survivor was apparently co-operative, in that she gave an ABE interview early and consented to analysis of her telephone data; but she replaced her telephones regularly and continued to communicate with her abusers.

5.917 The case was run on HOLMES, perhaps in anticipation of a Chalice-style network being uncovered. In contrast to Alpha and Beta, there was a Gold Group formed – in this case while the victim/survivor was still giving ABE accounts[661] - and it met regularly. The Group noted that Safeguarding were considering a section 47 assessment and that parental support had been offered by the Council's Cohesion Team; records showed that the victim/survivor had received support from CATE from the age of 12.[662] The Clinical Commissioning Group ("CCG") were also involved at Gold Group level, and a representative was tasked with obtaining medical records from GP and health providers.

5.918 The investigation relied heavily on forensic material: there was imaginative use of DNA testing, though without result; and analysis of telecommunication and social media data. This work was used to exclude links between suspects, and included seizure of 30 mobile phones – a number of which belonged to the complainant herself.

5.919 Initial investigations identified 70 potential suspects. The police took the decision to reduce the number to target.[663] The CPS considered 19 cases. However the operation resulted in a single conviction for sexual offences against the victim/survivor, a conviction by guilty plea. Two other individuals were convicted with non-sexual offences in relation to the victim/survivor; 16 other men had no further action taken against them based on evidential insufficiencies.

5.920 Gamma presented an entirely different method of offending from Chalice. WMP pursued appropriate technical and forensic enquiries in dealing with a dynamic situation involving a victim/survivor whose continuing exploitation put her at risk. In such circumstances I am

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of the view that the decision to limit and target offenders was inevitable and appropriate, and that the extent of the telecoms data obtained was instrumental in obtaining the sole conviction in the case.

Operation Delta

5.921 This Operation Delta ("Delta") commenced in 2016 and was focused around a child who, in a similar vein to the victim/survivor in Gamma, developed contact with her abusers via social media.[664]

5.922 In the summer of 2016 the child persistently went missing from home. She was assessed following a Return Home Interview ("RHI") by a police officer as being at high risk of CSE.[665] She had made disclosures of being trafficked on a number of occasions to a nearby city and of being raped by multiple men. There was a referral to CATE and to the police, and information was received from her school.[666]

5.923 Interestingly, the police operation appears to have been run by an OIC (a succession of Detective Sergeants) rather than a SIO.[667] In September 2016 the need for decisions to be taken "*at SIO level*" was highlighted.[668] I have not seen any explanation for why this investigation did not merit the allocation of a SIO; I suspect the absence of a dedicated SIO may have been on cost grounds, as I have seen further references to resources being limited for this operation.[669]

5.924 The police mounted a covert operation including obtaining the victim/survivor's telephone number and other telecoms data to identify, through analysis, an initial eight suspects, one of whom was identified as her 'boyfriend'. Forensic testing was carried out on items taken from her home address and from a suspect vehicle with no positive results. [670]

5.925 The police added a PNC CSE marker and completed a NRM referral in respect of the victim/survivor, though she struggled to engage with the police for a period of months.[671] This led to the operation being described as "*something a bit different… with potential civil orders rather than criminal charges".* [672]

5.926 The NRM Single Competent Authority made a 'reasonable grounds' decision that the victim/survivor had been trafficked.[673] Consideration was also given to applying for Sexual Risk Orders ("SROs") following suspects' arrests.

5.927 The investigation did reveal connections between the suspect network of men and other children, including some based in other force areas. As a result, the investigation was

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672 [redacted]
673 [redacted]

regarded as part of a regional investigation. I have seen an entry in the OIC notes which confirmed that debates took place at Detective Chief Inspector and Detective Inspector level about who should take primacy for the investigation – with the Detective Inspector in the case expressing the view that Delta should be "*closed down and sent to* [the neighbouring force] *as intel*".[674]

5.928 This chimes with an account I heard of WMP relinquishing a joint investigation with the other force, because a reactive CID Detective Inspector had 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*".[675] One officer described the senior officer's approach as "*totally wrong and totally inappropriate*".[676]

5.929 The next entry in the OIC notes refers to the victim/survivor having told CATE that she was ready to provide a statement.

5.930 The Inquiry heard that WMP had refused to accept primacy in investigating the trafficking offences revealed to have taken place on West Mercia's territory.[677] Despite the direction given above, I was told that the team had 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*".[678]

5.931 It was clear from evidence made available to me that there was significant disagreement between the officers involved in Delta as to how the operation should be run, but that impassioned junior officers continued to support the investigation.

5.932 In November 2016, a regional intelligence analysis noted that the WMP investigation had effectively come to an end; it linked a total of 11 suspects with 15 potential victims/survivors.[679] This became part of a dedicated operation taken up by the neighbouring force.[680]

5.933 Nonetheless, and despite previous reticence on behalf of the Detective Inspector, it was decided on 12 December 2016 that West Mercia would continue to investigate trafficking matters.[681]

5.934 It is apparent that at this stage the neighbouring force was seeking information concerning a known suspect for the purposes of considering a preventative order.[682] I have heard that officers were frustrated by the advice they received from WMP that such orders required "*the same kind of threshold as the criminal threshold of responsibility*".[683] Officers found

674 [redacted] pg 29
675 [redacted] pg 13
676 [redacted] pg 28
677 [redacted]
678 [redacted]
679 [redacted]
680 [redacted]
681 [redacted], pg 1
682 [redacted]
683 [redacted] pg 27

this difficult to rationalise with the fact that they felt there was a clear and present risk to the victim/survivor, which necessitated such preventative orders. However, the legal advice was that in order to secure those orders, the police needed to be able to prove 'beyond a reasonable doubt' that the risk was there, with a willing complainant giving supportive evidence. As one officer explained it:

"*The legal orders are to prevent or minimise future offending, but it's obviously very difficult to go to Court and say 'well he hasn't done anything for five years so why are you seeking to prevent something he hasn't been doing?'… we considered the legal orders in our world* [because] *it's active, but obviously the legal position is that the threshold is such that … our legal department see it as a bit of a bridge between a live investigation with a supportive complainant and a judicial outcome, so like a conviction*". [684]

5.935 Other forces, the officer noted, used preventative orders more widely and "*they are used when there isn't a willing complainant but there's other intelligence and information to suggest that those people are currently offending*".

5.936 In March 2017 arrests took place in respect of Delta, by a different force.[685] Information and data were shared with WMP as a result,[686] and in the autumn of that year the victim/survivor gave a formal statement to WMP.[687] From that point, WMP re-took ownership of the case, and the investigation eventually led to a conviction for human trafficking and rape offences in 2019.[688]

5.937 It seems to me that this operation demonstrates clearly the value of a RHI properly conducted and, moreover, that WMP acted on that information and received information from a wide variety of sources. There was appropriate use of covert and forensic techniques to pursue the investigation during a period when the victim/survivor was struggling to engage with the investigation. However, the operation was limited in resources and there was plainly a desire within reactive CID to end the operation and pass it to another force, which leads me to the view that the divisions between FPU and reactive CID generated competition over resources, to the detriment of efficient investigation.

5.938 Regrettably, it seems to me to be entirely possible that this decision to pass the case on to another force led to delay in the taking of a statement from the victim.

5.939 It is notable that Delta was used as an example in the business case presented for a standalone CSE Team in Telford[689] and that the formation of that team is regarded by those involved as important to the operation's revival.

684 [redacted] pg 28
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Commissioned Major Crime Review of Operations Chalice, Alpha and Beta[690]

5.940 In 2018, following Freedom of Information requests having been made by individuals named as victims of CSE in the Chalice investigations, WMP requested a review to be carried out by the Major Crime Review Team (the "MCRT Review").

5.941 The terms of reference were not to review the investigation as a whole but to consider those suspects and victims/survivors with whom WMP had not engaged during the original investigations. The goal was to "*ensure that any threat and risk created by the suspects identified in this enquiry are identified, understood and appropriately managed; to make appropriate decisions for each victim's needs…*" and with a view to the future, "*… to allow WMP to respond appropriately to any forthcoming external Inquiry who may seek to raise issue with the parameters of the investigation*".[691]

5.942 In particular, the MCRT Review was to "*ensure that the parameters that were set by Chief Officers for the SIO to manage victims in Operations Chalice, Beta and Alpha were appropriate, remain appropriate, and that the SIO worked towards them".*

5.943 The MCRT Review, dated April 2018, sets out the history of Chalice and the creation of Alpha and Beta. Oddly, in my view, it makes no reference to the First SIO on Chalice in the body of the review or even as a historical footnote.

5.944 The MCRT Review notes that Chalice led to identification of 128 potential victims. 114 crimes were recorded, 13 men charged and ten convicted.[692] As I have referred to above, the figures are difficult to reconcile; these figures in the MCRT Review are different from other reports about Chalice I have seen.[693] 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.

5.945 The MCRT Review continued:

"*… despite the large number of allegations and the complexity of the enquiry, an initial decision was made that the investigation should be run using the HOLMES lite system, as opposed a full HOLMES database*".

5.946 It recommended that "*due to the complexities of Operation Chalice, it would have been advisable to utilise a full HOLMES database*".

5.947 It does not, however, recognise that the decision to use HOLMES lite was made in the early stage of the investigation when the parameters of Chalice were much narrower. It seems to me that the criticism for not using full HOLMES is perhaps unfair, as it pays no regard to what may have been the resource implications of using the full system; as I have noted,

690 [redacted]
691 pg 7
692 pg 6
693 pg 8- 9

the cost of HOLMES lite was plainly balanced against the size of the investigation; and the fact that at the time of the assessment the Second SIO was dealing with a case of 37 potential suspects, not the hundreds seen later.[694]

5.948 Although the MCRT Review noted that the Second SIO "*showed a flexible approach by extending the investigation to include offences from an earlier time period … agreed and overseen by Chief Officers*" it does not address whether inclusion of these offences within Chalice was a sensible way to address them, although it specifically commends the decision to spin off Alpha and Beta. [695]

5.949 The principal focus of the MCRT Review were the victim and arrest strategies. It noted 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 remained who 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 description of a criminal offence.[696]

5.950 The MCRT Review looked at the outstanding 13 people and assessed the impact of the Third SIO's decision that people would not be seen if they were named by third parties and there was no further intelligence to suggest they may be or may have been victims/survivors of CSE: the result was that seven people had been excluded. The remaining six could not be traced.

5.951 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. Of those in respect of whom there was a policy decision not to engage, WMP held information on all but one of the seven.

5.952 It was suggested that it "*may have been preferable*" for the Chalice team to have made contact with the individuals never seen on policy grounds. Without expressly criticising the policy decision, that plainly is a criticism. With the benefit of hindsight, it is a valid one; had the Third SIO known that his policy decision would exclude seven, as opposed to, say 70, he might well have thought differently about it. It was, though, a decision made in the context of a case whose scope had 'exploded' and about which there was evident nervousness at command level within the force.

5.953 The MCRT Review recommended that there should be renewed effort to speak to the six untraced, and so far as the seven not contacted were concerned, there should be a reassessment to decide whether each should be seen, noting:

694 [redacted] and [redacted]
695 and [redacted] pg 6
696 [redacted] pg 18

"*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*".[697]

5.954 The same consideration should be given to those who had indicated they did not wish to pursue cases: that amounted to four individuals.

5.955 As to suspects, the Third SIO had taken the decision that 18 who had been named in Chalice, eight named in Beta and two named in Alpha would not be arrested. There were three separate grounds for this decision, all based around the principle that an arrest made where there is no possibility of a charge being laid would be unlawful; sometimes more than one ground applied in respect of a suspect. The grounds were:

5.955.1 That the victim/survivor did not wish to pursue the complaint against the suspect;

5.955.2 That the victim/survivor had been deemed to be unreliable by the CPS or by the Court; and

5.955.3 That it was not in the victim/survivor's interest to give further evidence.

5.956 The MCRT Review noted that while suspects could have been invited to voluntary interviews at that time, child sex offences generally require the support of a victim to provide evidence. Given that intelligence regarding these men had been accrued and recorded during the course of the investigations, arrest would – even if lawful – have served no purpose. It did not recommend arresting those who had not been arrested unless the decision had been made under ground one, and the victim/survivor had changed their mind about giving evidence.

5.957 I have considered the grounds. The first is unarguably proper. It is for an individual to choose whether to pursue a criminal complaint or not. Providing that decision is not based on myths about the process, which should be corrected by investigators, it must be respected. As to the second and third grounds, they are covered by the nature of the test to be applied by a prosecuting lawyer. That test's fundamentals have not changed during the span covered by this Inquiry and remain to ask:

5.957.1 First, is there a realistic prospect of conviction; and

5.957.2 Second, is it in the public interest to prosecute.

5.958 I have had the opportunity to consider the Chalice charging decisions in the course of this Inquiry. All the decisions seem to me to have been carefully reasoned and their conclusions proper. Where the decision has been that there is no reasonable prospect of conviction based on evidential grounds, the reasons have not been spurious or based in an anticipation of jury prejudice, but resting on fundamental inconsistency or unreliability – for example, irreconcilable inconsistency as to essential parts of the offence alleged, or admissions to

[697] [redacted] pg 30

giving false accounts. The third ground, which is essentially a narrow public interest ground, was based on the proven and seriously traumatic effect of the previous two trials upon a victim/survivor. I deal with this further in the section relating to the CPS at Chapter 6: Other Organisations.

5.959 The MCRT Review also considered the management of suspects not arrested. It agreed that on the legal advice as provided to the Third SIO, civil orders were not feasible, requiring "*each victim to give evidence in court".* Details of all suspects had been referred to Wellington Safer Neighbourhood Team staff, including PCSOs and Special Constables, to gain further intelligence.[698] At the time the MCRT Review was carried out, 27 of the suspects were alive; each was allocated to a Field Intelligence Officer ("FIO") who would have 'favourited' them on the GENIE system and marked them as a potential CSE perpetrator. As a result any NIRs, crimes or arrests involving those suspects will be automatically flagged to 'their' FIO.

5.960 The Chalice defendants (in the sense of those that were charged) had been classed as an OCG in November 2011[699] and as a result came under scrutiny with monthly reporting and a risk scoring regime.

5.961 Insofar as Chalice learning was concerned, the MCRT Review noted – as have I, earlier in this chapter – that no formal debrief took place. It remarked upon the Third SIO's report[700] which it suggested was a factor in the inception of the CSE Team, recommending as it did that "*future focus should be aimed at prevention and intervention for victims which are recognised within the current working arrangements of Telford's CSE team*".

5.962 It further noted that:

"*As a result of the investigations into Child Sexual Exploitation within Telford, a CSE vulnerability team was set up to cover Telford and Shrewsbury in January 2015, as part of an Alliance team consisting initially of a DS and three DCs. Subsequently Telford Policing Area established a full time CSE team… based at Telford police station*".[701]

5.963 It concluded 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*". The MCRT Review did not address the time taken to set up a CSE Team – three years following the Chalice convictions.

5.964 The MCRT Review concluded that:

"*regular operational reviews should take place to ensure that the current CSE response in Telford remains appropriately resourced and maintains effective processes to protect*

698 [redacted] pg 33
699 [redacted] pg 73
700 [redacted]
701 [redacted] pg 38

victims, investigate offending and also to monitor all identified suspects from all CSE cases including Operation CHALICE whether arrested or not".[702]

5.965 I have been told that ongoing monitoring of the scale of CSE is governed by the LSCB (now Safeguarding Partnership)'s CSE Thematic Subgroup;[703] I have not seen material relating to resource monitoring of the CSE Team and I note that, in common with the Council's specialist provision, it now bears responsibility for wider criminal exploitation of children.

Operation Epsilon

5.966 Operation Epsilon ("Epsilon") resulted from WMP's "*reactive investigation into the recent reports of non-recent child sexual exploitation in the Telford area*".[704] It was borne from the declaration by the force of a critical incident following the March 2018 Sunday Mirror reporting of non-recent exploitation in Telford.

5.967 A critical incident is "*any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family and/or the community*"[705]. A Gold Group was simultaneously instigated under a different operational name.

5.968 The Gold Group received an investigative update on 27 March 2018.[706] Epsilon had been created as the investigation; there was a Chief Inspector as the SIO, a Detective Inspector, a Detective Sergeant and six Detective Constables. There had been a 'precept request' and Detective Constables had been nominated from other divisions to be assigned.[707] It was noted that eight or nine people had come forward as victims/survivors of CSE following the newspaper reports, and work was proceeding with a view to:

5.968.1 Identifying the 13 potential victims/survivors who were not contacted as a result of policy decisions during Chalice (as referred to above in the MCRT Review);

5.968.2 Conducting a review of the Lucy Lowe murder investigation in 2000, to consider its approach to potential sexual offending against Lucy prior to her murder;

5.968.3 Ensuring that officers who had worked on Chalice, serving and retired, were to be offered suitable support; and to

5.968.4 Adopting a 4Ps approach to "*continuous improvement*".

5.969 Epsilon's aim was:

"*… to identify the extent of the issues highlighted in the recent press reporting and from the disclosures that had been made to police; to identify potential victims and witnesses*

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https://www.westmercia.police.uk/SysSiteAssets/foi-media/west-mercia/policies/c/wmp-critical-incident-policy-wmp.pdf
[redacted]
[redacted] pg 2-3

of non-recent CSE in the Telford area; 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."[708]

5.970 By the next Gold Group meeting on 17 April 2018, the number of new victims/survivors was said to be 15. Of those, two were willing to give ABE interviews; the remaining victims/survivors did "*not seek criminal justice outcomes".*[709]

5.971 The recommendations of the MCRT Review into Chalice were discussed; it was agreed that the further investigations would be undertaken by Epsilon including checking WMP systems for post-Chalice intelligence.

5.972 Epsilon's Witness and Complainant Strategy[710] separated potential witnesses into three groups:

5.972.1 Complainants and witnesses who were supportive of a complaint/providing evidence;

5.972.2 Complainants and witnesses who were reluctant/undecided if they wish to support a complaint/providing evidence; and

5.972.3 Complainant and witness names who came into the enquiry and would be approached by officers.

5.973 The Witness and Complainant Strategy set out that there should be an assessment prior to any contact with a potential witness. This would involve consideration of "*issues having an impact on their mental or physical health, learning disability, communication skills, safety and welfare*" because it was "*imperative that due consideration is given to the welfare and safeguarding of victims/witnesses in all cases, irrespective of whether or not they choose to cooperate with the investigation".* It recognised, as is proper in my view, that the events under investigation might have had a lasting impact on the survivor's emotional wellbeing and that they may still be suffering from trauma. The strategy acknowledged that "*in these circumstances any contact from the police informing them that an investigation has commenced could open their emotional wounds and exacerbate the trauma".*

5.974 It was therefore stated that officers who were engaged with victims and survivors should continually keep the wishes and wellbeing of the person under review, and must assist them "*to manage their trauma by facilitating their access to support in conjunction with social services and in accordance with the complainant care strategy. This might include a referral to their General Practitioner (GP), a referral to an Independent Sexual Adviser (ISVA) or a referral to local or national support groups*".

5.975 The settled approach of Epsilon was therefore as follows:

708 [redacted]
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"It has been accepted that it may have been entirely appropriate to decide not to contact a potential victim even where firm intelligence or evidence existed if the risk factors involved in doing so were considered to be so severe that they cannot be satisfactorily mitigated. These cases are, however, rare and most potential victims have been contacted where it is has been practical and proportionate to do so."[711]

5.976 The team took the following approaches dependent upon the responses they received[712]:

5.976.1 Where an individual stated that they were not a victim/survivor or witness to CSE – a letter from the SIO was sent to a personal email address, but further engagement with these individuals was not anticipated unless new information was received;

5.976.2 Where complainants and witnesses were supportive of a complaint/providing evidence – the complainant was entered into the criminal justice process as per the Witness and Complainant Strategy; victims/survivors were to be signposted to support services and supported by police as per the Victim's Code. These individuals were noted to "*qualify for an enhanced service*" and a victim/survivor contact strategy should be agreed. The need for additional support should be kept under constant review and dialogue with the ISVA or supporter should be maintained; and

5.976.3 Where dealing with complainants and witnesses who were reluctant/undecided if they wish to support a complaint/provide evidence – these individuals would be offered the opportunity to provide a visually recorded interview (or have their account captured in another formal manner) which can be used as intelligence.

5.977 By July 2018, the Gold Group was told that Epsilon had identified 113 potential victims/survivors; eight were identified by first names only; six were dead. 76 of the potential victims/survivors had been seen by officers, and of those, two individuals disclosed offences and were willing to provide complaints; 22 others had disclosed offences but were unwilling to complain; and ten had disclosed offences and accepted referral to ISVAs[713].

5.978 Epsilon had pursued the recommendations of the MCRT Review; it had traced those whom Chalice had been unable to locate (which included some victims/survivors referred to in D2276, see discussion earlier in this chapter); one chose to make a complaint about a sexual offence committed against her as an adult – and this was passed to reactive CID. 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 individuals disclosed offences which were recorded; three denied being subjected to or having any knowledge of CSE; and one made a complaint involving a number of suspects, of whom five were tried.[714]

711 [redacted]
712 [redacted] pg 4-5
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714 and [redacted]

5.979 As part of Epsilon, 48 potential suspects had been named, 11 by the two complainants willing to give evidence. Intelligence profiles were created on the suspects "*to identify any current safeguarding risks"*[715] and a divisional 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 nominals.[716] 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*".[717]

5.980 I have seen a copy of the non-recent suspect/offender management document which indicates that 28 nominals not arrested had been shared between FIOs; the 13 nominals charged during Chalice itself having been classified as an OCG with implications for regular review.[718]

5.981 The purpose of the exercise was to ensure that any future checks on these individuals would show they had featured in a CSE enquiry.

5.982 Further, a meeting was sought with WMP Legal to discuss civil orders in respect of six nominals.[719] The legal advice received – as previously – was that it was necessary to show recent offending to establish current risk; there was no evidence or intelligence to show any of the individuals considered had been involved in sexual offending for more than eight years, and as a result civil orders were not pursued.

5.983 Several of the suspects had been targets of previous operations and where those investigations were to be reviewed, the Gold Group was told:

"*This is more complicated than originally thought. There are a large number of victims and suspects from the original investigation (with various justice outcomes) and a discussion has been had with CPS about how these could be reviewed. Any review will require a CPS resource uplift. Regarding a joint scrutiny panel… it first needs to be decided what cases to review*"[720].

5.984 The Epsilon investigation resulted in the convictions of four men for offences under the 1956 Act including rape. This was plainly a positive result; it would have been a more positive result had it been pursued by WMP a decade prior.

Conclusions – Investigations Post-Chalice

5.985 The early post-Chalice investigations – Alpha and Beta – arose from enquiries made during the Chalice investigation. The allegations made revealed multiple offenders and identified a great many potential witnesses. In those circumstances, the decision to investigate separately from the ongoing Chalice cases seems to me to have been sensible and properly made in the interests of case management, though I have seen some suggestion that the

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decision was made because of the limitations of the HOLMES lite database used in Chalice; there may be support for that in the fact that both Alpha and Beta employed the full HOLMES system.

5.986 There seems to be little doubt that Alpha itself suffered significant delay in the investigation between October 2010 and March 2011, when a nominally dedicated seven officer team was attached and tasked.

5.987 The reality of the Alpha investigation, even after March 2011, was that it was under-resourced. The SIO was shared with Chalice. Half the team members were working on other commitments. Resources were admitted to be limited. It is no surprise in those circumstances that after an initial burst of enthusiasm, shown by a decision to cast the investigative net widely and look for further victims notwithstanding the limitations observed latterly in Chalice, that focus was narrowed once more. In particular, the decisions not to ask witnesses if they had been victims/survivors of CSE, and not to explore evidence relating to other potential perpetrators with existing victims/survivors, seem to me to be obviously borne from a nervousness about 'mission creep'.

5.988 I cannot conclude that the delay, the under-resourcing, or these policy decisions contributed to the failure of Alpha; the decision was that of the victim/survivor, and it is a decision that I understand she has stood by subsequently. It is perhaps legitimate to note that delay often obstructs complaints in matters of this sort and it is impossible not to wonder what the result may have been had the matter been pursued more effectively at the very outset.

5.989 It is important that I recognise that the SIO recorded that perpetrators identified as part of Alpha who did not feature in other cases would be referred to both police intelligence and to other agencies. Efforts were being made to ensure public protection short of prosecution.

5.990 The victim/survivor in Beta disclosed a staggering almost 100 offences by over 100 men. This, like Alpha, was plainly a case properly investigated separately from Chalice; it deserved long term resources of its own. In fact, Beta shared an SIO with Chalice, and during its currency there had been three different OICs.

5.991 While I accept there is an argument that the Chalice SIO should fulfil the same role in respect of Beta given his familiarity with the genesis of the investigation, it is unlikely that any different or wider approach would be taken by the same officer in this different case, and indeed once again there was a significant trimming of allegations where the complaints were adjudged insufficiently detailed, and without further investigation. The CPS made clear during its consideration of the merits of this case that pruning for efficiency brings its own problems where it involves allegations not being investigated.

5.992 Once again, no further victims/survivors were to be approached: this was explained as being to safeguard the victims/survivors and to ensure that they were not approached 'before they were ready': but in an area of crime where victims/survivors are often reluctant to complain without some support – how, absent an early visit, were the

victims/survivors to know they would be heard, and how were the police to know when the victims/survivors were ready?

5.993 I cannot say that any of these matters would have affected the outcome in Beta; the CPS review of the case was thorough and the difficulties very real. But the fact remains that after Alpha and Beta, real lines of enquiry were not pursued. I am driven to the conclusion that this was part of the close-down of Chalice and its associated cases; and that had a task-based team been created rather than a series of case based teams, those decisions may have been taken differently.

5.994 That CSE had not gone away is shown by Gamma and Delta and the many other investigations carried out by WMP in the 2010s and listed at Appendix J.

5.995 Gamma demonstrated again the gap that had existed in WMP for years: it was not investigated initially by a specialist team but by reactive CID. There had been an assumption that this case followed the Chalice 'gang' model – indeed, the HOLMES system was pre-emptively deployed and a Gold Group was formed - but the later analysis-heavy investigation showed the model to be quite different. Again there was a winnowing strategy, though this was applied after an initial investigation revealed duplication of complaints.

5.996 A stark difference so far as Delta was concerned was that there was no SIO. I regard that as an obvious omission, and have heard evidence to the effect that early tactical decisions needed to be made; not least, liaison with another force. As I have remarked in my analysis of the operation, there was pressure from a senior officer in reactive CID to cede the operation and that, combined with the evidence I have seen about a lack of resources and a determination on the part of the same officer that Delta officers return to their "*day jobs*" leads me to conclude that these decisions were influenced by costs considerations. The fact that the team ignored the directive from above and continued to work on Delta until the CSE Team was formed and able to take it over is in my judgment admirable so far as they were concerned; but it speaks less well of the senior officers in reactive CID or of the organisation as a whole. I take the view that, ten years after the first stirrings of Chalice, WMP should not have been taking officers off CSE cases with a directive to return to the 'day job'; there was more to be done by WMP, and I am fortified in that by the fact that it was WMP who ultimately took a statement from the victim/survivor and then reassumed ownership of the case.

5.997 If these four operations demonstrate a consistency, it is that there remained extreme pressure of resources on CSE investigations post-Chalice. There were still turf wars within reactive CID as to abstractions for these complicated and intensive investigations. There was a still a powerful desire to prune cases even to the extent that the CPS felt compelled to warn that the pruning might itself damage the cause. And all the while, the cases un-investigated at the end of Chalice remained un-investigated. This is a matter I have borne in mind when considering my recommendations for WMP, as set out at the start of this Report.

5.998 I believe there was a desire within WMP to 'move on' from "*the Chalice issue*", which is evidenced by the Third SIO's note that "*those offences which have not been investigated …*

will not be subject to any Major Crime Review" in order "*to effectively manage the high volume of reported crimes*" (as noted above). I do not consider that this was a decision which could realistically have been made by the Third SIO – and subsequently endorsed by a Gold Group - without the encouragement and approval of senior officers. I cannot conclude that there was any sinister intent, or overt directive in this regard; rather it seems to me that the need *"to effectively manage the high volume"* can only be interpreted that this was a decision made either on capability or cost grounds. Whilst I am told that WMP did maintain a system for regularly reviewing cases, I am not convinced that, had it not been for the Freedom of Information requests to review the decisions made at the end of Chalice, the outstanding named victims/survivors would ever have been visited.

5.999 The MCRT's view that it "*may have been preferable*" that the Chalice team make contact with potential victims/survivors not seen on policy grounds should not, in my view, have been expressed conditionally. The MCRT conclusion to review the decision in respect of the 13 was welcome.[721]

5.1000 So far as the MCRT's review of the decision not to arrest those named but not arrested, where there were obvious and compelling difficulties with mounting a prosecution, I consider that it skews towards recommending a useless step: it is in my judgment inconceivable that voluntary interviews would have produced results.

5.1001 The MCRT's conclusion that there should be regular reviews to ensure that the CSE response in Telford is appropriately resourced is one which I wholeheartedly endorse. As I have noted, I have not seen the material to judge whether this monitoring is effective; it seems to me that there needs to be rigorous internal monitoring with reporting to the Chief Constable and the PCC as well as any external monitoring by the Safeguarding Partnership.

5.1002 It is not immediately clear to me why, following the MCRT Review, an Epsilon equivalent was not immediately put in place; it seems to have taken further public scrutiny in the form of the Sunday Mirror report before there was an operational response. It suggests to me that WMP was operating a definition of a critical incident with the following addition (my emphasis):

"*… any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family and/or the community <u>if they know about it</u>*".[722]

5.1003 Epsilon was properly resourced and supported by a Gold Group. Its victim/survivor approach strategy was sensible and proportionate. Its success is shown by the fact that there were complaints from untraced Chalice victims and prosecutions were mounted as a result. The inescapable fact is that while it was a success, it was addressing the years-old failure of the Chalice close-down strategy.

5.1004 These selected post-Chalice operations and reviews demonstrate in my view:

721 [redacted]
722 [redacted] pg 40

5.1004.1 First, that there remained obstacles to the effective investigation of CSE caused by FPU not having investigative responsibility for non-familial cases;

5.1004.2 Second, that CSE cases, being resource heavy, placed pressure on reactive CID, and that this led on occasion to resentment;

5.1004.3 Third, that pressure on resources led to inadequate staffing including failure to appoint SIOs to at least one case which deserved such a role;

5.1004.4 Fourth, that there was in the early 2010s (post-Chalice), a wholesale adoption of the narrow focus that was adopted towards the end of the Chalice investigation;

5.1004.5 Fifth, that the Chalice close-down policy, which I consider must have been mandated at a very high level and certainly above the Third SIO, left CSE cases not properly investigated; and that given the expressed desire to avoid a major crime review, it must have been known that this was the case; and

5.1004.6 Sixth, that though those failures were identified in the MCRT Review they were not properly investigated until the Sunday Mirror investigation spurred the formation of Epsilon.

5.1005 I consider that all these difficulties stemmed from a lack of clarity as to what Chalice was for. It had begun, as I have shown, as an investigation into the Two Mispers. It grew around linked complaints but changed very significantly when it began to consider much earlier complaints. I have sympathy with those who (undoubtedly) took the view that Chalice should focus on those cases where court processes had begun; but what I find mystifying is why Alpha and Beta, while seemingly spun off as case investigations separate from Chalice, in reality shared key personnel but were not given separate resources.

5.1006 I consider that these subsequent operations and the MCRT Review reinforce a conclusion I have previously reached: what was needed after the Chalice convictions was not a series of case-based teams but a task-based team, as was ultimately seen post-2015; there was the plainest need in 2012/2013 for SOIT to survive Chalice, and in the absence of any explanation why it did not, I can only conclude that it was a casualty of the financial circumstances of WMP, and the nascent Alliance, at the time. Insofar as the current CE Team, it is clear that CSE in Telford has not gone away, and I have therefore made recommendations regarding the future provision and resourcing of this team, to ensure it remains capable of dealing with the continuing threat CSE poses to the community alongside other forms of criminal exploitation.

Inspections and Reviews

Introduction

5.1007 There have been numerous inspections and reviews of WMP throughout the period of time relevant to the Inquiry's Terms of Reference, many of which extend beyond the issue of CSE and therefore fall outside the scope of this Inquiry. However, in accordance with the

Terms of Reference, I am required to consider the response of WMP to CSE; the impact of any changes to policy or practice within the organisation and the impact this may have had on the response to CSE; and the extent to which there may have been any organisational or systemic failures in this regard.[723]

5.1008 I have been provided with a great number of inspections and reviews by WMP as part of its Corporate Submission. I have examined all of that material, but focus in this section on those reports which either consider CSE specifically, or relate to the systems and procedures for child protection within WMP into which CSE (or predecessor offences) would have fallen.

5.1009. In my view independent inspections and reviews are important to consider separately as they provide a contemporaneous and impartial measure of performance upon which I am able to rely when considering the acts or omissions of WMP over the years – insofar as CSE is concerned.

5.1010. Where this section refers to reports prepared by Her Majesty's Inspectorate of Constabulary ("HMIC"), more recently referenced reports are likely to be publicly available on the Internet. HMIC is the independent inspectorate of constabulary and changed its name to HMICFRS in 2017, after taking responsibility for inspecting the Fire and Rescue Services.

Pre-Chalice Inspections

HMIC Inspection Report - 1993[724]

5.1011. This report was published following inspections of WMP between 16 and 17 August 1993 (the "HMIC Report 1993"), and is a result of a Primary Inspection by HMIC examining the entire force and "*as many aspects as possible of its organisation and operations*".[725]

5.1012. The HMIC Report 1993 does not explicitly mention CSE or CSA, but comments on the basic infrastructure of WMP with reference to child protection. As noted at the start of this chapter, the divisional structure of WMP moved from three areas to nine sub divisions following a review in 1991 but it was noted by HMIC that *"the 'Area' concept of some support functions continues in respect of child protection…".*[726] The report made no further comment on the impact this 'Area' concept had in child protection investigations.

5.1013. HMIC identified the lack of an established departmental head of the CPU and recommended that the post was created. Inspectors praised the development of *"an impressive advanced course in child abuse investigation to cater for the training needs of Child Protection Units."*[727] These courses included practical and theoretical exercises and had input from the CPS and child psychologists. The report highlights that five police officers and seven social workers were *"jointly trained"*[728] on these courses. There had also been the identification

[723] Inquiry Terms of Reference, 2.6 and 3.
[724] [redacted]
[725] [redacted] pg 8
[726] [redacted] pg 8
[727] [redacted] pg 21
[728] [redacted] pg 21

of five locations to be used as *"sympathetic"* interview suites for obtaining child evidence.[729] This was in line with the move towards the Memorandum Interview approach to child witnesses to be adopted jointly between police and local authorities – indicating that WMP was, at this stage, operating in line with national practice.

5.1014. Following the HMIC Report 1993, there were no further reviews of significance (as far as I have been made aware) which addressed child protection measures within WMP. A further HMIC inspection took place in 1994, however this took the form of a 'Performance Review'; a new concept *"having its roots in the reforms currently taking place within the police service"*[730], and as such was a less detailed inspection than the 1993 inspection that preceded it. It did however acknowledge that a post had now been created for a Head of the CPU.[731]

HMIC Baseline Assessment - 2006[732]

5.1015. The 2006 Baseline Assessment by HMIC (the "Baseline Assessment") was "*designed primarily as a self-assessment, with the degree of validation/reality-checking undertaken by HMIC dependent upon a force's overall performance and the rigour of its internal assessment processes*". Seven 'baseline' areas were designated as "*priority for validation*" assessment, including protecting vulnerable people, defined as:

5.1015.1 Child abuse

5.1015.2 Domestic violence

5.1015.3 Multi-agency public protection arrangements/sex offender management

5.1015.4 Missing persons.

5.1016. So far as child protection was concerned, the Baseline Assessment noted that strategic leadership of the FPUs fell to an Assistant Chief Constable and that 17 additional posts had been created to support child abuse investigations. Multi-agency working arrangements between the five FPU teams and the four local authorities across the WMP force area had been established. Nevertheless the Baseline Assessment 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. Some inconsistencies in supervision and corpocracy demand attention, together with problems in the abstraction of specialist officers to general crime duties … BCU 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".[733]

729 [redacted] pg 21
730 pg 6
731 pg 19
732
733 pg 49

5.1017. The Baseline Assessment's conclusion matches the perception of at least one officer working within the PPU, who thought it "*hopelessly under-resourced … hopelessly inadequate for the amount of work*", though he conceded that WMP's response to the Baseline Assessment, and the changes made at the time brought by the appointment of a Detective Superintendent to head the PPU at Hindlip, transformed Telford's PPU, with staff numbers virtually doubling within a matter of a few months.[734]

5.1018. With reference to WMP's response to child abuse specifically, the Baseline Assessment noted:

> *"… the force has established a clear accountability framework and policy for the investigation of child abuse, but the highly devolved nature of the organisation has led to an inconsistent approach across BCUs on issues such as staffing levels, supervisory ratios and the management of workloads. No information was available to establish accurately the workloads of officers within these units to ensure that they are manageable. BCU commanders would be assisted in their determination of resource levels by clearer guidance and more robust monitoring by the force on acceptable workload levels for officers working in this high-risk area.*
>
> *Some BCUs are reported to be abstracting FPU officers for other duties such as burglary initiatives, or leaving vacancies unfilled. Given the high risk nature of these roles, the force should revise these approaches as a matter of urgency and issue clear guidance to BCU commanders on abstraction and vacancy policy*".[735]

5.1019. So far as public protection arrangements were concerned, the theme of concern in respect of staffing levels was repeated:

> *"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. It is difficult to determine reliably the actual workload of the public protection unit officers but on one division a detective constable carries a caseload of 120 RSOs and 30 PDOs. While there is currently no agreed national benchmark, the ACPO portfolio lead suggests that an officer should not be required to manage more than 50 RSOs per year, and that the number supervised should not include more than 20% very high or high risk sex offenders. 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".*[736]

5.1020. This finding corroborates the account of a witness who worked in offender management, who expressed concern that the unit had been considerably stretched, with insufficient staffing levels and increasing case numbers.

5.1021. It was also identified that WMP had no overall policy for public protection which was required *"as a priority"*. I note, though, that WMP did have a specific Child Protection Policy in place

734 [redacted] pg 5
735 [redacted] pg 50
736 [redacted] pg 51

from 2004 (the CPFP 2004 as referenced earlier in this chapter).[737] It is not clear to me the extent to which the absence of any wider policy would have impacted upon WMP's provision for victims of CSE, however.

5.1022. At the time of this Baseline Assessment, WMP had implemented the COMPACT system for managing missing persons (discussed in more detail later in this chapter) - a core part of police public protection work – and whilst the assessment was positive on this particular aspect, WMP's overall grade for protecting vulnerable people was found to be 'Poor' – one of only eight forces in the country to receive this rating, with the vast majority (32) presenting as 'Fair'.

5.1023. The Baseline Assessment found that WMP's standards had "*declined*" – which, according to the interpretation section of the assessment, means a "*significant decline in the performance of the force*". 'Poor' 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*" or a failure to achieve a "*dominant criterion*".[738]

5.1024. The Inquiry heard evidence from one senior officer confirming that the overall 'poor' rating for this Baseline Assessment forced WMP to *"invest time and energy into focussing on really seeking to understand the complexities of this area of policing".*[739] A strategic project around public protection was developed and the Detective Superintendent in 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".*[740]

5.1025. I have considered the findings of this independent Baseline Assessment against the backdrop of witness evidence obtained by the Inquiry, and in particular that of officers working within FPU during this time. Taken together, it is clear that WMP's approach to the protection of vulnerable people, including children, fell well short of the required standard at a time when, it has become clear, CSE was rife in Telford. The evidence suggests there were issues with workload and staffing levels within FPUs – and recalling what I have already said in this chapter about FPU only considering inter-familial abuse – it is clear that CSE was not being addressed at all within the PPU at this time.

5.1026. I have considered an action plan created by WMP in 2006,[741] designed to address the identified failings in their approach to protecting vulnerable people, and note that this action plan identified a number of objectives and associated actions, albeit I am unable to comment on whether all such actions were closed out. To select a few which I consider relevant, these included:

5.1026.1 A review of policy, procedure, practices and systems including:

- Reviewing and signing off the Child Protection Policy and Procedure.

737 [redacted] pg 6
738 pg 8
739 pg 8
740 pg 9
741

- Considering the need for an overarching Public Protection Policy.
- Reviewing and updating Policy and Procedure on Managing Sex Offenders.
- Reviewing and updating Missing Persons Policy and Procedures.

5.1026.2 Improvements in leadership aims and objectives including:

- Establishing a monthly strategic PPU meeting, chaired by a Superintendent in Public Protection.
- Arranging and completing an awareness day for PPU staff;

5.1026.3 Conducting a review of workloads, crime and recording levels;

5.1026.4 Carrying out a review of staffing levels with a comparison to other forces;

5.1026.5 Conducting a skills audit of staff with training requirements to be reviewed against current skills including delivering force training in respect of specialist child abuse investigation; and

5.1026.6 Carrying out an audit and review of the PPU including:

- A review of the current performance management framework, including divisions to identify best practice;
- A benchmark exercise of the framework against others forces identified as 'Good'; and
- A review of the management of the PPU by BCUs.

HMIC Inspection Report – 2008 - Major Crime[742]

5.1027. This Inspection (the "2008 Inspection") assessed the effectiveness and efficiency of WMPs Major Crime response. It followed a change by HMIC in the way that it would carry out inspections, instead focusing on specific areas for review rather than wholesale force performance. The first phase of reviews in 2008 therefore sought to focus on "*major crime*" – defined by HMIC as that which "*will normally require a force to set up a major incident room*" and "*includes any investigation that requires the deployment of a senior investigation officer and specialist assets*". This included rape and serious sexual offences, but there is no explicit mention of CSE.

5.1028. As part of the review, it was acknowledged that "*significant progress*"[743] 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*

742 [redacted]
743 [redacted] pg 9

protection in 2007".[744] Additionally, it found that in 2007, the decision to combine ANPR resources and intelligence officers into one unit ensured that intelligence hits concerning offences including serious sexual assault and vulnerable missing persons were actioned.[745]

5.1029. However, I found the following findings as areas "*for improvement*" to be relevant in the context of CSE investigations. The 2008 Inspection found 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

"While established relationships with other agencies exist at divisional level, major crime intelligence is not effectively shared outside statutory arrangements".

5.1030. It is notable that the 2008 Inspection took place just a few months after WMP completed its 'Building Protective Services' review - a two year programme commenced in 2006 which saw a commitment from the (then) Police Authority to invest £2.9 million in a number of crucial policing areas, including serious and organised crime; critical incident; and major crime. The timing of that two year programme is noteworthy; it began in the same year as the HMIC inspection on Protecting Vulnerable People which resulted in the increased resources, and effort, in PPU referred to above.

5.1031. I have seen an update on this programme written by WMP in January 2008[746], which indicates resource enhancements to the FIB, SOCU, CAB and MIU departments, and the newly established MCRT; yet there is no mention of funding being directed to any core child protection areas, despite the 'Poor' rating of the Baseline Assessment two years previously. This is acknowledged by the HMIC:

"Since the publication of the HMIC baseline assessment in 2006, where WMC was assessed as Poor in protecting vulnerable people, significant investment has been made in staff resources and improvements in working practices. The potential links between child abuse, domestic abuse, public protection and missing persons and major crime are now widely understood, and analytical support has been provided to target the most serious offenders. The level 2 TTCG [Tactical Tasking and Coordination Groups] *includes monitoring of sex offenders*".[747]

5.1032. However, when it comes sexual offences specifically, the 2008 Inspection identified that "*out of hours access to trained sexual offences liaison officers (SOLOs) is extremely poor and means that many victims of such offences are not allocated an officer who has received specialist training*". Whilst this finding is not specific to child sexual offences, I note and agree with the concern expressed in the report that "*most rape offences occur at a weekend*"; this was certainly so in the case of children in Telford, as the evidence showed that many children went missing and were exploited overnight or at weekends. The 2008 Inspection went on:

744 [redacted] pg 9
745 pg 30
746
747 [redacted] pg 33

"Current practice is for criminal investigation department (CID) officers to be used as hybrid SOLOs in some cases, but this presents a significant risk. It is acknowledged that a rape steering group has been set up under the chair of the ACC (specialist operations), with a dedicated DS appointed, but urgent steps should be taken to redress this situation and ensure that victims have acceptable access to trained officers at the time of reporting a sexual assault, to secure and preserve evidence and to provide the specialist advice necessary to the victim and investigating officers".[748]

5.1033. Indeed, it is this area that is highlighted as the sole, urgent recommendation in the 2008 Inspection report:

"Urgent steps should be taken to ensure that victims of rape and serious sexual assault have acceptable and timely access to trained officers at the time of initial reporting, and effective co-ordination and supervision of SOLOs should be implemented".

5.1034. Further, insofar as dealing with a major crime investigation (which I would take to include the investigations into the murder of Lucy Lowe and her mother and sister in 2000, and the death of Becky Watson in 2002):

"… the inspection teams found insufficient investigative capability in the force MIU to meet the predictable major crime investigation demands without the need to precept staff from divisions".[749]

5.1035. I pause to remind myself that some officers serving in Telford in the late 1990s attributed their ignorance of the 'child prostitution' intelligence reports to being abstracted to major incidents and away from their 'day jobs'.

5.1036. This was perhaps a premonition of what came to pass only a year or so later; the 2008 Inspection is of course right at the time when Chalice intelligence gathering was apace, and concerned officers were dealing with the Two Mispers and liaising closely with the CATE Team. To this extent, I have already commented that those concerned individuals were clearly identifying children involved in CSE as highly vulnerable and were, insofar as it was within their gift to do so, attempting to protect those vulnerable children from harm. However it appears that the structures around those officers, both in terms of PPU and major crime provision, despite improvements since the Baseline Assessment, were still not geared up for dealing with the type of investigation required in response to complaints of CSE.

2009 to 2013

5.1037. From information provided to me by WMP[750], I have seen that a number of further inspections took place in relation to child protective services – but not for some years, after

748 [redacted] pg 32-33
749 pg 46
750

the conclusion of the Chalice trials in 2012, and with the commencement of the Alliance with Warwickshire police, which had significant financial consequences for WMP as a whole.

5.1038. I am reminded that it was in this same year, in 2012, as part of the new Alliance arrangements, WMP set out a CSE Position Statement confirming that "*agencies which do not proactively look for child sexual exploitation will as a result fail to identify it*", and indicated that responsibility for the overall direction of the Alliance strategy to combat CSE "*will lie with the PVP strategic lead*". It also "*identified the need to develop a force procedure for the investigation of CSE related offences, informed by the lessons learnt both locally e.g. Chalice, and nationally through SCRs and thematic assessment e.g. Rochdale LSCB and CEOP Out of Mind, Out of Sight*".[751]

5.1039. Notwithstanding these recommendations it was, in fact, to be three years before the formation of the CSE Team.

5.1040. I understand that the first focused inspection of child protective services took place in 2013 and was a joint inspection of multi-agency child protection arrangements; although I have not been provided with a copy, I am told that this was a "*pilot inspection that took place in Herefordshire*" rather than Telford.[752] However, I find it relevant for WMP as a whole that the inspection found that "*CSE was now regarded as a priority in West Mercia albeit in the early stages of development*", and that, whilst COMPACT was identifying children regularly going missing "*it was unclear how this information is being used for child protection purposes*". Specifically, it stated that "*despite a number of children being identified as having gone missing in excess of three occasions no further assessment or harm reduction activity was instigated*".

5.1041. Given WMP's experience with Chalice, that failure to respond to missing episodes with assessment or harm reduction activity is an astonishing omission, leading inevitably to the conclusion that the lessons of Chalice had not been learned and the expertise of the officers involved was not being adequately employed.

Post-Chalice Inspections

5.1042. From 2014 HMIC began to carry out National Child Protection Inspections across all police forces. I comment below on those relevant to WMP.

HMIC - National Child Protection Inspection[753] – November 2014 (the "2014 HMIC Inspection")

5.1043. Prior to the inspection in 2014, WMP carried out a self-assessment of 33 cases against the HMIC criteria. 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

751 [redacted]
752 [redacted] pg 2
753 https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/west-mercia-national-child-protection-inspection.pdf and [redacted] pg 32

inspection and viewed only seven as 'Good', nine as 'Adequate' and 17 – almost half - as 'Inadequate'.

5.1044. WMP told the Inquiry that a number of these cases had an element of CSE, as they related to missing children or internet offending, but were "*not handled well*".[754] There was also an audit of five cases where children were categorised as at risk of CSE, of which HMIC assessed four as 'Inadequate'.

5.1045. In one audited CSE case, a child in care went missing and officers identified her at risk of CSE. The case was passed to PVP, but based on WMP's procedures at the time should have gone to reactive CID, as it was not an intra-familial incident. The missing person's report mentioned the child's presence at an address with a convicted male sex offender. The audit form states that officers took no positive action to arrest the male or obtain any evidence of potential offending. Although officers made various attempts to engage with the child to obtain her version of events, the child did not wish to speak with the officers or support police action and so the investigation was not proceeded with. The suspect went on to breach his Sexual Offences Prevention Order ("SOPO") after contact with other children led to images being recovered from his mobile phone. It was also discovered that other children had stayed at the suspect's address in breach of his SOPO. The perpetrator was charged and remanded in custody. The case was judged as 'Inadequate', on the basis that a convicted sex offender continued to exploit and abuse children but was not arrested for an offence against the child in this case. Proactive steps were not taken when it was established the male had committed an offence by breaching his SOPO that prohibited the child from being inside his address.[755]

5.1046. Critically, this inspection identified that "*poor investigations were particularly noticeable in cases of child sexual exploitation*".[756] 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*".[757]

5.1047. As a result the 2014 HMIC Inspection recommended that:

> "*West Mercia Police immediately reviews cases where children have been identified as being at risk and, with partner agencies, takes appropriate action to safeguard the children. Further recommendations, specifically including reference to CSE, called for improvements in referral allocation, investigation planning and supervision*".[758]

5.1048. The HMIC expressed the view that the development of HAUs was a step in the right direction, but they were backlogged with cases and had been introduced without sufficient

[754] https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/west-mercia-national-child-protection-inspection.pdf - pg 12 and [redacted] pg 6
[755] [redacted]
[756] https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/west-mercia-national-child-protection-inspection.pdf, pg 14 and [redacted] pg 6
[757] https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/west-mercia-national-child-protection-inspection.pdf, pg 13 and [redacted] pg 6
[758] [redacted] pg 6

attention to purpose and/or remit. This inspection also noted that WMP had committed to fund a police CSE team in recognition of its poor response – but that it had not yet done so at the time of inspection. It further recommended, as a result, that WMP should "*evaluate the impact of its investment in tackling CSE within six months*".[759]

5.1049. I believe this was not before time. I have seen material in which the Warwickshire CSE Coordinator responds to a Telford complaint about the lack of a dedicated CSE team as follows, suggesting that funding for CSE provisions was an issue across the board:

> "*We are experiencing similar issues in Warwickshire due to a lack of dedicated resources. Most of our success is down to the hard work and commitment of people working well outside of their 'remit' and day job to attempt to provide some sort of CSE service in Warwickshire*". [760]

5.1050. In addition to reviewing all cases where children had been identified as at risk, WMP was also required to take immediate action to engage further with the Council and LSCB to address additional concerns relating to strategy and provision.

5.1051. Within three months, the 2014 HMIC Inspection required WMP to ensure that:

5.1051.1 All child protection allegations were referred to and assessed by knowledgeable and experienced staff;

5.1051.2 Steps were taken to eradicate the backlog of cases in the HAU including the implementation of systems to ensure cases could be assessed quickly;

5.1051.3 Action was taken to improve child protection investigations, including CSE. Within this it was emphasised that changes should ensure that:

5.1051.3.1 Every referral received was allocated to a team with the correct skills and competence to conduct the investigation;

5.1051.3.2 Investigations were properly planned; and

5.1051.3.3 Investigations were supervised and monitored with further action and evidence required identified.

5.1052. Recommendations to address within six months included the general evaluation of WMP's investment in tackling CSE, in particular, how changes would lead to improved investigations, protective plans and greater confidence in WMP by children at risk.

5.1053. HMIC left WMP with no uncertainty as to how seriously it took these findings. It mandated that WMP must provide HMIC with an update as to its response to the 'immediate actions' within six weeks, together with an action plan as to how it planned to address the remaining recommendations within the three and six month periods. I have not reviewed WMP's

759 [redacted] pg 6
760 [redacted]

response or action plans which were submitted to HMIC – but instead, I have reviewed the 'summary' provided to the Inquiry as part of WMP's Corporate Submission.[761]

5.1054. I view the findings and recommendations of this report to be particularly disappointing, given the experiences of WMP, for example, in the Chalice investigation. The necessity for a bespoke CSE team, particularly covering areas like Telford, was without question, and there should have been no need for a HMIC inspection to trigger the process of reform. Indeed, the SOIT team, established during the period of Chalice, had demonstrated the importance and benefits of dedicated resources in CSE investigation.

5.1055. The fact that HMIC identified WMP CSE investigations were particularly poor, including an enormous deficiency in the way in which CSE cases were flagged is indefensible. It suggests 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.

HMIC - National Child Protection Inspection – Post Inspection Review – August 2015 (the "2015 HMIC Post Inspection Review")[762]

5.1056. WMP provided HMIC with an action plan in March 2015 – which I presume was that originally required within six weeks – which WMP says outlined its proposed response to the findings and recommendations in the 2014 HMIC Inspection. This post-inspection review was then carried out by HMIC in August 2015 to "*assess progress with the implementation of the recommendations*".

5.1057. The 2015 HMIC Post Inspection Review identified that "*WMP had prioritised child protection … and the force had a strong desire to improve the outcomes for children at risk of harm*". It also identified that WMP "*had invested significant extra resources into child protection*", and had reviewed its public protection structures and systems. Whilst some of these structures were not yet in place, the Review praised the fact that WMP had been successful in "*eliminating completely a backlog of works in the HAUs, which was a significant achievement*".

5.1058. Whilst steps had been taken to address the recommendations from November 2014, the 2015 HMIC Post-Inspection Review concluded that "*challenges remained*" for WMP and "*the force would need to maintain the current focus and momentum of improvement for some time to come*".

5.1059. There remained concern from inspectors surrounding the HAUs, whose assessments often lacked detail and whose recording of plans for multi-agency response was often poor. Whilst it viewed the development of a MASH as a pleasing step, the Inspectorate found that in terms of multi-agency working:

> *"Joint planning of investigations, with children's social care services and other partners, was not fully effective. Inspectors found few strategy discussions taking place at the start*

[761] [redacted]

[762] https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/west-mercia-national-child-protection-inspection-post-inspection-review.pdf and [redacted] pg 10

of incidents to agree both safeguarding measures and how to progress the case on a multi-agency basis".

5.1060. The 2015 HMIC Post-Inspection Review noted certain improvements, including the creation of the dedicated CSE Team, and the allocation of CSE Coordinators who were tasked with assessing investigations and developing risk management plans for the safeguarding of children. It noted that steps had also been taken to improve child protection investigations, including CSE, and cases were allocated to staff with appropriate skills, however the supervision of these investigations was not always adequate.

5.1061. During this review, then Inspectors assessed seven cases where children were categorised as being at high risk of CSE: WMP's approach was considered 'good' in three cases, 'requiring improvement' in two cases and 'inadequate' in a further two. It is not clear to me what those cases were, nor why HMIC found four of the seven as not up to scratch. However, no further recommendations were made as a result of the 2015 HMIC Post Inspection Review, and WMP was advised to "*continue to make progress against those areas identified in the original inspection*" from 2014.

Response of the PCC

5.1062. The PCC is required to publish its response to such reports.[763] The Inquiry has seen the response of the PCC to the 2015 HMIC Post Inspection Review findings and recommendations in a letter to the Home Secretary dated October 2015. It states[764]:

> *"There are also areas for improvement highlighted within the report and I am aware that since the initial inspection findings and the reports* [sic] *publication earlier this year there has been a focus of activity to address the issues raised. The force has reviewed its structures, systems and processes and has been able to invest significant extra resources into safeguarding and child protection, including the release of additional funds by myself and the Warwickshire Police and Crime Commissioner. This has enabled dedicated Child Sexual Exploitation (CSE) teams to be established, with CSE coordinators in place across the force area. These teams are able to manage higher risk CSE investigations and provide support for lower risk investigations allocated to non-specialist teams.*
>
> *Overall I am reassured that the force has taken steps to address all of the recommendations set out in the report, however there is still work to be done to fully implement all the improvements required to protect children from harm. In particular, the establishment of Multi-agency Safeguarding Hubs across the force area has yet to be completed and I shall be pressing the police and partners to ensure all the hubs are up and running as soon as possible".*

5.1063. Whilst WMP had made improvements and acted in response to the recommendations from the 2014 Report, it is concerning that after such a long-running CSE investigation as

[763] Section 55 of the Police Act 1996
[764] [redacted] pg 22

Chalice, and the damning findings by the HMIC, WMP did not achieve a more encouraging result in the assessment of the seven audited CSE cases.

Police Foundation Review - Report on the Alliance 2014 (the "2014 PFR")[765]

5.1064. In September 2014 this review by the Police Foundation noted that:

> *"The Alliance seems unbalanced in respect of transparency and devolvement, partly because Warwickshire was a highly devolved force and West Mercia was gripped from the centre, especially on finance and staffing issues. The Alliance exhibits both characteristics but not necessarily in the right ways …*
>
> *The West Mercia culture is characterised as more traditional, hierarchical and deferential with a tendency towards risk aversion".*

5.1065. The 2014 PFR further noted that there had been a redistribution of resources across protective services - including PVP - from "*over-provisioned*" West Mercia to Warwickshire. The 2014 PFR did sound a cautionary note, though, in respect of the *"… anticipated steep increase in demands on PVP".*

5.1066. Notwithstanding the 2014 PFR findings, I heard evidence that at this time "*PPU numbers were always stretched*" and resources were *"flexed"* to abstract reactive CID officers to PPU investigations, causing some resentment.[766]

5.1067. In particular, I heard an account, previously mentioned, of Telford relinquishing a joint investigation with WMiP because a reactive CID Detective Inspector had 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*".[767]

HMIC Inspection - Crime - 2014[768]

5.1068. HMIC's Crime Inspection Report of 2014 remarked upon a lack of access to officers specially trained in child protection at the weekends. It was suggested by the PCC that a change in working practices, rather than recruitment, alteration of shift patterns or an on call response would remedy the situation:

> *"One concern highlighted in the report was the lack of access to specialist skills to investigate child protection cases over the weekend. I understand that at present many specialist officers working hours are aligned to partner agencies work and availability, which is primarily 9-5 Monday to Friday to train more specialist officers, alter shift patterns or provide some form of 'on call' service are all possible solutions, but a more measured and longer term solution will be to ensure that the demand work being undertaken for the alliance change programme, captures these issues and that moving forward the policing*

765 [redacted] pg 39
766 pg 12-22
767
768 [redacted] pg 26

model designed provides adequate resilience in this area. I will be ensuring this happens as part of the bigger programme."[769]

5.1069. Part of that proposed change appears to have been the creation in 2015 of the dedicated CSE Teams in the North and South of West Mercia, as set out below.

College of Policing - Warwickshire and West Mercia Alliance – CSE Peer Review – 2 – 5 February 2015 (the "2015 COP Peer Review")[770]

5.1070. This peer review took place at the request of the Alliance in 2014. A peer review is an independent review conducted by a separate force or organisation. Its aim was to assess the capability of the Alliance to deal with the threat of CSE. The Review Team assessed the Alliance position with reference to the ACPO National Action Plan of 2013 and HMIC review criteria. This review examined how the Alliance responded to CSE and assessed its engagement with partner agencies. It also examined the support provided to victims/survivors of CSE and preventative measures implemented.

5.1071. The findings of the 2015 COP Peer Review identified that the Alliance recognised and was committed to the National Action Plan, with the establishment of specialist CSE Teams and a commitment to provide appropriate CSE training for front line staff. The 2015 COP Peer Review also indicated that the PCC showed a commitment to tackling CSE in relation to partner funding and additional funding for resourcing CSE investigation.

5.1072. The findings also identified a wish to standardise processes across partnerships with a view to ensuring consistency in how victims, risk and services were identified. It was acknowledged by the Alliance and its partners that more work was required to support the child and understand the issues surrounding vulnerability and sexual exploitation.

5.1073. Good practice was identified, particularly in Warwickshire, with co-location working and Barnardo's providing bespoke multi-agency training. Both police officers and staff in specialist teams within Warwickshire reported they had received good quality CSE training. In particular, this review found evidence of good multi-agency working in Warwickshire that supported vulnerable children and provided a pathway for disclosures of CSE, intelligence gathering and prevention.

5.1074. The 2015 COP Peer Review also identified a number of areas for development:

5.1074.1 The Review Team found that there were a number of risk assessment tools available across the Alliance for recognising CSE vulnerability – but that there were concerns over the "*level of awareness and knowledge of CSE within frontline response teams and safer neighbourhood team staff*".[771]

5.1074.2 It noted that the approach to training on CSE worked predominantly on a cascade model, the result of which meant that not all frontline police staff had received any training in relation to CSE and were not clear about their role in

769 [redacted] pg 6-7
770 [redacted] and [redacted]
771 [redacted] pg 13

tackling the issue.[772] Additionally, it was noted that there was little knowledge within WMP, at that stage, about the prevalence of 'peer on peer' abuse and other forms of exploitation that were on the rise (including online grooming, group exploitation and county lines, which may also incorporate elements of sexual abuse and exploitation) and that there may be a culture of not recognising the nature of such disclosures when made by a child. This is a view that was echoed to me by a member of the CATE Team, who explained that new forms of 'criminal exploitation' such as county lines became much more prevalent within Telford, and became an increasing issue for both Safeguarding and the police.[773]

5.1075. The 2015 COP Peer Review went on to say:

> "*The Review Team found that those staff within specialist CPUs had more experience of training on CSE and vulnerability more generally than investigators located in main CID units. This disparity concerned the Review Team given that a significant proportion of CSE incidents which occur "out of hours" are taken up by CID officers*".[774]

5.1076. It was recommended that a training programme for CSE across the Alliance should be multi-agency training, and delivered in person.

5.1077. Other areas identified in the Alliance response to CSE which required development included:

5.1077.1 A lack of clarity was identified concerning arrangements for supporting victims/survivors of CSE. Victims/survivors flagged with CSE markers who required support had a number of pathways to services and policing platforms that created confusion. In light of this, the 2015 COP Peer Review identified that referral and safeguarding processes needed to be aligned to ensure that vulnerable children received a consistent service. The review recommended that the Alliance required a consistent CSE risk assessment process.

5.1077.2 A significant gap was identified in services to victims/survivors of CSE, with particular reference to those who reached the age of 18 with no additional health issues. In these cases, the 2015 COP Peer Review identified that there was a loss in specialist service. Additionally, it was identified that "*drawing in victim support services further and ensuring they feel valued as partners will improve the overall support provided to vulnerable children and young people*."

5.1077.3 The five LSCBs did not express an 'appetite' for alignment as they perceived the public wanted local focus. An Independent Chair of a CSE Alliance was preferable to a police officer to avoid too much focus on policing. Partnership 'buy in' was identified as essential to the future success of the CSE Alliance.

772 [redacted] pg 14
773 [redacted]
774 [redacted] pg 23

5.1077.4 There were limited examples of CSE collaboration across the LSCBs. The 2015 COP Peer Review identified that more collaboration would ensure that best practice was embedded and costs of some services shared.

5.1077.5 There should be supervisory review of CSE investigations, which should be planned on a multi-agency basis. A number of issues, including the provision of live link evidence and the requirement of intermediaries for children under 11 years old required review to ensure they were best utilised. The link between delay in investigations and increase in attrition rates for victims/survivors was highlighted.

5.1077.6 There was uneven progress across the Alliance with reference to prevention activity and awareness raising. The Warwickshire OPCC had provided funding for awareness campaigns to commence March 2015.

5.1078. The Inquiry has heard evidence from a witness who was a senior police officer at the time the 2015 COP Peer Review was published.[775] He recalled reviewing the recommendations and agreed that its findings were an accurate reflection of the situation within the Alliance. He agreed that there were gaps in services for victims of CSE and viewed the recommendations for a more collaborative and multi-agency approach as sensible.

5.1079. A different witness, who was also a police officer at the time of the 2015 COP Peer Review, told the Inquiry that partner agencies in Warwickshire and West Mercia did not have the *"appetite"* for a consistent approach to CSE. [776]

5.1080. WMP has informed the Inquiry that, in response to the issues raised in the 2015 COP Peer Review, a Detective Inspector with specialist CSE experience was appointed as the Alliance lead for CSE. As part of this role, they would manage three CSE hubs and the CSE Delivery Plan. In addition to this, CSE Co-ordinators were introduced into Alliance CSE Teams supported by a Warwickshire CSE practitioner to assist in implementing best practice. [777]

5.1081. The National Child Protection Inspections 2014 and Post Inspection Review in August 2015 have already been discussed in this section of the Report. The deficiencies in the response to CSE had already been identified, but the evidence suggests critical issues remained in certain areas including resourcing, supervision and training. The analysis of the 2015 Post Inspection Review identified that the quality of WMP's response to high risk CSE cases was still concerning.

775 [redacted] pg 10
776 pg 64
777 pg 40

Missing children; who cares? The police response to missing and absent children – 2016 (the "2016 National Misper Review")[778]

5.1082. In March 2016, HMICFRS – previously HMIC, published this report on the police response to missing and absent children.

5.1083. The 2016 National Misper Review was not focused on the response of WMP, but a report to highlight the policing response to missing children across England and Wales. The report outlines research conducted by the University of Portsmouth's Centre for the Study of Missing Persons (the "Centre"). The Centre conducted research into the cost of police investigations into missing episodes using information from West Mercia and Warwickshire police forces.[779] The research found that half of WMP investigations concerned individuals who had gone missing on at least one prior occasion.

5.1084. With reference to wider investigations into CSE, Chalice was identified. The 2016 National Misper Review outlined that Chalice was *"supported by force-wide training and awareness raising and use of intermediaries and missing person co-ordinators. Although investigations were undertaken by specialists, the raised level of awareness across the force meant that the work was better coordinated and more cases were recognised."*[780]

5.1085. This report highlighted the link between missing episodes and sexual exploitation. Additionally, whilst acknowledging the time demand on responding to investigations into missing individuals, the 2016 National Misper Review identified the extremely serious consequences of failing to investigate, including leaving some children at risk of exploitation. HMICFRS used research of experiences gained by children in relation to police contact, and whilst there were some positive responses, the evidence demonstrated negative experiences by children in most cases.

5.1086. The 2016 National Misper Review identified areas for improvement in police practice which, due to the link between missing persons and CSE, was highly relevant to any police CSE response. In summary, the areas for improvement across police forces in general were as follows:[781]

5.1086.1 Ensuring accurate data on the nature and scale of the problem with missing children and their exposure to CSE.

5.1086.2 Addressing inconsistencies with risk assessments including:

- Confusion over the use of absent and missing categories.
- Incorrect risk grading leading to delay in response.

[778] https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/missing-children-who-cares.pdf and [redacted] pg 13
[779] Pg 28 of https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/missing-children-who-cares.pdf.
[780] Pg 44 of https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/missing-children-who-cares.pdf.
[781] Pg 58 of https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/missing-children-who-cares.pdf.

5.1086.3 Inconsistent standards of investigations.

5.1086.4 Negative attitudes towards missing children.

5.1086.5 Return Home Interviews/Safe and Well checks not being used effectively.

5.1086.6 The identified link between CSE and missing episodes not being addressed by police forces through planning activities.

5.1087. The 2016 National Misper Review also contained one recommendation for Chief Constables:

> *"By September 2016, chief constables should ensure that information management processes are in place which focus on outcomes for children who go missing, and to provide better analysis to understand the effectiveness of the police and multi-agency responses. Information should include the diversity of the communities the forces serve."* [782]

Protecting Vulnerable People - Review of Child Sexual Exploitation (CSE) in the Alliance – September 2016 (the "2016 PVP Review")[783]

5.1088. This internal review by WMP was intended to explain the Alliance response to CSE, and to review the position after the 2015 COP Peer Review. Additionally, the HMIC PEEL Inspection in 2015 had identified that whilst there had been an *"encouraging start"* in tackling CSE the missing persons processes gave rise to a 'Cause of Concern' and to associated recommendations (see further below).

5.1089. The Alliance CSE staffing structure was highlighted in the 2016 PVP Review. The CSE response was split into three teams. Warwickshire, West Mercia (Shropshire, Telford & Wrekin) and West Mercia (Worcestershire and Herefordshire). Each team had an individual CSE co-ordinator but all three were line managed by the same Detective Inspector.

5.1090. The 2016 PVP Review identified a *"lack of clarity or process around performance/demand"* in its CSE response.[784] CSE markers were used on systems where there was a CSE crime/incident, but the accuracy of this data was dependant on the individual officers applying the marker to the correct offences.

5.1091. A difficulty in the application of CSE markers was identified, with markers not always being attributed to CSE offending, resulting in the organisation being at risk of *"not fully understanding demand in this area".*[785]

5.1092. Safeguarding was not a recognised outcome and could not be used as a performance measure, but an 'Activity Tracker' was introduced in July 2016 that *"showed disruption to*

[782] Pg 64 of https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/missing-children-who-cares.pdf.
[783] [redacted]
[784] pg 12
[785] pg 12

perpetrators".[786] However, the 2016 PVP Review made clear that this tracker could not be used as a measure of performance.

5.1093. The 2016 PVP Review identified a number of areas for development in the Alliance CSE response, including:

5.1093.1 A lack of consistency in CSE preventative work.

5.1093.2 A lack of intelligence collection.

5.1093.3 Little progress regarding perpetrators and diversionary opportunities.

5.1093.4 There would be benefit in standardising good partnership working across the Alliance requiring the 'buy in' of numerous local authorities.

5.1093.5 Warwickshire was the only CSE Team with fully integrated analytical support. This review indicated that this should be considered in West Mercia, providing greater understanding of issues like threat and risk of CSE.

5.1093.6 The statistics indicated that between 50% and 65% of missing individuals had a CSE profile. Missing Coordinators could be located with CSE Teams to share information and work in partnership.

5.1094. These areas for development in the 2016 PVP Review tend to suggest that a number of perennial deficiencies had not been solved. Lack of intelligence, lack of diversionary work, lack of analysis of the problem and lack of a clear performance framework were all issues which had been apparent for years. By way of a single example, the lack of CSE preventative work identified in the 2015 COP Peer Review was an issue raised in this review.

5.1095. It is 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 PVP Review 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 team now existed, it is clear from this report that it did not have the tools at its disposal – in particular – analytical support and proper use of CSE markers – effectively to address the problem of CSE in Telford.

5.1096. In respect of the most well-known CSE risk indicator, the Alliance had still not co-located their Missing Person Coordinators with CSE Teams notwithstanding the underlining of the importance of the issue in the 2015 PEEL Report (discussed further below) and the 2016 National Misper Review. WMP should have considered this option sooner; it had been an early leader in the collection of missing persons information, but it is clear that its use of that material was less effective for decades.

[786] [redacted] pg 12

Mainstreaming of CSE

5.1097. The option of 'mainstreaming CSE' is outlined in the 2016 PVP Review. Essentially, I understand this to mean the transfer of specialist CSE Teams into local policing units, with officers forming part of wider investigation teams. Although the word is not used in this Review, I assume this is what I have seen elsewhere called the 'Pathfinder' model, or is founded on the same principle – that a wider corps of trained officers is preferable to a highly specialised CSE response.

5.1098. This 2016 PVP Review urges great caution in mainstreaming:

> *"Policing in general is on a journey of understanding CSE. Following a number of high profile cases where victims were not recognised, therefore not safeguarded and also perpetrators able to offend without being brought to justice, there has been a great deal of effort nationally channelled into this area of business. CSE now sits within the strategic policing requirement. This is therefore a time of a great deal of scrutiny around CSE. It is also a time where partners have invested greatly. If this area is to be mainstreamed at this time it is very possible that drive, focus and partner relationships could diminish, along with policing understanding of this area regressing.*
>
> *When the above is considered the question has to be asked regarding timing if the alliance were to mainstream CSE. Until policing fully understands this area of business there is a strong argument to say the most professional response is to have specialist multi-agency teams, working with victims and getting to hear the 'voice of the child'. They will get to understand vulnerabilities, victims and perpetrators. They will also, with appropriate analytical, support map issues within our policing area.*
>
> *It is no coincidence that the predominance of operations to address significant CSE concerns exists in Warwickshire, all of which are proactive based and have been developed from sound inter-agency information sharing through the dedicated multi-agency service. The same is true of Telford, where such operations also regularly feature. This is a developing picture still in its immaturity across the Alliance …"*[787]

5.1099. I agree with the authors: specialist teams mattered in 2016 just as the formation of a specialist team mattered in 2006. As I detail in other parts of this report, the Council had attempted to 'mainstream' CSE response on two separate occasions – each was a poorly veiled attempt to dismantle the specialist team without proper thought for its continued existence. I fear that 'mainstream' in respect of specialist teams is bureaucrat's code for 'disband'; and while I appreciate that small teams do not fit easily into broader structures and lines of command, it seems to me to be plain that pressing problems demand skilled and specialist response. A desire to 'mainstream' in these circumstances shows, in my judgment, a continued failure to understand the nature of seriousness of the underlying problem.

5.1100. Happily, as I have noted elsewhere, Telford's CSE Team not only avoided the negative consequences of mainstreaming but was strengthened and received useful resources – for

[787] [redacted] pg 17

example, analyst capability. If it was this 2016 PVP Review that led to that, its authors deserve thanks.

Vulnerability & Safeguarding Business Unit – Commissioned 4Ps Review of Police CSE Services at Telford LPA – 2018 (the "2018 4Ps Review")[788]

5.1101. This review of police CSE services at Telford was published on 1 August 2018. Its focus was police activity and specifically not inter agency partnership working. Its terms of reference were to:

> *"… undertake a supportive, internal 4Ps Review of the current police service provision by Telford LPA in respect of Child Sexual Exploitation; utilising best practice, national guidance, and findings from national inspectorate activity; to shine a positive light on areas that would add value to, and enhance, the work already being undertaken"*.

5.1102. This 2018 4Ps Review noted that staff within the police CSE Team work a rotational late shift in order to be proactive. Staff told the Inquiry that this was intelligence led and there was flexibility around hours as required.

5.1103. The authors of the report commented:

> *"There is excellent proactive work by the CSE team which includes assigning each DC from within the team responsibility for a particular patrol shift. The DCs subsequently attend patrol briefings which breaks down barriers and allows the sharing of information"*.

5.1104. The CSE Team reported good communication with the SNT, with officers approaching them for advice. There were more formal meetings with SNT officers at weekly and monthly tasking meetings, although:

> *"It is acknowledged that due to the location of SNT, staff do not have ready access to the CSE team. A newsletter has been devised to inform them of current issues, which remains under review to ascertain if it is the most effective method of communication. Issues have been highlighted by SNT staff regarding the frequency for receipt of the newsletter, and this may require a review from within the LPA"*.

5.1105. This 2018 4Ps Review identified that the CSE Team provided *"individual feedback"* to officers concerning professional curiosity, that could be adapted if an individual was underperforming. The CSE Team Coordinator would manually search intelligence logs for CSE using keywords to identify any missed opportunities.

5.1106. It was identified that the need for individual feedback *"demonstrates a recognition that CSE may not be fully embedded across all roles within Telford Local Policing Area".*[789]

788 [redacted]
789 [redacted] pg 5

Athena

5.1107. This review found that following the implementation of Athena the ability to view incidents of a particular type by 'tag' had been removed, together with the ability to view intelligence logs through the same pages; an update to the system had been promised.

Training

5.1108. WMP's proactive work with hotels and taxi drivers was identified, and led to a taxi driver calling the police due to concerns for a child attending a hotel with an older male. This review was concerned that police staff receiving calls from members of the public did not recognise and/or log these circumstances as creating the potential for CSE. It was told that CSE training was provided for all new staff, but they were not aware of some of the new proactive work in the area. In light of this, it was suggested that call handling staff be provided with more training in relation to potential triggers for CSE and kept informed of proactive work.

5.1109. The integration with partner agencies was identified as a strength within Telford LPA. In particular, this review noted fortnightly meetings between police and the CATE Team. These meetings were identified as providing a forum for information sharing. Additionally, the 2018 4Ps Review found that the CSE Team reviewed intelligence logs and shared relevant information with partner agencies. Issues in the sharing of certain sensitive information were discovered, but a mechanism was in place for a Detective Sergeant in the Team to liaise with the LPA Intelligence Manager with a view to ensuring no unnecessary barriers to sharing existed. Additionally, the Team Analyst triaged and identified relevant information for sharing at the earliest opportunity.

Missing Persons

5.1110. It was identified by the 2018 4Ps Review, that the Telford CSE Team recognised the link between 'missing' and CSE. A Missing Persons Coordinator worked twice weekly with the CSE Team and attended tasking meetings when CSE was on the agenda.

5.1111. The COMPACT system was monitored by the CSE Team, and at risk individuals had a 'shadow' or 'ghost profile' created on the system, which included a link to their Risk Management Plan (including an image where possible). The system also included the ability for an email to be sent to the CSE Team following a missing report, and the system informed officers that an individual is at risk, including information concerning the frequency of missing episodes. All missing episodes were reported as missing with no other qualifying markers (such as 'absent' or low risk').

Staffing Levels

5.1112. Staffing levels in the CSE Team were found to be secure, with staff "*protected*" from abstractions. It was found that CSE Team staff attended shift briefings on a regular basis to provide updates and awareness of CSE to other officers in the area.

Licensing

5.1113. Licensing checks were also being conducted by Special Constables and placed on police record keeping systems, reducing the demand on other policing resources. Special Constables were trained by the Harm Reduction Hub.

Integration with Partner Agencies and other Organisations

5.1114. Telford LPA was identified by the 2018 4Ps Review as having a *"rolling programme"* of engagement and operations where numerous partners including hotels, pubs, clubs and taxi marshals had been trained to identify and report CSE. A vulnerability awareness day was also extended to a week where police and the Council visited local schools at lunchtime.

5.1115. Regular communication between the CSE Teams and school safeguarding leads was also identified, with a monthly meeting taking place with College A[790]. CSE concerns were discussed at these meetings, and a working protocol had been developed regarding unauthorised access to the site with vehicle registration checks.

5.1116. The Harm Reduction Unit ("HRU") was also providing 'Crucial Crew' training to 10 and 11 year olds, based on personal safety and education. The 2018 4Ps Review outlined that the HRU had links with 53 schools in the area and delivered training by way of the Youth Engagement Team concerning issues such as drug and alcohol safety.

5.1117. A positive approach by Telford LPA was identified in the placement of 'Tell Somebody' posters in its police stations. Social media was used in this campaign, and CSE Coordinators used Twitter to publicise the initiative.

5.1118. A Care Home Coordinator also worked within the CSE Team office to ensure that correct procedures were implemented with care providers to safeguard vulnerable children. The 2018 4Ps Review identified that monthly meetings were held between Care Home Managers, the CATE Team and WMP's CSE Team to review, discuss and task action in respect of CSE concerns.

5.1119. CSE risks of 'Looked after Children' arriving into the Telford area were identified and communication made with the CSE Team Coordinator. The Coordinator was then charged with developing activity to ensure safeguarding whilst the child resides in Telford. This review identified that the CSE Coordinator had been notified of ten looked after children assessed as at risk of CSE.

5.1120. The dedicated CSE Team in Telford now had an Analyst, in addition to one Detective Sergeant, five Detective Constables and a Coordinator. The 2018 4Ps Review identified that no specific terms of reference existed for the role of CSE Investigator, but CSE Team members had to be ICIDP ("Initial Crime Investigators Development Programme") qualified and have undergone SCAIDP training. I have noted in the earlier section of this report regarding WMP's officer training, that the SCAIDP training became mandatory for those working in specialist child abuse teams within WMP and I note from this review that it

[790] As previously defined in Chapter 3: The Council Response to CSE in Telford.

appears that there was a more general target for 30% of all police officers/staff be SCAIDP qualified.[791]

5.1121. Notwithstanding the existence of the CSE Team, the 2018 4Ps Review 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 SCAIDP. The 2018 4Ps Review stated that it was told by a reactive CID Sergeant that because of "*abstractions due to limited resources there was no ability to release staff for additional training such as SCAIDP*".

5.1122. The Review Team assessed how Telford LPA managed the risk of un-convicted individuals that presented a risk to children. Individuals who were identified but not arrested as part of Chalice were allocated a 'marker' and managed by the CSE Team/Intelligence Department. It was found that those who had been arrested but not convicted were not accurately monitored, with only nine from a total of 32 having a CSE marker. Seven individuals had no markers at all.

5.1123. Weaknesses in managing those with only 'information markers' was also identified, as management by the Offender Management Unit ("OMU") and MAPPA process was dependant on previous offending behaviour. Individuals who had no previous convictions could not be subject to this process of management. The 2018 4Ps Review identified that this was due to the criteria for these processes rather than a failure of Telford LPA.

5.1124. CSE Team investigations were reported as being subject to monthly review when a CSE marker was attached to the investigation. The Review found that staff were confused by the existence of CSE and CSA markers and did not know which to use in certain cases.

5.1125. The Telford Management of Sexual or Violent Offender ("MOSOVO") Team was reported as having an uplift in resources, with two further officers placed into the Team, resulting in the Team having resources to conduct their own warrants.

5.1126. Multi-Agency Risk Panels were held fortnightly, where safety plans for implementation by the CATE Team were created and assessed.

5.1127. Overall, the 2018 4Ps Review concluded:

> *"The provision of a dedicated CSE Team ensures early identification of victims/suspects and provides re-enforcement to other officers, that this is a priority for the LPA.*
>
> *Prevention of CSE can be demonstrated with the close inter-agency working, whereby staff from within the CATE team attend meetings at the Police station and have regular contact. This is further cemented by the proactive work from members of the CSE team who actively attend shift briefings and seek alternative methods of communication (i.e. SNT newsletter) when accessibility to the team is an issue. The 'tell someone' posters are displayed in prominent positions within Telford Police Stations, thus ensuring attention to CSE remains*

[791] [redacted]

a focus. Additionally the work in creating skeleton COMPACT records for those at risk greatly assists the reactive work undertaken when an individual is reported as missing."[792]

5.1128. Recommendations included that:

5.1128.1 There should be a review of the effectiveness of the 'CSE newsletter' to the SNT;

5.1128.2 The difficulties with Athena searches/CSE markers and intelligence logs should be addressed as a matter of urgency;

5.1128.3 Call Centre staff should be provided with knowledge and training in CSE;

5.1128.4 The CSE Team should have terms of reference;

5.1128.5 The LPA should achieve 30% SCAIDP trained staff;

5.1128.6 The LPA should ensure management of un-convicted offenders, including those not arrested in Chalice;

5.1128.7 A CSE problem profile should be created; and

5.1128.8 Consideration should be given to the location of SCAIDP trained staff to ensure proper coverage.

5.1129. I consider that the 2018 4Ps Review is very positive. It demonstrates that real progress had been made in WMP's CSE response. There is evidence that many of the recommendations from previous inspections and reviews were adopted into operational practice, and the response during this period is specialised and structured, providing an excellent platform for an effective CSE response.

5.1130. Missing Persons Coordinators were at least partly co-located with the CSE Team and this review identified the link between missing and CSE had been established. The use and functionality of the COMPACT system assisted in this process, and unhelpful categories for missing persons were no longer in use. Additionally, an Analyst was employed within the Team to provide important information on CSE profile.

5.1131. Human error and/or confusion in the application of CSE markers was still identified as an issue, including some shortfalls regarding training and the processing/sharing of intelligence. The management of individuals not arrested and/or not convicted remained an issue in the CSE response. Notwithstanding this, the multi-agency specialised approach demonstrated by the findings of this review indicate that very significant progress in Telford LPA's response to CSE had been made.

[792] [redacted] pg 20

HMICFRS - PEEL Inspections

5.1132. The Inquiry has seen how HMICFRS conducts inspections into specific areas of policing such as child protection. Additionally, the Police Act 1996 requires HMICFRS to inspect and report annually on the effectiveness, efficiency and legitimacy of every police force in England and Wales.

5.1133. Through its evidence to the Inquiry, WMP has provided reference to several PEEL reports that may provide relevant information concerning its approach and response to CSE. The PEEL inspections assess a force on effectiveness, efficiency and legitimacy separately, but it is the effectiveness assessments that have provided the Inquiry with particularly useful evidence concerning CSE response, as this pillar of assessment incorporates a force's performance in protecting vulnerable people. In assessing a police force, HMICFRS grades it as 'Outstanding', 'Good', 'Adequate', 'Requires Improvement' or 'Inadequate'. In some cases, the inspectorate may raise a 'Cause of Concern' where a particular policing response requires urgent review.

2015 – Effectiveness (the "2015 PEEL Report")[793]

5.1134. This report was published in February 2016. I note that WMP was assessed as 'Requires Improvement' in respect of the inspection question: *"How effective is the force at protecting from harm those who are vulnerable, and supporting victims?"*. The overall judgement in respect of this question and area for inspection stated:

> *"West Mercia Police generally provides a good service in identifying vulnerable victims and responds appropriately with its partners, and the public can be confident that many victims are well-supported. However, in some areas improvement is needed to ensure that the force provides a consistent service to victims and gives vulnerable people, particularly missing children, the response they need and keeps them safe.*
>
> *HMIC found that the force's approach to responding to vulnerable missing children and assessing the risks to domestic abuse victims is not consistently good enough. This means that the force is not always fully addressing the needs of some of the most vulnerable victims. However, where risk and vulnerability has been correctly identified, the police response to victims is good.*
>
> *Generally, investigations into crimes against vulnerable victims and victims assessed as high risk are conducted by specialists to a satisfactory standard with effective supervision. The force works well with partner organisations to share information and jointly safeguard and support victims.*
>
> *This inspection only considered how well prepared the force is to tackle child sexual exploitation. The force has made an encouraging start in ensuring it is adequately prepared to tackle child sexual exploitation, however some of its missing persons processes mean*

[793] [redacted] pg 6 and [redacted] pg 9

that further work is required if the public can be confident that this preparation is sufficient."[794]

5.1135. The 2015 PEEL Report also identified an inconsistent provision for CSE training, with WMP acknowledging the existence of a skills gap.

5.1136. Whilst this 2015 PEEL Report identified the provision of an automatic alert on IT systems to highlight those children at high risk of CSE with trigger plans in regular missing cases, a 'Cause of Concern' was received for WMP's response to missing and absent children. This was based on weaknesses identified in the way that WMP assessed the risk to children and young people who go missing. In particular, it identified factors that should escalate a risk assessment, such as CSE, were missing from assessment criteria. The Report identified that this resulted in a lack of consistency in safeguarding and protection to missing children, particularly those in care. The Report also identified that evidence from pervious missing episodes was not consistently used to improve investigations plans and address safeguarding concerns.[795]

5.1137. Recommendations made to address this 'Cause of Concern' were as follows:

5.1137.1 Staff using systems should understand how to use the categories of 'missing' 'absent' and how to identify factors that increase risk of harm to children;

5.1137.2 Missing persons investigations to be properly supervised and make appropriate decisions in accordance with any risk assessment; and

5.1137.3 The response to persistent and repeat missing children should be improved by the use of evidence from previous episodes to develop a prioritised response.

5.1138. The 2015 PEEL Report identified a number of 'Areas for Improvement'. One of these appears to directly relate to CSE. WMP was directed to improve its ability to retrieve digital evidence from electronic devices, such as phones, to reduce delay in investigations.

5.1139. WMP was also assessed against the question: *"How effective is the force at tackling serious and organised crime, including its arrangements for fulfilling its national policing responsibilities?"*.[796] WMP was assessed as 'Requires improvement' in relation to this assessment, but, in fairness, it was the first year HMICFRS had graded police forces against this question. The Report identified the need for WMP to develop its understanding of the threats posed and the requirement to map emerging OCGs providing a full threat assessment.

5.1140. The 2015 PEEL Report suggests an encouraging start was made by WMP to ensure it was adequately prepared to tackle CSE. However, I believe the start of this process should have occurred much sooner and the 2015 PEEL Report raises critical deficiencies in WMP's

794 [redacted] pg 6 and [redacted] pg 9
795 [redacted] pg 10
796 [redacted] pg 6

response to missing children. By this time, the link between missing children and CSE risk should have been well understood.

5.1141. Additionally, of course, gaps in CSE training were also identified by the 2015 COP Peer Review as discussed above - but the evidence indicates issues with training had not been resolved at the time this inspection took place.

5.1142. Despite the structural changes made and the introduction of CSE Teams, the failures in provision for missing children demonstrates that WMP was still not properly responding to pertinent and interconnected factors required for an effective CSE response.

2016 – Effectiveness (the "2016 PEEL Report")[797]

5.1143. This report was published in March 2017. WMP's overall assessment in relation to Effectiveness was 'Good'. WMP was further assessed against the question *"How effective is the force at protecting from harm those who are vulnerable, and supporting victims?"* - and the force showed a progression from 2015 with the assessment in this area now assessed as 'Good'.

5.1144. The 2016 PEEL Report found that:

> *"The force has addressed our concerns about its response to missing and absent children. It has removed the category of 'absent' in its description of missing children and now categorises episodes as either 'medium' or 'high' risk. We also found that the force's day-to-day practices reflect a greater understanding of the factors that increase the risk of harm to children. Changes to call-handling and incident management within the control room are supported by the daily management meeting (DMM) process. They include an appropriate level of oversight of missing persons investigations, in accordance with the level of threat or risk of harm posed to a child. West Mercia Police has responded well to HMIC's recommendations; its action plan is thorough and it has worked with care homes and different agencies to improve its response to persistent and repeatedly missing children. It is using peer assessment to evaluate its processes and performance, and four missing persons co-ordinators have also been appointed across the strategic alliance, who work with partner agencies to reduce the number of incidents involving missing people."*[798]

5.1145. The 2016 PEEL Report also identified that protecting people from harm was a strategic priority for WMP and that the force *"aspire[s] to be great at protecting the most vulnerable"*.[799] It also identified that WMP had developed several problem profiles including one for CSE and commented that these profiles were "*good*", and that the number of officers trained in child abuse and investigation had doubled since the Pathfinder model had been introduced (with a further 180 to be trained by the end of 2018).[800]

5.1146. Whilst there were no recommendations, some 'Areas for Improvement' were identified in the 2016 PEEL Report. These areas included taking steps to understand why a *"high*

797 [redacted]
798 pg 28
799 pg 29
800 pg 29 and pg 33

proportion of crimes (including those related to domestic abuse) fall into the outcome category 'Evidential difficulties; victim does not support police action'" and that this should be addressed in order *"to ensure that it is pursuing justice on behalf of victims."*[801]

5.1147. WMP 'Required improvement' when assessed against the question *"How effective is the force at tackling serious and organised crime?"*, with an 'Area for Improvement' identified that WMP should *"engage routinely with partner agencies at a senior level to enhance intelligence sharing and promote an effective, multi-agency response to serious and organised crime".* [802]

5.1148. This 2016 PEEL Report indicates that WMP had improved its response to missing persons and CSE, addressing issues that had previously been raised in the 2015 PEEL Report. The findings are somewhat at odds with Areas for Concern identified by the internal 2016 PVP Review, however the focus of the 2016 PEEL Report seems to concentrate on WMP's approach to missing persons rather than a distinct focus on its approach to CSE.

2017 – Effectiveness (the "2017 PEEL Report")[803]

5.1149. The overall assessment for Effectiveness in the 2017 PEEL Report and the assessment against the newly phrased 'Protecting Vulnerable People'[804] for WMP was 'Requires Improvement'. The assessment had therefore regressed since 2016.

5.1150. In making its assessment, HMICFRS examined how staff identify vulnerable people when they first come into contact with WMP via the control room. This inspection also examined the initial response to incidents involving vulnerable people. Both these examinations appear to focus on victims of domestic abuse, however, rather than vulnerable children.

5.1151. Insofar as relevance to cases of CSE is concerned, this inspection examined how crimes against the vulnerable were investigated. It found that whilst WMP *"generally investigates crimes involving vulnerable victims to a good standard",*[805] there was evidence of defective investigation in 17 of 18 cases inspected. It was identified that some officers spoken to were *"uncertain of their ability to investigate crime effectively".*[806] Nevertheless, I note that the 'Areas for Improvement' in this category focused on WMP's response to domestic violence, and so I do not automatically view these findings as applicable to CSE matters.

5.1152. However, the assessment against the newly phrased 'Tackling Serious and Organised Crime'[807] had declined since the 2016 PEEL Report to an assessment of 'Inadequate'. This inspection found that WMP had a *"limited understanding of the threat posed by this type of criminality".*[808] It identified that the approach to serious and organised crime was a 'Cause

[801] [redacted] pg 40
[802] [redacted] pg 49
[803] w.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-police-effectiveness-2017-.
[804] This replaced the previous question of *"How effective is the force at protecting from harm those who are vulnerable, and supporting victims?"*
[805] Pg 16 of https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-police-effectiveness-2017-.
[806] Pg 16 of https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-police-effectiveness-2017-.
[807] This replaced the previous question of *question "How effective is the force at tackling serious and organised crime?"*
[808] Pg 19 of https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-police-effectiveness-2017-.

of Concern' and was putting the public at risk of harm. I do consider this relevant to CSE. Recommendations in this area included:

5.1152.1 engaging routinely with partner agencies to establish information sharing arrangements;

5.1152.2 ensuring OCGs are mapped and assessed at regular intervals in line with national standards;

5.1152.3 begin to measure activity on serious and organised crime;

5.1152.4 assign lead responsible officers to OCGs as part of a multi-agency approach to dismantle them; and

5.1152.5 identify those at risk of being drawn into serious and organised crime and implement preventative initiatives.

5.1153. This 2017 PEEL Report contained limited information concerning WMP's CSE response, but the regression from 2016 in the area of 'Protecting Vulnerable People' may indicate the response to CSE also declined in Effectiveness. I regard the overall grading of WMP in 'Tackling Serious and Organised Crime' as a concern, given the understanding that I believe the force should have now had regarding the serious and organised nature of CSE offending experienced in Telford.

2018/19 – Effectiveness (the "2018/19 PEEL Report")[809]

5.1154. In the 2018/19 PEEL Report WMP was graded as 'Requires Improvement' in an overall assessment of Effectiveness. In relation to the category 'Protecting Vulnerable People', the force was also assessed as 'Requires Improvement'. I note, though, that the analysis of performance in this inspection remains heavily weighted towards WMP's response to cases of domestic violence, as was the case in 2017.

5.1155. Within the category 'Protecting Vulnerable People', this inspection identified issues with the Telford HAU as follows:

"The most effective MASH arrangements involve the daily exchange of information through a joint dashboard, with a single manager responsible for overseeing the processes. None of the HAUs fully meet this standard, although some come close. Telford HAU is located in the Telford and Wrekin MASH. It enjoys close partner working and good information sharing. In Worcestershire, partners have been co-located for approximately four years".[810]

5.1156. The 'Areas for Improvement' relevant to CSE were:

[809] https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-assessment-2018-19-west-mercia.pdf.
[810] Pg 28 of https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-assessment-2018-19-west-mercia.pdf.

- *"The force should consistently enforce bail conditions to better safeguard vulnerable people";* and

- *"The force should work with partners to introduce effective MASH arrangements in all parts of the force".*[811]

5.1157. The assessment of WMP in 'Tackling Serious and Organised Crime' improved to an assessment of 'Good'. It identified that WMP had made *"significant improvement"*[812] since the 2017 PEEL Report.

5.1158. I note that, whilst not specific to CSE, WMP was however graded as 'Requires Improvement' for the category of 'Investigating Crime'. The 2018/19 PEEL Report found that at times *"the force does not have enough capacity and capability to cope with investigative demand. This adversely affects the service that it gives to the public. The force keeps victims waiting too long to see an officer, and it takes too long to investigate some crimes".*[813]

5.1159. This deficiency created a 'Cause of Concern' leading to recommendations that WMP should implement within six months.[814] These recommendations included improving its response to crimes and the allocation of investigations to appropriately trained officers. Clearly, my concern here is that the failure to investigate crimes properly in general, may have had a knock-on effect on the investigation of CSE crimes specifically. Investigations relating to CSE are often the most complicated and time consuming; they may be most at risk when investigative capacity reduces. Crucially, where a CSE complaint is made the victim/survivor must be seen with all expedition before any sense of reluctance is allowed to take hold.

5.1160. WMP failed to improve its grading for 'Protecting Vulnerable People' from the 2017 PEEL Report, but I make no further comment here, as I have noted that this inspection was heavily weighted towards the examination of issues relating to domestic violence; and as I have further noted, this was at a time when WMP's CSE Team was on a sound footing.

Missing Persons

5.1161. During the relevant time period covered by the Terms of Reference, the way that WMP has dealt with missing persons or 'mispers' has evolved from an unsophisticated paper-based system to the searchable computerised system with automated functionality to allow notifications to be sent to other agencies, known as COMPACT, which is used today. I understand that the current version of the electronic system now links to a charity to allow texts to be sent to the missing person's mobile telephone to offer independent support, which is a positive development in my view.

5.1162. The WMP literature I have reviewed confirms that missing person cases differ from other police incidents, in that they do not usually result in an allegation of crime as, in the majority of cases, the individual returns unharmed having gone missing of their own free will. However, in my view, missing persons cases involving children add a layer of complexity

[811] Pg 23 of https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-assessment-2018-19-west-mercia.pdf.
[812] Pg 30 of https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-assessment-2018-19-west-mercia.pdf.
[813] Pg 15 of https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-assessment-2018-19-west-mercia.pdf.
[814] Pg 16 of https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-assessment-2018-19-west-mercia.pdf.

and whilst I appreciate that the majority may not result in any allegations of crime, they should receive an appropriate level of attention and not be dismissed: children do not tend to go missing without a reason. Appropriate resource should be allocated to exploring the reasons behind these episodes.

5.1163. Despite the link between CSE and missing children becoming more prominent nationally and locally in the mid-2000s, I note that CSE was not specifically referred to in any WMP literature or joint protocols regarding missing children until 2009. I have been told that from 2002, WMP relied heavily on its Strategic Lead for Missing Persons, who was a member of the National Working Group and was, on the evidence I have seen, clearly dedicated to improving WMP's approach to missing persons. A number of significant changes were made to the way that WMP dealt with missing children during the time that this officer dealt with the issue. I have been told by several witnesses that he was instrumental in introducing the COMPACT computerised missing persons database in 2003; improving safe and well checks; launching a joint protocol with partner agencies; and implementing various successful prevention methods.[815]

Pre-2003

5.1164. WMP's Corporate Submission[816] confirms that prior to 2003, officers dealt with missing person cases by recording details and actions on a hard copy 'Missing Person Form C3' ("C3 Form"). I have been unable to review any completed historic C3 Forms as I understand that copies have not been retained (in line with the Management of Police Information ("MOPI") requirements) which is reasonable given the passage of time. I have been told that a version of the C3 Form[817] is still used by WMP to record initial details of missing persons, with the information from the paper copy form added to the COMPACT system.

5.1165. The C3 Form itself was fairly comprehensive and recorded details of missing persons, including their address, description and full details of the circumstances of the case, as well as the details of the person making the report. The form was intended to record all addresses and associates of the missing person to be checked by the police, and details of the risk assessment for the individual. There was also an aide memoire for officers and guidance to be provided to family and friends of the missing person.

5.1166. I have been told that upon receipt of a missing person report, the C3 Form would be completed and the Investigating Officer would share details with the Local Intelligence Officer ("LIO"), who would then update the PNC with information regarding the missing person. This would then lead to a marker being placed against the person's name and if the PNC was checked anywhere in the country, police colleagues would be able to establish whether the person was recorded as missing.[818]

5.1167. The C3 Form was a working document that was updated throughout the duration of the missing enquiry and once the enquiry was concluded (i.e. the missing person had returned)

815 [redacted] pg 5-6
816 pg 131
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818 pg 131

completed forms were sent to the LIO who reviewed and filed the originals, keeping a hard copy record book with all missing persons listed within. I was told that the LIO's review was intended to identify intelligence in respect of crime, vulnerability and future missing episodes.[819]

5.1168. I have heard from an officer involved with missing persons cases at the time, who told me that the C3 paper-based system was "*cumbersome, ineffective and unreliable*"[820] and I am inclined to agree with this view. The system required all individuals to be on top of paperwork and to keep track of loose papers which were often sitting on a desk for 24 hours. In reality, only one person could access the document at a time which meant that information was not shared or updated appropriately and was easily lost. I heard that C3 Forms moved with the officer on the case which meant that the Duty Sergeant was required to go and physically find the paperwork to update it. Having heard this explanation, I can understand why papers relating to missing persons were often lost during busy shifts and why officers may not have completed the document properly if they were unable to locate it. It is clear to me that the paper-based system did not work effectively and that missing persons cases could not be monitored to identify any patterns or repeat cases. A further problem related to the fact that the system was not task-based, so it was not possible to keep track of what had been done and any actions taken, unless the officer recorded that information, and even then, there was no central searchable log, just a hard copy list maintained by the LIO.

5.1169. I have heard that during this period, missing person investigations were managed via the local uniform supervision structure.[821] A Duty Inspector would be responsible for managing all activity on the division and was ultimately responsible for the progression of all missing person enquiries, but the day to day investigation work was completed by uniformed officers who would attend the location from where the report was made to take initial details. Actions would be progressed to locate the missing person with supervision provided by a response team Sergeant. I note that in any 'high risk' cases or cases where a crime was considered to be 'in progress', the investigation would be directed by a CID Detective Inspector, or rank above. When a missing person enquiry spanned a shift, a Sergeant was responsible for ensuring all appropriate enquiries were conducted in a timely manner and for handing over outstanding enquiries to the next shift. This handover pattern would continue until the missing person was located. The Duty Inspector would raise the incident at Tasking and Coordination meetings chaired by a Command team member to ensure progress and resourcing was appropriate. I have heard that the quality of the handovers varied and that even when actions had been recorded and completed, no one was keeping a track of this, so previous actions would be forgotten.[822]

5.1170. Another witness told me that before the creation of COMPACT, a category of 'child protection incident' was created on the CRIMES system with sub-categories of 'emotional', 'physical' or 'sexual'. A child missing from home could therefore be recorded as 'child protection incident, emotional' along with the details of the case.[823] The duty Detective Constable or

819 [redacted] pg 132
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821 pg 133
822 pg 7
823 pg 20

Detective Sergeant would be tasked with reviewing all child incidents recorded on CRIMES and deciding whether a referral to Safeguarding was required. The Inquiry has not been provided with any historic records which confirm the use of the 'child protection incident' category for missing children.

5.1171. Once a missing person had been returned, officers would conduct what is known as a 'safe and well check' which was effectively a wellbeing check which would seek to identify 'push and pull' factors – which I understand to be, effectively, the potential reasons for the disappearance – in order to prevent the recurrence of further missing episodes. The officer would also try to establish whether the person had come to any harm whilst they had been missing. I discuss safe and well checks in more detail later in this section.

5.1172. In the event that an individual was reported missing again, to research previous incidents the investigating officer may have been able to access locally held paper records (if they had not been destroyed), or they could have checked the WMP intelligence system (CRIMES) or the 'Missing Persons' book retained by the LIO. I note that in the absence of a reliable record of previous missing episodes, it is highly unlikely that any patterns or repeat missing incidents could have been properly identified using just the paper-based system. I have been unable to ascertain the level of information sharing between WMP and the Council regarding missing children prior to 2003 but have been told by one witness that records from the OIS system were faxed to Safeguarding to notify them of children who had been missing and found.[824]

IMPACT/COMPACT

5.1173. In 2003, a computerised system, now known as COMPACT, was launched by WMP to help to coordinate missing person investigations. The system was initially known as IMPACT (Intelligent Missing Person and Case Tracking) and was intended to improve the way that missing cases were managed. I understand from the WMP Corporate Submission that, prior to 2003, missing person enquiries would run on the Command and Control ("OIS") system, which was the system used to handle all calls for service by the Command and Control Centre. I was told that OIS records had limited search functionality which meant that valuable information and intelligence could be lost and the volume of data recorded made the system unwieldy and difficult to search. I have read evidence from a former WMP officer that missing cases were an anomaly that had traditionally been dealt with on paper and that this practice had continued despite the introduction of various systems, *"… then the command and control system came along but we were still running our missing persons investigations on paper and then our CRIMES system came along and we were running our crimes investigations on IT but our missing investigations were still being run on paper."*[825]

5.1174. The launch of COMPACT was a significant milestone for WMP as it meant that for the first time a record of all previous missing enquiries would be retained "*providing an invaluable insight into previous risks and vulnerabilities, risk assessments and actions leading to the missing person being located".*[826] I understand that the standard functionality of COMPACT

824 [redacted] pg 15
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826 [redacted] pg 133

was upgraded by WMP to ensure that the Council would receive an email alert once a missing person entry was recorded on COMPACT. This was a valuable addition which alerted Safeguarding to the situation in real time and allowed them to consider the most appropriate safeguarding response for children flagged as missing. Once the missing person was returned home, a second email was sent to the Council who could then respond to the requirement to offer a RHI. Rather worryingly, this capability is acknowledged to have been *"the first real regular engagement between Police and partner agencies in dealing with the issue of managing missing person investigations*".[827]

Post 2003

5.1175. I have seen evidence that following the introduction of COMPACT, day to day missing person investigations were carried out by police response officers in accordance with ACPO Guidance 2005. Upon receipt of a report, missing child cases were risk assessed and any considered to be high risk were retained by the response policing team, with investigations overseen by CID supervisors. High risk cases included cases where there were substantial grounds to believe that either the missing individual or the public was in danger as a result of the missing person's own vulnerability or mental state.[828]

5.1176. In terms of policy documents which governed the approach to missing persons cases, I note that in 2004, the WMP Force Missing Persons Policy and Procedure (the "2004 Procedure") replaced Force Policy 26/1999. The Inquiry has been unable to view the earlier document as WMP has been unable to locate any copies of the 1999 policy. The 2004 Procedure set out in detail the management of missing person investigations, providing guidance on action to be taken in respect of high, medium and low risk missing persons.

5.1177. The 2004 Procedure specifically excluded children in care who, after being risk assessed by the local authority "*appear only to have absented themselves without permission for a short period of time",* which therefore prevented them being formally recorded as missing. The 2004 Procedure suggested that for these cases:

> *"Social Services should take reasonable and practicable steps to establish the whereabouts of the child. They are responsible for updating this risk assessment regularly and contacting the Police sooner if they consider the risk level has increased. This period should not exceed 24 hours. Their initial risk assessment should be reviewed after six hours".*[829]

5.1178. The 2004 Procedure reiterates this exclusion of children in care and states that an absence should be recorded on the OIS system for 'Information Only' and that WMP should be informed if the Council risk assessment showed a 'medium risk'. In what appears to be an attempt to delineate responsibilities for children in care, it was considered to be the responsibility of Safeguarding or Education to locate and return the child unless there were issues with safety or public order, in which case, WMP could be contacted and asked to

827 [redacted]
828 [redacted] pg 15
829 pg 2

assist. I understand that children in care who were reported missing were logged by WMP on the COMPACT system as 'Unauthorised Absent', 'Missing' or 'an Absconder'.

5.1179. I am reassured that WMP appear to have recognised the importance of information sharing in missing persons cases and from 2003, local policing team members, including Sergeants, Constables and Police Community Support Officers attended multi-agency meetings in respect of children going missing.[830] The Lead Responsible Officer, a Chief Inspector, would have responsibility for missing person investigations and provide direction around the review points – i.e. when cases were to be reviewed by the Divisional Crime Manager (a Detective Chief Inspector) and at later stages, a force Senior Investigating Officer. Whilst the oversight mechanisms in place at the time are commendable, it is unclear from the WMP Corporate Submission precisely how many missing person cases involving children reached the desk of a SIO, what the escalation triggers would have been, or how frequently this happened, if at all.

2007 to 2009

5.1180. The Inquiry has noted that as a result of learning at a national and local level, WMP's approach to missing persons developed and from 2007 onwards, a Duty Inspector managed the policing response to missing people, including children and vulnerable people. When cases were deemed to be high risk, information was shared more widely and the Duty Inspector would notify the CAIU Detective Inspector and a decision would then be made in relation to the necessity of a strategy discussion with partner agencies.

5.1181. I have heard that if a child was still missing after seven days, the Area Crime Manager and CAIU Detective Inspector would attend a strategy discussion between agencies to establish whether all actions necessary were being taken to safely locate the child. When a child was found, a safe and well debrief would be undertaken by WMP, to understand why the child went missing, what they did, and who they were with, for the dual purpose of assessing risks, vulnerability and welfare and to allow further considerations for referrals to other agencies to be made.

5.1182. The prominence of missing person cases had been elevated during this period, I imagine following Chalice, and cases were now discussed at Daily Management Meetings in Telford which I am told were chaired by a Command team member. During these meetings, repeat missing persons were highlighted and they were then discussed at the Monthly Tactical Tasking and Coordination Meeting. During these meetings, the local Police Inspector was held to account by attendees in relation to appropriate engagement with missing persons, carers, guardians and Safeguarding.[831]

5.1183. In the 2008 Inspection discussed above, WMP was graded as 'Good' in respect of missing persons.[832] I consider that the rating from an external review perhaps provided an additional layer of comfort to WMP that missing persons procedures were working well.

830 [redacted] pg 135
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2009 to 2011

5.1184. By 2009, I was told that each BCU 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*".[833]

5.1185. It was also during this year that the Joint Protocol for Reporting Missing Young People 2009[834] (the "Joint Protocol") was agreed between the Council, WMP, Worcestershire County Council, Herefordshire Council, and Shropshire Council. The Joint Protocol referred to situations when children in the care of the local authority went missing from children's homes or foster placements. A witness with awareness of the Joint Protocol explained that prior to 2009, there had been no formal protocol in place despite several attempts to formalise matters, and it had been *"a task in itself, trying to get all local authorities to agree on what the process should be."*[835] The reason that the Joint Protocol was required was as a result of the statutory guidance for the police to notify the local authority every time a child went missing and the perceived lack of clarity regarding children placed in care out of their local area. I have been told that for looked after children, the guidance did not specify whether the notification had to be made to the authority who had placed the child (the "Placing Authority") or to the authority housing the child (the "Host Authority"). Understandably, this caused problems when children were placed out of their local area as invariably the Host Authority did not see themselves as ultimately responsible if the child from a Placing Authority went missing.

5.1186. One witness said:

> *"… if they go missing in Shropshire, or Telford, it'd be Telford local authority, but if they're a placed child, like in Shropshire from London, then Telford aren't going really want to know, 'cause they're not dealing with a child, they're not responsible for the child, unless there are the surrounding things and exploitation going on in Telford, just a single missing incident, perhaps there's not going to be that much interest to them if it's not got other risks attached to it, so a lot of forces at that point were making notifications manually, which probably were not being done, were probably not being done very well, or in some cases not being done at all."*[836]

5.1187. The Joint Protocol aimed to clarify the situation and COMPACT was utilised to lessen the burden for WMP with the introduction of the ability to send automated notifications for all missing children under the age of 18 to the relevant local authority.

5.1188. The Joint Protocol recognised that children who went missing were likely to place themselves and others at risk and the reasons for absence were varied and complex. It was considered that "*every missing episode should attract proper attention from the*

833 [redacted] pg 136
834
835 pg 16
836 pg 16

professionals involved … and they must collaborate to ensure a consistent and coherent response is given to the missing person on his/her return." The same categories of absence as the 2004 Procedure were in place: 'absent without authority', 'missing' or 'absconder'.

5.1189. In progression from the previous literature, CSE was now specifically mentioned within the document. I note that references to CSE included:

5.1189.1 Consideration of the circumstances of the missing child and their absence, including *"predatory influences on the child… may relate to others wanting to use the child for crime, sex or drugs…"*[837]*;*

5.1189.2 Procedures to be followed upon the return of a missing child who had been at risk of sexual exploitation; or

5.1189.3 Any other factors indicating significant harm whereby the matter should be referred to the Detective Inspector in charge of the PPU.

5.1190. There was also reference within the appended risk assessment which reflects the growing recognition of the link between CSE and missing vulnerable children. I have also seen reference to a '60 Second Learning Guide' for CSE produced by WMP, which included missing persons as one of the key warning signs. I understand this was produced around the time of Chalice and was circulated to all officers in WMP.[838]

5.1191. As I have observed previously, unauthorised absence was a category allocated to looked after children who were absent without any apparent risk, and who were considered by WMP and Safeguarding to have chosen to absent themselves from their placement. In these circumstances, upon receipt of a missing report, carers would generally be advised to manage the incident for a maximum period of six hours, making relevant enquiries as to the whereabouts of the child including checking with associates and any suspected hotspots, after which the police would deal with the situation as a missing person.

5.1192. Having reviewed the data provided by WMP which sets out the number of children reported missing in Telford as recorded on COMPACT between 2003 and 2020,[839] (see below table) I note with interest that there were no 'U18 absent reports' between 2003 and 2013. The category was populated for the following four year period before reverting to nil returns. Witness evidence indicates that this category was not initially used by WMP, which explains the initial void period; I am driven to the assumption that there was a further change in recording practice leading to the reversion to nil returns. I am fortified in that by the overall increase in missing figures in the years after U18 absence returns to zero. However the rationale behind these recording changes is not clear.

5.1193. By 2009, following significant work undertaken by a member of the national police group on missing people, WMP recognised that missing episodes involving children should not be considered as low risk. It was agreed that missing person cases involving children would be treated by WMP and partners as either medium or high risk. I agree with the logic of this

837 [redacted] pg 12
838 [redacted] pg 5
839 [redacted] pg 142

decision and accept that the welfare of missing children was now being taken into account but I fail to comprehend how any missing child case could previously have been considered to have been low risk.

5.1194. I have been told that by 2009, each policing area in West Mercia had a PPU, led by a Detective Inspector who had responsibility for reviewing missing person reports. Around this time, WMP had begun to take more of an interest in missing person reports and started to monitor repeat and high risk reports. Perhaps as a result of Chalice, the information sharing between partner agencies regarding missing children cases also increased, with more proactive liaison between WMP and local authorities. There was also assistance from the SNTs who appear to have been involved with preventative work and who I am told helped to identify any issues with the ultimate aim being to reduce the risks associated with the person going missing to prevent them from going missing in the first place.

5.1195. At partnership meetings, either a Constable or Community Support Officer who was a member of the SNT would represent WMP. They would also take part in intervention meetings with partners and the missing child. Documents reviewed by the Inquiry confirm that the intervention meetings were part of the prevention strategy whereby it was agreed that Safeguarding and WMP would monitor absences of individual children and absences from each residential establishment. The findings were presented in a quarterly report prepared by WMP and shared with Safeguarding. An escalating system of interventions was operated with the aim of reducing the likelihood of a child repeatedly going missing.

5.1196. Intervention meetings were the first stage in the prevention strategy and were held within a week of any trigger episode; they were designed to identify:

> *"… any 'push' or 'pull' factor in the case and any other voluntary or statutory agency, which has an interest, or may take an interest, in the Missing Person's welfare and circumstances. In the case of 'pull' factors it may be necessary to target those in the community who harbour the Missing Person or exploit them with regard to crime, sex or drugs."*[840]

5.1197. It was recognised that for the intervention meetings to be successful, they needed 'buy in' from all partners with appropriate attendance and clarity of purpose. I agree with this sentiment and have noted on several occasions in my report that lack of engagement or interest has been an issue with the topic of exploitation response generally across the various agencies involved in the care of children in Telford. The evidence I have heard regarding the topic of missing persons suggests that the levels of commitment between agencies varied and that missing children were often considered to be a nuisance, and that it was only after several years of hard work from a dedicated group of individuals that improvements started to be made.

5.1198. The Joint Protocol sets out the approach to be taken for children who go missing on more than one occasion, for example, when a child went missing three times or more in 90 days, or four to six times in one year, then an intervention meeting would be convened. These meetings were seen as a key part in joint problem solving and reducing vulnerability of repeat missing children. If the meeting failed to achieve the objective of stopping missing

[840] [redacted] pg 26

person incidents, then the local Inspector would then chair a meeting with agencies to eliminate any barriers, for example, a reluctance on behalf of a Placing Authority to take action in respect of a child put into a placement that failed to meet their needs.[841] I have heard from witnesses that this was a common problem encountered by WMP and it has been suggested that this might be more prevalent in the Shropshire area due to the volume of children's homes and the number of children that are placed there by other local authorities. In any event, it is clear that those who created the Joint Protocol were keen to ensure increased clarity with respect to responsibilities to protect and support vulnerable children who were reported missing repeatedly.

5.1199. In 2009, WMP formally appointed a Strategic Lead for Missing Persons, Mental Health and Vulnerable Adults to advise on best practice and national guidance along with providing guidance in investigations. The Strategic Lead worked closely with the national working party as well as various missing persons charities, and the COMPACT missing persons' database developers. As a result of their combined efforts, the TextSafe initiative was introduced. I understand that TextSafe is a tool which allows the Missing Persons Charity to establish text contact via the missing person's mobile phone following a missing report in COMPACT, and offers the missing person access to free and independent support.

5.1200. Witnesses have told me that the Strategic Lead played a key role during this period, in ensuring that all cases were being recorded on COMPACT appropriately so as to build WMP intelligence on missing persons. The Strategic Lead's work in the area impressed staff at other agencies who were inspired by his dedication to the issue. I was told that one of the most significant contributions he made was 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 harm, which he recognised to be the opposite of the reality. The witness said they:

> *"… 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".*[842]

5.1201. Another witness told me that the use of the word 'streetwise' to describe missing children was not confined to WMP and the term was not recognised as an indicator of CSE at that time:

> *"… if you went to a strategy discussion… in a multi-agency setting and you would have conversations about streetwise children and so what we would now know as a clear indicator or a point of concern around CSE would at that time, have been talked about by children and social care and the police as really irritating behaviour on the part of a young person, whether you liked it or not. It was irritating, a child that repeatedly went missing after school for a couple of hours is irritating as opposed to at risk, back then".*[843]

841 [redacted] pg 137
842 [redacted] pg 27
843 [redacted] pg 17

5.1202. I consider that the wrongheaded and outdated perception that these children were 'streetwise' is likely to have influenced the risk assessments conducted by WMP and local authorities and consequently reduced the sense of urgency applied to their cases, particularly in the years pre-COMPACT and prior to the introduction of any formal protocol, which could have led to a number of children remaining at risk because they were considered to be 'naughty' or 'irritating' rather than vulnerable. I have seen evidence that the Strategic Lead felt passionate about helping missing people, particularly children and felt strongly about improving the processes in place within WMP to better support children who were reported missing.

5.1203. The Telford & Wrekin Safeguarding Children Board Missing Persons Group was established during 2010. Its purpose was *"to develop resilient partnership pathways in respect of missing persons, and to hold partners to account for compliance with those pathways."* It appears that, as with other groups I have commented on within Chapter 3: the Council Response to CSE in Telford, prior to the establishment of this group, previous attempts to meet to discuss missing people had suffered from a lack of engagement.

Post Chalice

5.1204. As knowledge around missing children developed, post Chalice, and the Strategic Lead shared learning more widely, the concept of 'skeletal missing person plans' was introduced. The Inquiry was told that these proactive plans began to be created on COMPACT for looked after children ahead of the first missing child incident taking place. This approach was commended by a former member of the PPU:

> "[the Strategic Lead] *did not wait for children to go missing, but rather, once a child had been identified as vulnerable and likely to go missing, his team ensured that the care home received information about that child at the start of the placement, including a photo and details of where they would be likely to run to and any trusted adults they were likely to seek out. Hotspots 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*".[844]

5.1205. The focus began shifting towards preparation and prevention of such missing incidents along with a more comprehensive joined up partnership approach. In my view, this preventative work was crucial as some children would go missing regularly, with evidence I have seen showing one child who had over 100 missing episodes in a 12 month period.[845]

2013 to 2016

5.1206. I note that in 2014, the work to increase the profile of missing persons continued and WMP recruited a Missing Persons Coordinator ("Misper Coordinator") in order to focus on preventing missing person incidents in both the Shropshire and Telford Policing areas.[846] The Misper Coordinator arranged monthly operational meetings with partners, including the

844 [redacted] pg 6
845 pg 49
846 pg 138

local authorities to discuss missing persons. More of a focus was given to repeat missing children, with plans being developed to reduce repeat missing episodes. I understand that these meetings have been a success and still take place today.

5.1207. The Warwickshire and WMP Missing Persons Policy and Procedure 2014 (the "2014 Procedure") was introduced during the Alliance period, and adopted the following definition of 'missing':

"Anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be the subject of crime or at risk of harm to themselves or another".[847]

5.1208. The 2014 Procedure introduced a new category of 'absent' but stipulated that this category was not to be applicable to children in care, who were to be recorded as either 'unauthorised absences' or 'missing'. I note that the focus of the 2014 Procedure was to continue to improve early engagement and interaction between WMP and partners to effectively review current cases with the aim of preventing future cases.

5.1209. The WMP Corporate Submission confirms that in 2015, a joint CSE Team was formed across the Shropshire and Telford policing areas with the aim of identifying potential victims and supporting victims of CSE, in partnership with Safeguarding. The WMP 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 or young person who was regularly going missing and therefore likely to do so again.[848]

5.1210. I am encouraged that the partner agencies were working towards improved mechanisms to support victims of CSE and missing persons by sharing information and intelligence and planning disruption strategies, although the evidence I have seen suggests that WMP recognised the importance of the links between missing children and exploitation and acted on this in a more urgent fashion than its partners, who at times appeared reluctant or unwilling to take action to track missing cases or support missing children.

Post 2016

5.1211. According to WMP's Corporate Submission, the Authorised Professional Practice ("APP") with regard to missing persons was adopted by WMP in around 2016 and this resulted in a change in the definition of 'missing' which had a subsequent impact on the data collated by WMP. The new definition was:

"Anyone whose whereabouts cannot be established will be considered missing until located and their wellbeing or otherwise confirmed".[849]

[847] [redacted] pg 6
[848] pg 139
[849] pg 140

5.1212. WMP has provided me with the data at Diagram 1 below[850], which confirms the number of missing children and young people under the age of 18 from 2003 to 2020. There is a significant increase in the number of reports from 2015/16 to 2016/17 which may be attributed to the change in data collection following the revised definition of missing.

Diagram1: Missing Children and young person (under 18 yrs) report for Telford, as recorded by Impact / Compact 2003 – 2020

	2003 - 2004	2004 - 2005	2005 - 2006	2006 - 2007	2007 - 2008	2008 - 2009	2010 - 2011	2011 - 2012	2012 - 2013	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	2018 - 2019	2019 - 2020
U18 Missing Reports	162	351	314	345	498	556	442	522	351	363	378	383	584	655	688	560
Repeat Mispers (U18)	32	72	47	63	91	95	75	10	65	67	74	80	119	150	123	117
U18)# Reports from Repeats	89	234	172	249	372	432	362	443	269	291	275	304	474	562	617	445
In-Care Individuals	0	0	0	0	1	0	7	28	35	57	73	72	101	98	92	69
In-Care Reports	0	0	0	0	1	0	14	99	118	223	199	215	325	296	368	197
Foster Care Individuals	0	0	0	0	0	0	0	0	2	4	8	12	23	22	17	12
Foster Care Reports	0	0	0	0	0	0	0	0	7	19	10	33	46	63	144	61
Found harmed U18	0	0	0		6	13	6	5	3	5	7	9	9	11	12	7
Found dead U18	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Possible Missing CSE	0	0	0	0	7	3	1	4	6	17	76	126	124	130	263	100
U18 Absent Reports	0	0	0	0	0	0	0	0	0	0	44	54	3	0	0	0
U18 Absent Individuals	0	0	0	0	0	0	0	0	0	0	33	37	2	0	0	0
# Absent Harmed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
# Absent Dead	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

(note data for 'Absent Harmed' and 'Absent Dead' is not available)

5.1213. In 2016, efforts to reduce the unnecessary criminalisation of looked after children continued with the introduction of a project, known as the Resilient Care Home Project.[851] This project involved local care providers and was aimed at reducing the volume of missing person cases and the harm associated with those cases. I have not heard any evidence on this project from any other witnesses but I have seen reference to a project in around 2019 involving the Council's CATE Team and the Youth Justice Service with similar aims.

5.1214. By 2017, WMP had accepted that repeat missing episodes were an indication of potential exploitation and had put in place various mechanisms to identify and support children who repeatedly went missing. Inter-agency working improved further during this period with WMP working closely with CATE colleagues at the Council to identify signs and symptoms of CSE at CSE panels, strategy meetings and intervention meetings. The focus on repeat missing persons and repeat locations of interest also improved with the introduction of a fact sheet that was compiled by WMP and circulated to partners on a monthly basis by the MPPO and which highlighted the number of repeat missing episodes.

850 [redacted] pg 142
851 pg 140

2018 onwards

5.1215. I understand that from around 2018, the Council focused its attention on RHIs by ensuring that a member of the CATE Team debriefed each missing child to establish whether there were any links to exploitation. This information was then shared with WMP and added to COMPACT by the MPPO.[852]

5.1216. In 2019, the Philomena Protocol was launched across all police forces. It was based on a previous successful national initiative to support adults who were at risk of going missing and was aimed at children in care who were identified as being at risk of going missing. The Philomena Protocol introduced a requirement for care homes to share an enhanced personal profile for new admissions in respect of their risk factors and missing persons history so that police and partners could plan and prepare for the child's needs. One witness told me that "*this* [gathering information about children in care] *was something that WMP had been doing for a while*", particularly for children from out of the area. The witness explained that:

> "*… we* [WMP] *effectively couldn't rely on the local authorities where they were moving a child to our area and that was creating vulnerabilities for the child, for us and for all partners. So we went to the care homes they were at and said "Will you work with us and tell us about children who are going to be moved to your house, your care, tell us about the risks and provide a photograph for us" … and we can put a care package in place on our systems and should they go missing we are not having to delay our investigations to find out why they are in Shropshire … we had been doing that for a while and then Durham came along and said "we are going to call it the Philomena Protocol"".*

5.1217. In 2019, the missing person portfolio holder launched a monthly care home report. This report contains similar information to the missing person's report, but the care home report provides focus on risk and vulnerability which is used by the Resilient Care Home Officer to manage demand and vulnerability.

5.1218. I understand that the current WMP position with regard to missing persons is that when a person is reported missing, it 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.[853]

Return Home Interviews/Safe and Well Checks

5.1219. As from 2014, when a looked after child returned from a missing episode, the local authority was required by statutory guidance to offer a RHI.[854] Evidence provided to the Inquiry suggests that if the interview was actually completed, it was more of a tick box exercise

[852] [redacted] pg 141
[853] [redacted] pg 29
[854] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

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, therefore if the missing person refused, an interview was not completed and the requirement was considered to be met.[855] I consider that it is possible that the attitude of those conducting the interviews may have influenced the quality as those who had gone missing were frequently considered to be troublesome or irritating so staff completing interviews may not necessarily have devoted sufficient time or resource to understanding or capturing valuable information when a child returned home.

5.1220. WMP also carried out what was known as a 'safe and well' check for all missing children, although I have seen evidence from an officer and noted from documents disclosed to the Inquiry that the usefulness of the safe and well checks was variable, as children were often reluctant to speak to anyone in authority upon their return, least of all the police. 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".*[856]

5.1221. Another witness described a general attitude of apathy towards safe and well checks and RHIs, particularly those involving multiple missing episodes, where the perception was that the interview was a 'paper exercise' and "*I've got to do this so let's get it out the way, let's get it done, let me write this on the file … I'm going to interview you today because I know you're going to be missing tomorrow. And you'll go missing again tomorrow and then I'll come back and see you the day after, and then I'll come back the day after that".*[857]

5.1222. Another officer summarised the general approach as follows:

> *"No consideration was ever given to the level of experience or interest of the officer going to that* [previously missing] *person. Perhaps it should be somebody of a detective level who would go around and make an assessment of that individual, it should be an experienced detective to make an assessment of that individual when they return home as to do they warrant further investigation as to what's happening to them. And particularly if they're young females with a degree of vulnerability, they should be spoken to at length".*[858]

5.1223. There appears to have been some tension between the Council and WMP with regard to the status of children who were missing from care and who should be responsible for interviewing them. The 2004 Procedure requires that all missing young persons are to be interviewed when found, ideally within a short time of their return and before the missing person is returned to their home or place of accommodation. The primary purpose of the interview was to protect the welfare of the individual and seek to ascertain where, how and with whom the child had spent their time whilst absent. The importance of the officer taking

85[redacted] pg 11
85[redacted] pg 25
85[redacted]
85[redacted]

accurate notes was flagged, together with a reminder that the interview should be terminated if any criminal offences or allegations were disclosed.

5.1224. A former officer told the Inquiry that a free text box was available on the COMPACT system to allow officers to record findings from the safe and well checks and it was intended that the free text box would allow more detail to be recorded. Once it was identified by WMP that officers had defaulted to not giving much detail following safe and well checks, an officer worked with partners to identify 19 questions to be asked at safe and well checks so that more detailed information could be collected and recorded on COMPACT then shared with partner agencies. Thankfully, as a result of these changes, the quality of information collated and the ability to identify issues to prevent repeat missing episodes improved.

5.1225. The Joint Protocol confirmed that WMP was responsible for ensuring that a return interview (to WMP, formerly the safe and well check) is conducted for each missing episode, and that the debrief will contribute to the closing report within COMPACT. It is 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 to protect their support network of friends and associates … they may see it in their best interests to remain mute …".*[859] It was recommended that Safeguarding was also responsible for ensuring that a RHI was conducted for each missing episode and that a separate interview should be conducted if information is not forthcoming from the police interview. RHIs were to be completed as soon as possible and within 72 hours of the child's return.

5.1226. In a departure from what had appeared to be the case previously, the Joint Protocol was clear that the interview was not to be viewed or conducted as a tick box exercise or a routine administrative task. When RHIs lead to a disclosure that required specific action, it was referred to the Detective Inspector in charge of the PPU in matters of sexual exploitation or any other factors which indicated significant harm. It appears that there was a reluctance on the part of the Council and initially WMP to dedicate sufficient and appropriate resources to interviewing missing children upon their return home, particularly those children with repeated missing episodes, which is once again perhaps indicative of the perception that these children were not at risk and were simply 'acting out'.

5.1227. The Inquiry was told that some local authorities commissioned third parties to conduct RHIs on their behalf, with Shropshire being held out as a successful example of how this worked in practice, with interviews being conducted by the Children's Society until fairly recently when funding is said to have run out. The commissioning of third parties was inferred to have resolved the issue with regard to interviews for children who were placed out of the area and who would not have been interviewed if the Placing Authority was responsible for conducting its own interviews due to geographical restrictions, and where the Host Authority was unlikely to interview them due to a lack of resource.

5.1228. The quality and output of RHIs conducted by commissioned services were notably better than those conducted by local authorities, perhaps as a result of their ability to dedicate more time and resource to the interviews. One witness told the Inquiry that:

[859] [redacted] pg 22

"… commissioned services actually did a really good job in actually providing some really detailed information and actually getting some quality return interviews and I'm not saying that's not the case with local authorities but my experience certainly … has been when you compare a commissioned service to a service that's provided by overworked social workers with a heavy workload, who aren't dedicated to doing return interviews, then I think the quality is generally far better from commissioned services and the relentless attempts by commissioned services to actually get the child to engage is key as opposed to the social working saying, "I've got to go through this process and ask you these questions" and then be told, "Well I don't want to participate" and not asking again. I think the commissioned services go the extra mile in terms of not wanting to give up".[860]

5.1229. The Inquiry was told that in 2010, the Council had discussed taking a similar approach, with the suggestion that the NSPCC be commissioned to undertake RHIs; and documents indicate that WMP officers supported attempts for shared funding initiatives, as this had been successful in other local authorities, but each came to naught. I have dealt in Chapter 3: The Council Response to CSE in Telford, with the Council's apparent reluctance to cede any responsibility to third sector or shared initiatives, regardless of the quality of its own provision.

Other Local Authority ("OLA") Children

5.1230. For children placed out of their local authority (referred to herein as OLA Children), I consider that there is an expectation gap in terms of any RHI. I have been told that the position is that the responsibility to conduct the interview rests with the Placing Authority rather than the Host Authority and that the Council and other local authorities have relied on this requirement to avoid completing RHIs for missing OLA Children. I find this to be a worrying practice which I fear could lead to significant gaps in intelligence as well as increased risk to missing children. Whilst I consider the practice of avoiding these interviews creates a serious risk, I do have some sympathy and agree with witnesses that it is unrealistic to expect the Placing Authority to conduct an interview when the child is currently living elsewhere and in circumstances where the Placing Authority has no day to day involvement with that child.

5.1231. In addition to the problems identified with the responsibility for RHIs, I note that difficulties often arose as to which police force should undertake an enquiry when the person reported missing normally resided elsewhere, for example, an absconder from care or a child who had been trafficked to another force area. The 2004 Procedure confirmed the position to be the same as in homicide cases, that is, that the force with the best chance of resolving the matter should deal with the investigation; in most cases this was likely to be the force responsible for the area where they went missing which would mean that WMP were responsible for enquiries for OLA Children.

[860] [redacted] pg 21

Repeat Missing Episodes

5.1232. I have seen evidence 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.

5.1233. The Joint Protocol sets out an analysis and confirms that in 2008/9:

5.1233.1 WMP formally investigated 3,306 missing reports which related to 1,810 people;

5.1233.2 2,304 of those reports related to people under the age of 18;

5.1233.3 984 individuals were responsible for the 2,304 reports;

5.1233.4 213 young people under the age of 18 went missing three or more times; and

5.1233.5 one child went missing 51 times alone.[861]

5.1234. The statistics for children in care confirm that each child went missing, on average, close to four times a year. Academic research together with local analysis completed by the Force Missing Persons Champions and local authority staff at the time showed that children who run away are often very vulnerable and at a heightened risk of being victims of crime, being sexually exploited, becoming involved in substance misuse or becoming involved in crime and disorder. I am reassured that the improved partnership working, problem solving and performance management that I have noted from documents provided to the Inquiry and witnesses who have spoken about this important topic, seemed to be having an effect as it was recognised that since 2003, incidents of repeat runaway behaviour had reduced by 14.5%.

5.1235. A number of witnesses have expressed concern about the volume of missing reports that some individuals had amassed and the resulting risk that they faced. One particular case was flagged to the Inquiry by a number of witnesses who recalled the details purely because of the sheer volume of missing incidents recorded: a vulnerable child went missing over 100 times in 12 months during the Chalice investigation. I share the concern that a vulnerable young person can go missing so many times, yet nothing appears to have been done to support them or to prevent the missing episodes. Having reviewed this case, it is apparent that the individual was at high risk of CSE and had a history of missing episodes dating back a number of years. The child concerned was accommodated at a care home in Telford which was known to be a 'hotspot' for children targeted for CSE, and who were frequently reported missing.

[861] [redacted] pg 3

5.1236. One witness explained:

> *"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."* [862]

5.1237. Following a significant period of failed inter-agency attempts at intervention, one witness told me that they considered part of the problem lay with the home itself as staff 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."* [863]

5.1238. Options including arrest of the child were considered by WMP and the Council, but were not pursued. The situation did not reach a satisfactory conclusion, and I am saddened to note that the individual eventually dropped off the missing persons and WMP radar, as they appeared to move location and missing reports stopped. I have been unable to establish whether the individual genuinely stopped going missing - which seems highly unlikely given the pattern of behaviour that had spanned several years - or whether the Council simply stopped submitting missing reports because there was no longer a requirement once the individual was no longer being accommodated by them. I suspect that the latter is the more likely scenario which is of serious concern and a missed opportunity to support this individual who was clearly being exploited.

5.1239. I consider that the perception of risk associated with repeat missing episodes and the risk of exploitation was identified at a fairly early stage by WMP and procedures were put in place to work with partners, some of whom I am aware were not quite on the same page in terms of recognising the risk, to identify patterns and reduce repeat missing episodes.

5.1240. One witness summarised the position as follows:

> *"It was a change in thought processes to cross reference the category of missing with CSE, and understand that, potentially, whilst a young person may be less at risk of failing to arrive home on that particular occasion of their location being unknown, if this is repeat behaviour; they may be more at risk of something else, such as exploitation. It seems self-evident now, however, it took some considerable change in procedures – with Missing Person guidance documents for police procedures, themed inspections around missing and CSE for forces, assessment of numbers of missing reports recorded. In West Mercia police there was a working party set up and a lead officer for Missing, to address this change in procedures, and perception of risk."* [864]

862 [redacted]
863 [redacted] pg 52
864 [redacted] pg 18

Harbouring Notices/ Child Abduction Warning Notices ("CAWN")

5.1241. Once it became more widely known in around 2008/2009 that there was a link between exploitation and missing persons, WMP explored potential disruption tactics that could be employed in an attempt to reduce repeat incidents, to reduce the risk that children were exposed to and to protect potential victims of CSE from going missing with known perpetrators. One such tactic was the Harbouring Notice which later became known as Child Abduction Warning Notices ("CAWN").

5.1242. Harbouring Notices were used by WMP at an early stage, prior to any prosecution of offenders where children were persistent absconders and continued to be harboured by the same individual, often known perpetrators who were still under investigation. WMP developed a warning notice to be served on those who harboured repeat missing persons and which threatened prosecution under section 2 of the Child Abduction Act 1984 for anyone who "*takes or detains*" a child under 16 without lawful authority.

5.1243. The Joint Protocol stated:

> "*Where children and young people are persistent absconders and continue to be harboured by the same individual consideration should be given to prosecution under the Child Abduction Act … If the harbourer is suspected of sexual exploitation or other abuse consideration should be given to securing evidence to prosecute at the earliest opportunity. If evidence suggests that the harbourer has no malicious intent then the primary intent is to ensure that the warning notice is effective so that their behaviour changes and a prosecution is not necessary".*[865]

5.1244. I have seen a copy of a blank Harbouring Notice which states that the [harbourer]:

> "*… is receiving an official warning that the parent/carer of* [the child] *being a child under the age of 16 years has absolutely banned outright with no exceptions* [the child] *from visiting any address which you reside, or you are at, and/or from associating with you at any place. If you subsequently allow* [the child] *to be at an address at which you reside or are at and/or associate with this child* ***you will be arrested for Child Abduction****."*[866] *(*emphasis from the document).

5.1245. The drafting is unfortunate. It has not been written with clarity in mind. It is difficult to imagine that this notice would have had any impact upon its target audience. Indeed, I have seen evidence of proceedings for child abduction notwithstanding service of these notices.[867]

5.1246. One witness told me that the suspect in her case had been issued with a CAWN whilst investigations continued in relation to potential CSE against her, and mockingly told her that he would ignore the CAWN, despite knowing the consequences of not abiding by it, as he knew that the police would not follow up any breach. He was proved correct as no action

865 [redacted] pg 37
866
867 [redacted]

was taken when the CAWN was subsequently breached, and the individual continued to go missing and be exploited by the suspect.[868]

5.1247. In around 2011, Harbouring Notices were replaced by CAWNs. The WMP Guidance relating to CAWNs dated April 2011 notes that CAWNs are:

"*… simply part of an administrative process. If issued properly, these Notices can provide evidence to support the prosecution of other criminal offences and/or to support civil proceedings such as ASBOs, evictions or injunctions*".[869]

5.1248. In the event that WMP obtained evidence that the CAWN had been contravened, it was possible to arrest and interview the subject of the CAWN in relation to potential offences under the same legislation as the Harbouring Notice (i.e. the Child Abduction Act for children under 16) but it was and still is not possible to arrest for a breach of the CAWN as no such criminal offence exists. This leads me to conclude that CAWNs are a toothless and ineffective mechanism, in respect of managing vulnerable young persons at risk of CSE.

Conclusions – Missing Persons

5.1249. WMP was fortunate in having an officer who was interested in and engaged with the issue of missing children; its response was largely driven by that officer from 2002 onwards.

5.1250. WMP adopted the IMPACT/COMPACT dedicated missing persons system early, though it is right to note that prior to that introduction, missing had not been integrated into data systems and relied upon paper records. However, notwithstanding IMPACT/COMPACT, I take the view that learning and practice relating to missing was not embedded early in WMP's practice: I am fortified in that view by the fact that 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.

5.1251. Embedded practice and culture matters: it is pointless collecting data on missing persons unless it is used to generate information which can be used to establish patterns and trends. It is pointless to know that a child has returned home unless they are spoken to by an officer who can coax information from them and ensure that such information is then appropriately disseminated.

5.1252. RHIs – whether so described or not – were plainly of variable quality. This is a problem that has plagued the CSE response across both the Council and WMP for the majority of the timespan I have investigated. Much depends on the talents of the person interviewing, and their appreciation of the significance of the interview. It seems to me that the Council's solution, latterly adopted, that RHIs are conducted by specialists, is a sensible one that should have been replicated in some way by WMP.

5.1253. So far as children in care were concerned, the exclusion of 'missing' by the 2004 Procedure of children who "*appear only to have absented themselves without permission for a short*

868 [redacted] pg 13
869 [redacted] pg 3

period of time" misunderstands the nature of CSE and in my view deprived WMP of potentially valuable information about patterns of vulnerable children's behaviour.

5.1254. Further, the fact that until 2009 a missing child could be categorised as 'low risk' seems to me to be astonishing. Any missing child should plainly be regarded as a priority.

5.1255. Nevertheless, under the guidance of the Strategic Lead, WMP continued to develop imaginative approaches to missing persons; I particularly note the 'skeletal missing person plans' as an innovative way to ensure that data was quickly shared in respect of persistently missing children.

Civil Orders

Protective Orders under the 2003 Act

5.1256. The 2003 Act gives a Chief Constable the power to make stand-alone civil applications to the Magistrates' Court for protective orders, designed to protect children and/or individuals from sexual harm. In summary, these powers mean that the police have the power to apply for orders that can prohibit defendants from a range of different activity, including contacting children or visiting a specific address or location. An application for these orders can be made by the police before a suspect is charged or convicted and even after it has been decided no prosecution lies, as the threshold criteria do not require the commission of a crime.

5.1257. In examining the facts and circumstances of CSE in Telford, I have considered whether WMP has made effective use of these civil orders in its safeguarding response to CSE. I have also noted the media coverage after Chalice, which suggested that senior officers believed that applications for these orders were *"too much trouble".*[870]

5.1258. There were some amendments to the legislation in 2015[871] and changes made to the name of the orders and the threshold for application[872], but the thrust of these legislative powers remained essentially the same. In this section, I will explain the powers as they were before the 2015 amendments – and therefore during the Chalice investigation - and set out the basic legal principles and criteria that would have applied to applications at the time. I will also consider evidence obtained by the Inquiry regarding the application of such orders.

5.1259. The 2003 Act also gave the Court power to make a protective order immediately following conviction for a qualifying offence;[873] several individuals convicted in Chalice were made subject to such an order. This section is intended, however, to focus on the stand-alone police powers that exist in respect of these orders and their application.

[870] [redacted]
[871] Changes came into force 8 March 2015 by virtue of the Anti-Social Behaviour Crime and Police Act 2014.
[872] Sexual Offences Prevention Order (SOPO) became Sexual Harm Prevention Orders (SHPO) and Risk of Sexual Harm Orders (ROSHO) became Sexual Risk Orders (SRO).
[873] Section 104 (2) of the Sexual Offences Act 2003

5.1260. The two main civil orders available to the police before 2015 were Sexual Offences Prevention Orders ("SOPOs") and Risk of Sexual Harm Orders ("ROSHOs").

Sexual Offences Prevention Orders ("SOPOs")/ Sexual Harm Prevention Orders ("SHPOs")

5.1261. The power of the police to apply for a SOPO came into force with the 2003 Act. The police were able to apply for these orders until the 2003 Act was amended in 2015. From 8 March 2015, SHPOs replaced SOPOs. The police could still make an application for a SHPO on a stand-alone basis in the same way, and the legal criteria for a SHPO and their practical effect is very similar, and the same prohibitions can be imposed.

5.1262. Section 104 (5) of the 2003 Act allowed the Chief Constable to make an application to the Magistrates' Court for a SOPO if it appeared that:

(a) *The person is a qualifying offender, and*

(b) *The person has since the appropriate date acted in such a way as to give reasonable cause to believe that it is necessary for such an order to be made.*

5.1263. A person was a *"qualifying offender"* under the 2003 Act if they had been convicted of an offence listed in Schedule 3 or 5 or had been cautioned in respect of such an offence[874]. The list of criminal offences in Schedule 3 and 5 include rape and child sexual offences. There were other gateways to be a 'qualifying offender', including being found not guilty of such an offence by virtue of insanity. Whilst I am mindful of the criteria in their entirety, it is beyond the scope of this report to comment on each individual gateway further.

5.1264. Section 104 (1) (a) says that a court "*may"* make an order if:

"… it is satisfied that the defendant's behaviour since the appropriate date makes it necessary to make such an order, for the purpose of protecting the public or any particular members of the public from serious sexual harm from the defendant". [875]

5.1265. A SOPO prohibited the defendant from *"doing anything described in the order"* and had effect for a fixed period (but not less than five years) or until further notice.[876] The prohibitions in the order had to be *"necessary for the purpose of protecting the public or any particular members of the public from serious sexual harm from the defendant".*[877]

5.1266. Once the necessity to make an order is established, the Court must consider every condition proposed in the application and ask whether it is a proportionate response to the risk posed.

5.1267. Should any application for an order not be determined at the same time as it was made, the Court had the power to grant an interim order imposing the prohibitions until the

[874] Section 106 (6) of the Sexual Offences Act 2003 – Schedule 3 and 5 contain a substantial list of sexual, violent offence and other related offences.
[875] Section 104 (1) (a) of the Sexual Offences Act 2003
[876] Section 107 (1) of the Sexual Offences Act 2003
[877] Section 107 (2) of the Sexual Offences Act 2003

application for the full order was determined. The Court could grant an interim order if it considered it *"just to do so".*[878] This was a low threshold and would depend on the evidence presented with the initial application.

5.1268. It is important to note that a breach of an order was a criminal offence, with the Court able to impose a custodial sentence of up to five years.

Risk of Sexual Harm Orders ("ROSHOs")/ Sexual Risk Orders ("SROs")

5.1269. The power of the police to apply for a ROSHO came into force with the 2003 Act. The police were able to apply for these orders until the 2003 Act was amended in 2015. From 8 March 2015, SROs replaced ROSHOs. The police could still make an application for a SRO on a stand-alone basis in the same way. The legal criteria required for a SRO is slightly different, but their practical effect is extremely similar in nature to ROSHOs.

5.1270. Section 123 (1) of the 2003 Act allowed the Chief Constable to make an application to the Magistrates' Court for a ROSHO if it appeared that:

(a) *The defendant has on at least two occasions, whether before or after the commencement of this Part, done an act within subsection (3), and*

(b) *As a result of those acts, there is reasonable cause to believe that it is necessary for such an order to be made.*

5.1271. Section 123 (3) defined the relevant acts as follows:

(a) *Engaging in sexual activity involving a child or in the presence of a child;*

(b) *Causing or inciting a child to watch a person engaging in sexual activity or to look at a moving or still image that is sexual;*

(c) *Giving a child anything that relates to sexual activity or contains a reference to such activity;*

(d) *Communicating with a child, where any part of the communication is sexual.*

5.1272. The 2003 Act defined a communication as sexual if any part of it related to *"sexual activity"* or a *"reasonable person would, in all the circumstances but regardless of any person's purpose, consider that any part of the communication is sexual"*.[879] *"Sexual activity"* was an activity that a *"reasonable person would, in all the circumstances but regardless of any person's purpose, consider to be sexual".*[880]

5.1273. It is clear that whether communication could be described as sexual would depend on the evidence presented but the test was objective in nature.

[878] Section 109 (3) of the Sexual Offences Act 2003
[879] Section 124 (6) of the Sexual Offences Act 2003
[880] Section 124 (5) of the Sexual Offences Act 2003

5.1274. A key difference between a SOPO and a ROSHO was that a ROSHO did not require a previous conviction/caution for an application to be made. The defendant for a ROSHO application could therefore be of previous good character.

5.1275. The Court could make a ROSHO if it was satisfied that:

(a) *The defendant has on at least two occasions, whether before or after the commencement of this section, done an act within subsection (3); and*

(b) *It is necessary to make such an order, for the purpose of protecting children generally or any child from harm from the defendant".*[881]

5.1276. A ROSHO *"prohibits the defendant from doing anything described in the order and has effect for a fixed period (not less than 2 years) specified in the order or until further order".* [882]

5.1277. The prohibitions could only be such as were *"necessary for the purpose of protecting children generally or any child from harm from the defendant".* [883] The prohibitions could be the same or similar to those in a SOPO and the Court had the power to make an interim order in the same way.

5.1278. It is important to note that a breach of an order was a criminal offence, with the Court able to impose a custodial sentence of up to five years.

The Legal Tests in Practice

5.1279. In relation to both types of order, the application criteria can be explained as a two stage process:

First stage

5.1280. Before a Chief Constable could make an application for a SOPO, they were required to show a qualifying previous conviction or caution existed, and that the defendant *"acted in a way that gives reasonable cause to believe that it is necessary for such an order to be made".*

5.1281. In contrast, before a Chief Constable could make an application for a ROSHO, they were required only to show that on at least two occasions, one of the acts described in section 123 (3) had taken place.

5.1282. In order to pass these thresholds for both types of order, the Chief Officer was first required to prove the act(s) to the criminal standard of proof (so that the Court is sure that the act(s) occurred).

[881] Section 123 (4) of the Sexual Offences Act 2003
[882] Section 123 (5) of the Sexual Offences Act 2003
[883] Section 123 (6) of the Sexual Offences Act 2003

Second stage

5.1283. In addition to proving the acts in the first stage, a Chief Constable had to prove the orders were necessary on 'the balance of probabilities' (so that the Court considers necessity more likely than not).

5.1284. The criminal standard of proof in the first stage was therefore a more stringent one: the qualifying acts had to be proved to the same standard as a criminal offence. This required strong evidence that was often missing. After all, if the evidence existed to prove the sexual behaviour to the criminal standard, formal criminal proceedings would almost certainly have been brought. However, the acts required for these civil orders may not amount to criminal offences but required the same standard of proof.

Post 2007 - Serious Crime Prevention Orders ("SCPOs")

5.1285. SCPOs are a further protective order potentially available in cases of CSE. Such orders are mentioned by the COP in the 2015 COP Peer Review of the Alliance (which I have discussed in more detail above); the COP believed that there could be greater use of SCPOs to tackle CSE.

5.1286. SCPOs were introduced under Part 1 of The Serious Crime Act 2007 (the "2007 Act") to allow the Crown Court to make SCPOs in a defined set of circumstances – i.e. a SCPO can be imposed post-conviction for a "*serious offence*" on application by the Director of Public Prosecutions or the Director of the Serious Fraud Office. Before making an order, the Crown Court must also have "*reasonable grounds to believe that the order would protect the public by preventing, restricting or disrupting involvement by the person in serious crime in England and Wales*".

5.1287. Section 2 (2) of the 2007 Act defines a "*serious offence*" as one which "*is specified, or falls within a description specified in Part 1 Schedule 1*" or "*is one which, in the particular circumstances of the case, the court considers to be sufficiently serious to be treated for the purposes of the application or matter as if it were so specified*".

5.1288. Part 1 Schedule 1 of the 2007 Act includes offences under any of the following sections of the 2003 Act (as are relevant to CSE):

- Sections 57 to 59A involving trafficking for exploitation;
- Section 14 (arranging or facilitating commission of a child sex offence);
- Section 48 (causing or inciting sexual exploitation of a child);
- Section 49 (controlling a child in relation to sexual exploitation);
- Section 50 (arranging or facilitating sexual exploitation of a child);
- Section 52 (causing or inciting prostitution for gain); and

- Section 53 (controlling prostitution for gain).

5.1289. The sexual exploitation offences created by the 2003 Act are therefore expressly covered by the 2007 Act as grounds for seeking a SCPO from the Court.

5.1290. A SCPO can contain prohibitions, restrictions and requirements as "*the court considers appropriate for the purpose of protecting the public by preventing, restricting or disrupting involvement by the person concerned in serious crime*". These are set out in section 5 of the 2007 Act and include, restrictions on a person's travel, finances or working arrangements, or prohibiting them from certain premises, for example. The maximum duration of a SCPO is five years and an order cannot be made against a person under the age of 18 years old. A breach of a SCPO is a criminal offence, carrying a maximum sentence of five years imprisonment.

5.1291. I note that the 2007 Act also allows for the High Court to make a SCPO on a standalone basis without the requirement for a conviction. In these circumstances, a court can make the order where it is "*satisfied that a person has been involved in a serious crime*" and where "*it has reasonable grounds to believe that the order would protect the public by preventing, restricting or disrupting involvement by the subject of the order in serious crime…*". The order can contain the same restrictions and requirements as one made by the Crown Court following conviction.

5.1292. While this Inquiry has not taken any direct evidence concerning the application of these orders in practice, it is relevant to note that such orders have existed since the 2007 Act as an option for the Court – but, importantly, not for the police; unlike other orders it is not open to the Chief Constable to seek SCPOs. This is, in my view, a limitation to the effectiveness of a SCPO in CSE cases. Despite this restriction, investigating police forces are able to communicate suggestions to the CPS and work with the prosecuting authority in order to seek such orders upon conviction. By contrast, SHPOs can be made for an indefinite period of time and the Chief Constable is able to make applications on a standalone basis, meaning those orders are much more accessible to police forces investigating allegations of child sexual abuse and exploitation.

Use of Civil Orders by WMP

5.1293. In its evidence to the Inquiry, WMP explained[884] that in relation to seeking civil orders in CSE cases:

> "*… each matter is considered on its own facts and set against the legal tests that need to be satisfied for each type of order … we also take into account Home Office Statutory Guidance and current case law*".

5.1294. The ultimate decision on whether to make an application rests with the Chief Constable.

5.1295. The Inquiry asked WMP for clarification of the extent to which preventative orders (as opposed to orders imposed on conviction) have been sought by WMP in relation to CSE.

884 [redacted]

WMP informed the Inquiry that, in the last five years, there have been 35 applications, of which 31 were successful. Of these, 29 were aimed at protecting children from the risk of sexual harm[885] but only 13 were relevant to CSE[886]. The Inquiry was not provided with any statistical data for applications before this period. Based on those statistics, this means that almost 42% of civil orders sought in the last five years were linked to CSE.

5.1296. One witness, who worked for WMP[887] from the late 1990s through the early 2000s told the Inquiry about their experience of SOPOs and ROSHOs at the time. They explained that the MOSOVO Unit was responsible for managing individuals subject to these orders, and whilst the MOSOVO was not responsible for making the applications itself, other police officers would often seek its advice on whether an application could be made.

5.1297. In approximately 2010/11, another witness recalled being approached by an intelligence officer who wanted advice on the issues relating to suspects who were not charged as part of the Chalice investigation. The witness described the officer believing the individuals were *"up to no good"* and that they had ongoing access to children. The witness recalls being told that there were potentially 25 ROSHO applications that could be made. The witness believes the information concerning ROSHOs was passed to the SIO of Chalice, but, as I have made reference to above, there were reports that these were viewed by senior officers as *"too much hassle".*

5.1298. This witness told the Inquiry they initially viewed this as an *"outrageous"* decision. The witness voiced their dismay, but said they did not believe their concerns were escalated. The concern was that the suspects who were not considered for ROSHOs may have gone on to offend in circumstances where the ROSHO would have prevented contact. The witness further explained that to seek the ROSHO applications would not have been a "*hassle*"' and would not have involved any additional investigative work, as the evidence had already been gathered and a file simply needed preparing and sending to WMP's solicitor for review.

5.1299. The Inquiry sought evidence from officers involved in Chalice as to the decisions taken in relation to ROSHOs. I have not seen any evidence to corroborate the suggestion that the SIO or any other senior officers viewed the ROSHOs as "*too much hassle*", and indeed this comment is not in keeping with my assessment of that SIO's approach during Chalice.

5.1300. I also heard evidence that the MOSOVO was, at this time, *"snowed under with work"* and did not have enough capacity to take on further work in respect of the ROSHO applications.[888]

5.1301. An officer[889] who worked on Chalice also told the Inquiry that they could not recall civil orders being considered at the early stages of the operation, but recalled that an intelligence officer created a matrix of suspects who had not been prosecuted, but who may still present a risk of harm to the public.

885 [redacted] pg 149
886 pg 40
887
888
889 pg 9

5.1302. I have also heard evidence from a different witness[890] who worked for WMP during the time of Chalice. He told the Inquiry that he could not remember any such applications being brought to his attention during this period. This witness stated he had some responsibility for these kinds of orders, so would have expected to have been aware of them, had applications been sought. The same witness also commented that it was not *"uncommon"* for SOPO and ROSHO applications to be rejected by internal police legal services[891] and officers were *"really quite scared to make a decision"*[892] on such orders, in case they were blamed if the applications were unsuccessful.

5.1303. The Inquiry also obtained witness evidence from the SIO on Chalice who made the decision not to make applications for civil orders in respect of those suspects who were not arrested in Chalice.[893] The witness described reviewing a 'risk matrix' of suspects to establish whether the police could make an application for a ROSHO against 19 men who fell into this category. He described obtaining advice from WMP legal services, and said that he was advised that a Court was unlikely to grant ROSHOs in cases where complaints concerned historic offending, with no recent evidence of sexual misconduct. He was advised that WMP would not be able to show the suspects presented an ongoing risk of sexual harm, which was necessary to secure the orders. It seems to me that there is merit in that advice, however unwelcome it was.

5.1304. In respect of the remaining suspects that were arrested but not prosecuted, the witness explained that he made the decision not to pursue civil orders as he believed this would constitute *"two bites at the cherry".*[894]

5.1305. I assume that by saying this, the officer believed it was wrong to try and take further action because the criminal process was not pursued. He instead made the decision to manage the individuals through community engagement and by way of CSE markers on the intelligence system. I have however, seen evidence from the 2018 4Ps Review (discussed above), which concludes that the management of suspects in this way was not entirely successful.[895]

5.1306. The MCRT Review, discussed earlier in this chapter,[896] confirms that consideration was given to civil applications by WMP, but following legal advice:

> *"… it was considered that this was not a proportionate course of action … it was considered that any application for civil orders were highly likely to be opposed which would have required each victim to give evidence in court. This course of action was therefore not considered appropriate both for the potential trauma it could cause to the victims".*

5.1307. I note that there were a number of suspects in relation to which no legal advice was sought or given, and an independent decision made by the OIC not to make applications.

890 [redacted] pg 40
891 pg 67
892 pg 67
893 pg 12-13
894 pg 13
895 , pg 13
896 pg 846

Conclusions – Civil Orders

5.1308. The fundamental point to be remembered here is that for a relevant order to be made, the facts must be proved to the criminal standard. In a case where the only acts that can be relied upon to apply for an order are allegations of crime, and the CPS or the police have taken the view that – for whatever reason - those crimes cannot be proven, they can no more be proven for the purposes of a protective order. Applications for civil orders are therefore heavily dependent upon the availability of witness evidence.

5.1309. It is not the case that protective orders are dependent on proof of the facts of an underlying crime where there is other evidence that establishes threshold behaviour. In this way, simply to assume that to apply for a protective order was to have *"two bites at the cherry"*[897] is not in all cases correct. Where there is evidence that establishes threshold behaviour not amounting to criminality, for example, a sexual communication falling short of an invitation to sexual activity – then an application could be made notwithstanding that a prosecution for other criminality was not viable.[898]

5.1310. Equally, the need for victims/survivors to provide evidence would depend on the nature of the acts. Proof of acts or the way a defendant has acted does not always impose a requirement for a victim/survivor to give evidence – as per the example above, evidence of text messages or other forms of communication could stand as reliable evidence without a victim/survivor account. Having said that, it has not been practical within the scope of this Inquiry to review every aspect of every suspect's (potentially non-criminal) behaviour to determine if an application for a non-witness based protective order might have been possible.

5.1311. The 'second stage' necessity criteria can also be a significant barrier, as this will depend on a number of factors including the behaviour of the defendant since the relevant acts took place and the nature/frequency of the acts themselves: people change - a person who has committed a sexual offence against a child at age 18 in 1972 and has not offended since, would be unlikely to be regarded by a Court in 2022 as presenting the same risk of offending against children.

5.1312. Ultimately, the police decision on whether to pursue these applications will always be a matter of fact and degree in each individual case. It is entirely appropriate that the police seek legal advice in respect of such applications, and it is the duty of any force solicitor (or any lawyer) to advise according to their assessment of the facts and the law, not according to their client's wishes. Although it is not necessary to prove the suspected underlying offence to found a protective order, it is necessary to prove threshold acts to the criminal standard. As a result, considerations of availability, reliability and credibility of witnesses will be paramount; and, in a CSE case, the potential effect of being named in an application may be a significant feature discouraging witness participation. Stand-alone protective orders are a significant imposition upon their subject's liberties, and that is why they are not easily won.

[897] [redacted] pg 13
[898] Section 124 (6) of the Sexual Offences Act 2003

5.1313. In the result I cannot conclude that there was an improper 'reluctance' by legal services to provide positive advice, or that that any advice was flawed. The standard of proof remains the single greatest barrier to successful application.

5.1314. Specifically, the evidence does not lead me to conclude that the potential for utilising stand-alone civil orders was ignored or considered *"too much hassle"* by WMP, or that protection of the public from unprosecuted suspects was paid too little heed. The reality is that the Inquiry has seen evidence that a risk assessment of suspects who were not arrested/prosecuted was created and reviewed anxiously by the SIO of Chalice.[899]

5.1315. A word on post-2015 orders. As I have already explained, in 2015 the 2003 Act was amended and ROSHOs were replaced with SROs. Whilst the criminal standard of proof remained for the threshold acts, it became necessary simply to prove an *"an act of a sexual nature".* This perhaps supports the view that the legal criteria were initially too complicated/difficult to overcome. In addition to this, at the same time SOPOs were replaced with SHPOs. In relation to these orders, whilst the criminal standard of proof again remained for the acts in question, the necessity test was again arguably made less stringent: in order to grant a SHPO, the Court need only be satisfied that the order is necessary to protect children from 'sexual harm'. The higher threshold of 'serious sexual harm' was therefore removed.

5.1316. Both these changes perhaps support the view that while pre-2015 protective orders were well intentioned, there were significant barriers to their use in cases of this sort.

Complaints and Corruption

5.1317. The Inquiry's Terms of Reference require me to examine the response of WMP to allegations of CSE, both as an organisation and insofar as individuals are concerned, and to this extent it has been relevant for me to consider whether or not I have seen evidence of any complaints about WMP in this regard – or indeed any evidence of misconduct, performance issues or indications of corruption within WMP, which may have impacted negatively upon the policing of CSE in Telford.

5.1318. In considering this aspect of the Terms of Reference I have taken the approach set out below.

5.1318.1 The Inquiry requested disclosure of any complaints and associated documentation in respect of the WMP investigations into those individuals selected as Case Studies (as per Chapter 8). This included specific requests in relation to certain officers, based on material I had reviewed and questions I wished to raise when considering those Case Studies.

5.1318.2 Further, the Inquiry made requests for any Independent Police Complaints Commission ("IPCC")/ Independent Office for Police Conduct ("IOPC") referrals relating to cases involving child sexual offences, and copies of any serious case

[899] [redacted] pg 117-135

reviews conducted in relation to individuals involved in, or affected by CSE activity in Telford.

5.1318.3 Aside from any specific complaints, I have also considered as part of my review of a number of WMP's policing operations into CSE, including those set out in this chapter and within Chapter 8 itself, whether or not there is evidence of individual wrongdoing on the part of WMP officers or staff members. Where relevant, the Inquiry has sought evidence from those individuals and/or other witnesses in order to explore those issues further. This also informed the Inquiry's requests for further complaints material, as explained above.

5.1318.4 Where either witnesses or documents have made reference to any relevant complaints or concerns, and where this has fallen squarely within the Terms of Reference, the Inquiry team has followed those up by carrying out research of existing documentation; speaking to other witnesses; or where necessary seeking further disclosure in order to assist me in reviewing that complaint or allegation in the round.

5.1318.5 Finally, I have considered whether or not, in reviewing all of the above material, I have seen sufficient evidence to suggest that, during the Terms of Reference of this Inquiry, there was any corruption within WMP. This includes corrupt practices within the organisation, as well as corrupt individuals. I have set out below what I interpret the term 'corruption' to mean, in this regard.

5.1319. Before considering each aspect of the above, I have set out briefly the particular framework within which police forces must operate when considering officer conduct and complaints.

Police Professional Standards and Complaints Handling

5.1320. Police forces have had the power to address officer poor performance and misconduct throughout the period of time prescribed by the Inquiry's Terms of Reference. The internal discipline regimes of police forces have seen many regulatory changes, but all have provided the ability for action to be taken against those officers whose conduct falls short of the expected standard.

5.1321. Complaints and conduct matters are dealt with by WMP's Professional Standards Department ("PSD").

5.1322. While I have, in considering this section, sought to remind myself of the statutory regimes relating to the handling of complaints and allegations of misconduct, I consider it beyond the scope of this Report to set the legislative regime out in detail. Briefly, the historical statutory regime for addressing complaints was contained in the Police Act 1964, the Police and Magistrates' Court Act 1994 and the Police Act 1996.

5.1323. The operational methods of the PSD are underpinned by statute and regulations which stem from the Police Reform Act 2002. Schedule 3 of that Act provides the basis for the statutory framework within which complaints and misconduct issues are handled, including provision for when cases should be referred to what is now the IOPC. In short, a complaint is assessed

by PSD, and if it relates to allegations which, if proven, would amount to a criminal or misconduct matter, then these are formally recorded and investigated by the PSD.

5.1324. Throughout the period of time relevant to the Inquiry's Terms of Reference, misconduct and performance matters have been regulated by various iterations of the Police (Conduct) Regulations ("PCR").

5.1325. I have adopted the definition of misconduct as *"a breach of the Standards of Professional Behaviour"* and 'gross misconduct' is defined as *"a breach of the Standards of Professional Behaviour so serious that dismissal would be justified"*.

5.1326. The Standards of Professional Behaviour ("SPB") are the standards expected of every police officer[900] and are underpinned by the College of Policing's Code of Ethics. This code is used by all police forces in England and Wales.[901] The SPB include matters such as honesty and integrity; equality and diversity; and authority, respect and courtesy. The 2012 SPB specifically stated that:

"Police officers do not abuse their powers or authority and respect the rights of all individuals".

5.1327. Police forces have a wide variety of sanctions to apply where complaints are upheld, ranging from 'management advice' to dismissal. Where the conduct being complained about, even if proven, would not justify disciplinary or criminal sanction, the complaint may be dealt with by way of 'local resolution'.[902]

Complaints about WMP and/or the Conduct of Officers

5.1328. The Inquiry has been informed by WMP that, since 2003/4, an electronic system called 'Centurion' has been used to record all complaints from members of the public, as well as misconduct investigations. Prior to this a paper recording system was used, and WMP explained there was a process of back record conversion from paper to Centurion. However, no records of complaints or misconduct matters exist prior to 2002.

5.1329. This system has pre-defined data fields and it is notable that neither CSE nor a CSE marker is within these fields. However, a 'free text' search capability is available and, in response to the Inquiry's disclosure requests, WMP conducted a search of the system using the following terms:

- CSE;
- Groom;
- Exploit;

[900] Schedule 2: The Police (Conduct) Regulations 2012
[901] Section 39A of the Police Act 1996
[902] Police Reform and Social Responsibility Act 2011

- Child Sex Exploit;
- Child Sexual Exploit;
- Child Sexual Abuse (Excluded Familial);
- Epsilon;[903] and
- Hydrant.

5.1330. I understand that the process for searching and identifying potential conduct investigations or complaints concerning CSE using 'Centurion' is not comprehensive and may not have listed all cases involving CSE dealt with by the PSD. WMP states that this is due to the limitations of the 'free text' search function which only looks for the words in the searchable fields and not in the body of the documents themselves.

5.1331. I have reviewed the Centurion searches and other disclosure provided to me by WMP regarding internal investigations by the PSD, to determine the volume of complaints and whether or not complaints against individual officers have been investigated appropriately.

5.1332. The search returned 24 results in total. Some results were obviously relevant to the Inquiry's Terms of Reference, while others were caught peripherally by the key word search – for example, a failure to submit correct paperwork during a CSE-related search.

5.1333. Of the relevant Centurion matters, I noted:

5.1333.1 An officer was issued with a written warning for failing to expedite an offence of child grooming;

5.1333.2 An officer was issued with management advice for failings in an investigation of offences against children;

5.1333.3 WMP offered apologies in two separate cases for failing adequately to update a victim/survivor;

5.1333.4 There was local resolution of a complaint of lack of victim/survivor contact;

5.1333.5 There was local resolution of a complaint that an officer had used inappropriate language during a grooming enquiry;

5.1333.6 There was local resolution of a complaint of lack of police interest in a grooming case;

5.1333.7 There was local resolution of a complaint involving a comment made by an officer dealing with children vulnerable to CSE;

[903] Using the actual operation name, however.

5.1333.8 A PCSO was issued with management advice for their reaction to a complaint that they were not taking CSE seriously; and

5.1333.9 An officer accused of gross misconduct in relation to making indecent images was dismissed.

5.1334. The Centurion material provided is insufficient for me to comment on the handling of these complaints or the appropriateness of the results – and it is beyond the scope of this Inquiry to investigate each individual case. I would simply note this: that it is obvious that not all valid complaints relating to a CSE case should result in dismissal. Failures in the use of appropriate language and attitude happen at times, and I consider it will often be appropriate in such cases to take a non-punitive course that allows officers to learn from their mistakes and for complainants to be reassured that their experience will not be repeated.

5.1335. I have seen further material relating to CSE-relevant complaints. One was a reflective complaint some years after a CSE investigation in which a parent expressed frustration at the length of time an investigation took to come to trial, which they attributed to police inaction.[904] The complaint was recorded appropriately and deemed suitable for local resolution. Given the material I have read in relation to this case, I do not consider that this was a decision which could properly be criticised. However, the progress of the case thereafter is not entirely unimpeachable, for two reasons – first, it took over six weeks for a senior officer to arrange a meeting with the complainant; second, that meeting was a further month ahead; and third, the senior officer left no record of the content of that meeting before the case was closed.[905] Plainly if there is to be public confidence in local resolution then the steps taken in pursuit should be properly recorded.

5.1336. I have also reviewed a 2014 file[906] involving a complaint against WMP as an organisation, expressing a feeling of general inadequacy of treatment during a CSE investigation over a period exceeding five years. The complainant expressed frustration at a lack of support and continuing difficulties they experienced as a result of the (then-concluded) investigation. I have carefully considered this file and note that many of the incidents complained of did not relate to police conduct. It is also plain that the investigating officer took tremendous pains to discuss the complaint in detail, to learn about the complainant's situation, and to take steps within WMP and with outside agencies to attempt to make things better. In my judgment the reality is that this was not a complaint about the police but a complaint to the police about an undoubtedly difficult situation; and that while WMP could have easily closed the case without this demonstrating a failing, the officer's response was compassionate, meaningful, and in my view does WMP credit.

5.1337. However, in addition to the complaints information disclosed to the Inquiry, and what this reveals about potential police 'performance' – and I use this term intentionally to capture all aspects of behaviour, including that which may fall short of formal conduct proceedings – it has also been right that I consider the evidence I have reviewed in CSE cases where there may not have been any official complaint by either a witness or a member of the

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public, but where I might nevertheless consider that questions may legitimately be asked about the conduct in that case.

5.1338. In doing so, there is one striking example that I believe merits individual mention – and this case is one that I have selected as a key Case Study for this Inquiry, and is discussed at length within Chapter 8: Case Studies. It is the case of Becky Watson.

Death of Becky Watson - 2002

5.1339. Following the Inquiry's review of the material disclosed in relation to the death of Becky Watson, I felt it necessary to send a request to WMP asking for details of any steps taken by WMP to investigate deficiencies in the investigation including the actions of officers involved. This request included details of action taken concerning officer performance.

5.1340. In response, the Inquiry received an email from WMP explaining that there are no records of any complaints or conduct issues relating to the death of Becky, or the subsequent re-investigations carried out by WMP, held on PSD systems.

5.1341. The evidence provided to the Inquiry indicates that in 2012, WMP carried out a review of the original 2002 investigation into Becky's death.[907] An initial report was produced, as part of this review, dated 21 November 2012, although it appears to have been submitted a month later, on 28 January 2013, and was sent to the Serious Crime Review Team for allocation. A second review was then carried out by the Major Crime Review Unit[908] and a closing report was produced in June 2015.[909]

5.1342. The reviews conducted identified a number of concerning failures in the original 2002 investigation. In particular, officers failed to investigate critical intelligence and/or evidence available at the time of the investigation including:

5.1342.1 An intelligence report created following another female's[910] disclosure of Becky having been raped in Manchester.

5.1342.2 An A4 piece of paper found in Becky's bedroom with the word 'rapist' by the name of a male who could have been investigated.[911] Notebook entries of officers indicated an important witness[912] had been spoken to that day but the A4 paper had been handed back to a family member.[913]

5.1342.3 An incident log relating to a witness's[914] visit to Wellington Police Station, and an officer notebook entry made by an officer who visited the witness and recorded her disclosure that Becky had been raped.

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5.1342.4 Threats that Becky had reported to a friend citing her fears that "*they* [the Asians] *are going to kill me*".[915]

5.1342.5 A30 (police report) entries that Becky and another female friend[916] were in trouble with Asian men. There were also entries that this female[917] had told a friend that Asian males had threatened to blow her house up.

5.1342.6 The investigation briefing notes in 2002 record that enquires are to be made regarding any connection between the road traffic collision and social services/child protection. The Council had recorded contact notes and/or referrals that should have assisted investigating officers identify a link with CSE. Additionally, there were notes from a second briefing which contained entries regarding Asian males, 'prostitution' and pestering children.

5.1342.7 A failure to carry out a forensic examination of clothes worn by Becky on the night she died.

5.1342.8 A failure to examine Becky's diary which was handed back to the family.

5.1342.9 A failure to examine Becky's mobile phone.

5.1343. I reiterate that these were failures in the original 2002 investigation into the fatal road traffic collision, in relation to disclosures that were made or evidence found during that investigation – not in relation information obtained prior to Becky's death. However, given the extent and nature of the failures identified in these reviews, it is in my view reasonable to suggest that these findings should have led to a formal internal investigation of officer conduct in the original 2002 investigation. There is sufficient evidence from those reviews to raise serious questions about what officers clearly knew, or ought to have known, as a result of the evidence I have listed above, at the time of Becky's death, and therefore questions should have been asked by WMP as to whether the conduct of the investigating officers could have amounted to *'misconduct'* or *'gross misconduct'*.

5.1344. The investigation concerned the death of a 13 year old child in unusual circumstances and it is clear on any view of the case that obvious and available lines of enquiry were not followed up at the time.

5.1345. In the conclusions to the review in 2012, the reviewing officer states:

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

915 [redacted] pg 58
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I present the above not as a criticism or even as an indicator that decisions may have been made in 2002 because of that attitude but that it is a consideration that should be borne in mind [nevertheless] …

It is also clear from the review in my opinion for whatever reasons things were not done or missed which should have been done not only in 2002 in respect of the rape allegation and the circumstances of Becky's death, but also again when [the officer] *carried out his review in 2010".*[918]

5.1346. The failures identified in the 2002 investigation, including the failure to investigate available intelligence and evidence (including mobile phones/clothing and the way this evidence was handled) could have, in my assessment of the relevant regulations in place at the time, amounted to actionable misconduct by certain officers.

5.1347. The subsequent failure of WMP to, at the very least, refer the concerns to the PSD for review and/or to consider any other internal performance management process (of which there is a separate process in place within the police) was, in my estimation, a significant failure by WMP, and an opportunity missed to acknowledge serious shortcomings in the 2002 investigation.

5.1348. Whilst I accept the initial investigation would, by that time, have been 10 years old and some officers may have retired or moved on, I believe these steps should nevertheless have been taken to assess the force's position, as some of the officers involved in the investigation may have still been in service. With this in mind, WMP failed to ensure lessons were learnt and failures addressed by not using the internal procedures in place.

Corruption – as defined, and as perceived

5.1349. As noted in the Independent Police Complaints Commission's '*Report on Corruption in the Police Service in England and Wales*'[919] (the "IPCC Report"), there is no authoritative single legal definition of the word 'corruption'.

5.1350. So far as police behaviour is concerned, the Criminal Justice and Courts Act 2015 (the "2015 Act") provided that a police officer is guilty of the offence of "*corrupt or other improper exercise of police powers and privileges*" if he or she:

"(a) exercises the powers and privileges of a constable improperly, and
(b) knows or ought to know that the exercise is improper."[920]

5.1351. A police officer will be considered to have exercised their powers and privileges improperly if he or she does so for the purposes of achieving a benefit for themselves, or a benefit or

[918] [redacted] pg 3
[919] https://webarchive.nationalarchives.gov.uk/ukgwa/20170914190740mp_/http://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Corruption_in_the_Police_Service_in_England_Wales.pdf
[920] Section 26(1)

detriment to another; and if *"a reasonable person would not expect the power or privilege to be exercised for the purpose of obtaining that benefit or detriment".*[921]

5.1352. While I consider the 2015 Act offence to be a useful indication of what amounts to corrupt behaviour, I do not propose to pass every concern expressed to the Inquiry through that legalistic filter. I have to bear in mind 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. The IPCC Report, for example, contained focus group research on public perceptions of corruption, which at its most basic amounted to "*doing something wrong*".[922]

5.1353. I have considered 'corruption' to be any behaviour that includes an element of deliberate and intentional wrongdoing by police officers, which would likely amount to a serious breach of the SPB or where conduct would constitute a criminal offence. This would include, for example, evidence of dishonesty, bribery or deliberately and with an improper motive failing to investigate allegations.

5.1354. I do consider this to be different from 'bad practice', where a particular culture or attitude may develop within an organisation, and which may in turn have affected the views and approaches taken by individuals – but which may nevertheless be perceived by members of the public at large to represent 'corrupt' practice, even though such behaviours do not fit the legal definition of the offence.

5.1355. It is right that I consider not just material disclosed by WMP but also the views expressed to me by witnesses in assessing the nature and extent of any corruption (actual or perceived) within WMP.

Racial Bias Leading to Corruption

5.1356. In examining the issue of race/racial tensions in Telford and any such links to CSE, 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[923], or because the involvement of Asian males in CSE meant that to investigate would potentially attract negative headlines;[924] in essence, such concerns related to police inaction driven by a fear of dealing with difficult issues. I have also heard evidence of allegations of preferential treatment of certain individuals.

5.1357. As to the 'inaction' point, which I discuss in more detail in Chapter 9: Attitudes and Impact, I am quite satisfied 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 have heard so many officers recognise the concept of a 'no-go area' that I am quite sure that this was how the locality was perceived among officers. It is an obvious conclusion that any police force which allows such a situation to develop is failing the community, but I have seen no evidence that this

[921] Section 26(4)
[922] 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
[923] [redacted]
[924] [redacted] pg 23

attitude developed for 'corrupt' reasons. Rather, I regard it as the development of bad culture and practice.

5.1358. As to preferential treatment – which I regard as falling more naturally within the definition of corruption – I have seen accounts with different themes.

Parking

5.1359 First, parking. I heard evidence from one individual who recalled that in the late 1990s through to the early 2000s, there was a practice of allowing individuals from the Pakistani community to use the police car park in Wellington as a 'privilege'. The witness described this as a way to "*pacify*" the community.[925]

5.1360. I have heard other evidence on the point concerning the alleged car parking at Wellington station from a different witness who was a police officer at the time; I accept this repeated account as accurate. This other witness did not consider the indulgence over parking to be indicative of any overt corruption within the force, but went onto explain:

> *"No I don't think so. No, not for a minute, not for a minute with corruption as such, but of course it becomes corruption".*[926]

5.1361. I understand this to mean that such indulgence risks leading to familiarity with individuals and, perhaps, a less rigorous attitude to those individuals than might be expected: the same witness felt that allowing such closeness with members of the community could compromise the police:

> "*… it becomes corrupt or the system does when a decision is made… where a decision is reached perhaps, right, perhaps we won't act on that intelligence because it's that person and we need to protected* [sic] *them because they're an informant. I wouldn't be at all surprised if that did go on …" .*[927]

5.1362. I have, however, seen no indication and heard no evidence to suggest that there was any such compromise of integrity, or that individuals were allowed any favours beyond parking. It seems to me that, if anything, this episode – which I accept took place – 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. It is not necessarily 'corruption' (as defined) for the police to offer a favour, but it strikes against the core duty that the public are treated equally, and gives an impression of bias, which in turn may be perceived as corrupt practice; as a result it is almost always unwise to offer any such favours.

925 [redacted] pg 26
926 pg 22
927 pg 22

Improper association

5.1363. Second, improper association. A witness told the Inquiry that they had heard of a senior police officer dining in a restaurant associated with the family of a CSE perpetrator. [928] I treat this evidence seriously, but with caution: it is not a first-hand account; it is not supported by other evidence or material disclosed to the Inquiry; and fundamentally, it does not show - even taken at its height - anything more than that the police officer was a customer of the restaurant.

5.1364. I can see how, externally, this could lead to members of the public assuming connections between individuals that may not exist, and that this in turn could lead to suggestions of 'corruption'; and to that extent great care must be taken by all officers to see that they are alert to the possibility that even innocent actions may give an adverse impression.

Immunity from investigation

5.1365 Third, immunity from investigation. Another witness recalled 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".* [929]

5.1366 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).

5.1367 Further, I have not seen any other evidence or material in support of this allegation, and without such evidence I do not feel able to accept this account as accurate.

Undue influence

5.1368. Fourth, undue influence. Another witness told the Inquiry that there was a small section of the Asian community that were *"really dictating"* things in Telford, and they were allowed to *"get into bed"* with senior police officers. The witness told the Inquiry:

> *"I'm not saying it's corruption, I'm not saying that brown envelopes changed hands, but certainly things went on that allowed sections of the community… and it wasn't the white community, the African Caribbean community, the Indian community, certainly they were never given the same* leeway [as the Asian community]". [930]

5.1369. Again, this evidence has the potential to amount to an allegation of police corruption as it tends to suggest that sections of the community were dictating the actions of police officers and receiving preferential treatment. Again, though, this has been relayed to me as second

928 [redacted] pg 26
929 [redacted]
930 [redacted] pg 82

hand speculation, rather than first hand evidence; further, it is notably unspecific as to cases or what "*leeway*" was given.

5.1370. I do not have enough material to know whether this allegation is true or not; what I can say with confidence is that senior officers should strive to ensure that the culture among officers and the public perception is such that there could be no reasonable belief in allegations of this sort.

5.1371. Further with regard to undue influence, another witness told the Inquiry that they knew of two police officers who were deliberately moved from the Wellington policing area by senior management after making a number of arrests which resulted in complaints from the Pakistani community.[931] The witness does not elaborate on the motive behind these moves, but the inference I drew from their evidence was that it was suggested this was done to prevent active policing in the area or further investigation of those individuals arrested; the officers had breached the 'no-go' understanding of policing in that area.

5.1372. Again, if proven to have happened this would be a very serious allegation of corruption; however, in considering this evidence I bear in mind that it is given by a person not directly involved with the related events, whose sources the witness concedes may be "*not objective*", and may have had "*axe[s] to grind*". It is also relevant that the allegation is not supported by any other evidence available to the Inquiry, least of all from any of the supposed participants. In all the circumstances I am unable to conclude that this incident occurred, still less that it was indicative of any corrupt practice linked to racial bias.

Dereliction of duty

5.1373 Fifth, dereliction of duty. In their evidence to the Inquiry, one victim/survivor supported the view expressed by others that they believed the police were more prepared to look the other way in relation to CSE, as they may have been "*doing deals*" with the perpetrators.[932] Whilst the evidence of victims and survivors has been invaluable to the Inquiry, I must also view this evidence – which was an expression of belief without any associated factual basis – as speculation, and with caution in the absence of any other supporting evidence which would strengthen the assertions made.

Bribery

5.1374. Sixth, bribery. 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 IOPC referral in 2019.[933] I have reviewed that investigation carefully, as plainly these allegations are of the highest seriousness. The investigation was, it seems to me, very thorough. It noted a number of important features, including that:

931 [redacted] pg 31
932 pg 12, pg 39, pg 43, pg 51, pg 52
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5.1374.1 The complainant had previously made allegations of unspecified corruption against another officer, but had not previously alleged bribery;

5.1374.2 There were inaccuracies in the complainant's account of the officer's involvement with the CSE investigation;

5.1374.3 The description of the accused officer was materially wrong;

5.1374.4 The officer concerned had denied the allegation; and

5.1374.5 The complainant was considered unreliable due to numerous changes in their account, each time it was retold.

5.1375. The investigation concluded that there was no case of corruption for the accused officer to answer.

5.1376. The investigation further noted, however, that this allegation had first been made some years before on two separate occasions. While the matter had been recorded by the officers to whom the complaint was made, and those officers had reported the allegations, there was apparently no subsequent referral to the Anti-Corruption Unit ("ACU"). The investigation concluded that there had been failures by PSD or the ACU (if referral had, in fact, taken place) to record the allegation, to perform any investigation, and to record any findings or outcome. The trigger for the investigation had been the public repetition of the allegation.

5.1377. I have said that it is no part of my function to review every CSE-related conduct investigation undertaken by WMP's PSD during the times of my Terms of Reference, and I stand by that. Given the seriousness of this allegation, though, and given that I have set it out in some detail, I consider it necessary to record that I regard the investigation's findings as well-reasoned and entirely reasonable. There were good grounds to find the complainant unreliable and his allegations were contradicted by independent factual evidence.

5.1378. There is, though, as the investigation itself concluded, room for criticism of the original handling of the complaint. While I appreciate that police officers will often face unfounded allegations of misconduct, and further appreciate the frustration and indignation that may cause amongst those complained about and their colleagues, it is no answer to adopt an informal triage system that simply discounts allegations which officers see as fanciful. This allegation, dutifully recorded by the officers who first heard it, either was not referred to the appropriate authority within WMP or it was not acted upon by that authority. That is a basic failing: an early investigation of the sort I have seen may have brought comfort to the complainant and the accused officer.

5.1379. Delay has the potential to feed suspicion, resentment and public disquiet. It plainly did so in this case. Any complaint or allegation of corruption of this sort should be dealt 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

5.1380. In addition to the conclusions I have drawn throughout this section, 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 am, though, a little concerned that there is no marker on its recording systems which makes these complaints more easily identifiable.

5.1381. I have however seen two specific instances in which there were delays in dealing with complaints – one a matter of months, and one of years. 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.

5.1382. 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). The 'no-go' understanding can only have fostered this. 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.

5.1383. 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 (which I have identified on the part of WMP in the course of this chapter, and particularly in the pre-Chalice era), whilst falling short of 'corruption' as defined, is still a very significant failure, and only further erodes public trust in the police.

5.1384. 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.

Victim/Survivor Voice

"I've really had enough of life now, I can't take it anymore. I need to get away from here. No one understands me or listens to me. I've got no one to turn to. I wish I was dead and then I wouldn't feel the pain anymore. I've got nothing I can call my own not even my body… that's always being passed round I just want someone to love me and take me away from all this.

…

I'm getting what I want out of it, I'm surviving off them. Without them I wouldn't have credit, vodka, fags, jewellery, food, money, clothes, and lifts wherever I wanna go…

…

When I'm with Asians though they make me feel important and loved but when I'm away I feel shitty. Sometimes when I'm in the bath I scrub and scrub myself but it feels like the dirt just won't come off and I swear I'll never go near them again but as soon as they ring me I'm all hyped up and can't wait to meet them. It's like they've got a hold on me somehow. If you say no to them they get really nasty and say they'll hurt you and your family and blow your house up but when you're nice to them and do as you're told they really do look after you and buy you what you want. I need them right now, they're all I've got, they never judge me, always listen to me and put a smile on my face."[1]

1 [redacted] pgs 13-15