Report of the Independent Inquiry Telford Child Sexual Exploitation

Chaired by Tom Crowther QC

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Chapter 3: The Council Response to CSE in Telford

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3. The Council Response to CSE in Telford

Introduction

3.1 As I have already noted in Chapter 1: Background to the Inquiry, it is important to remember that Telford & Wrekin Council (the "Council") did not exist until 1 April 1998. References to the "Council" before that date therefore refer to the actions of Shropshire County Council.

3.2 Over the course of the Inquiry, the Council has disclosed a total of 187,103 documents/1,165,098 pages of material to the Inquiry. In addition, the Council was invited to prepare a Corporate Submission. It was asked to set out certain background information and detail of relevance to the Terms of Reference including: the Council's role, responsibility and obligation in relation to Child Sexual Exploitation ("CSE") and how these have changed and developed; any policies and procedures that may have existed historically, and how these have changed within the organisation over time; and the impact of any changes in legislation or guidance upon standards or practice adopted within the Council. To assist the Council with this process, I provided a list of areas and questions which I asked the Council to address.

3.1 The Council provided its Corporate Submission to the Inquiry and responded to a number of queries raised subsequently. The Council indicated that some aspects of the Corporate Submission had only been answered in part as a result of the fact that some information or evidence was no longer available due to the passage of time; I accept of course that these difficulties were real. The result was that the Corporate Submission did have a number of gaps. Information available in minutes of meetings, audits and especially commissioner reviews were sometimes absent from the Corporate Submission, but available in the documents disclosed to the Inquiry. There were some inconsistences between the documents and the information contained within the Corporate Submission. I do not think that the omission of certain important issues from the Corporate Submission was a deliberate attempt to mislead the Inquiry, but it is relevant to note that it made the task of piecing together all of the documents and producing a coherent timeline much more difficult and time consuming.

3.2 To assist me in the task of reviewing the Council response to CSE, I have been aided by the Inquiry's social care expert, Jane Wiffin. She has offered advice on matters within her area of expertise and I have benefitted from her direct experience of the issues under examination. She has also acted as a sounding board in terms of my Recommendations relating to this chapter, which can be found at the beginning of this Report. I have taken her expert opinion into account when drafting this chapter and I am very grateful to her for her input and expertise.

3.3 In terms of the structure of this chapter, I have considered three distinct time periods 1989 to 2004; 2004 to 2012 and 2012 to date. I have reached conclusions in respect of each of these time periods. I have separately considered four specific issues which I consider to be of particular importance and worth examining in isolation, namely: support offered to parents of victims/survivors of CSE; the Council's approach to missing children; the Children Abused Through Exploitation ("CATE") Team's access to the Protocol system over the course

of the relevant period; and the response of agencies to a report concerning an HIV diagnosis of a CSE perpetrator. As required under my Terms of Reference, I have considered the findings of three existing reviews and reports, dating from 2014 to 2016, and considered whether they drew accurate conclusions. To conclude this chapter I have considered the issue of CSE in the context of the education sector.

3.4 Given the vast amount of material disclosed, it will be no surprise that this chapter is very lengthy. It is also detailed and dense. Any reader hoping completely to untangle the bureaucratic web that developed around the Council's provision(s) for CSE may be disappointed; too often lines of responsibility were not clearly drawn; committees and groups overlapped, and shared names, participants, and responsibilities; and came and went without explanation. That bureaucratic culture is an aspect of the Council's operation on which I comment during the chapter.

3.5 I have already set out an Executive Summary in some detail, and do not propose to rehearse that; but at the outset of each of the three time periods, I have set out a brief summary of the key developments over that period, in an attempt to give context to what follows. Appendix G is a timeline which sets out the headline events for each time period, to illustrate what was being done on a national basis and comparing this to the local picture.

3.6 I should note that the terminology used to describe the Council's Children's Services provision has changed over the period under review and it has been described as 'Social Services', 'Children's Social Care', 'Children & Family Services' and 'Children's Services'. I have sought to use a consistent term for ease of understanding, and the Council's social work child protection response will be described as 'Safeguarding', unless named differently in a document to which I am referring. To further clarify, where I have used the phrase 'Social Services', by way of example, this will be capitalised if used in relation to a Council department, but otherwise it will not (except for when used within a quote, in which case the original text will be used). I encourage readers to also have reference to the Glossary to the Report, which includes a number of regularly occurring terms and acronyms.

1989 to 2004

Key Developments

3.7 In the period before the mid 1990s, children were perceived by society generally and in law to engage willingly in sexual activities for financial gain. They were labelled as 'child prostitutes', and they were considered as no different from adult prostitutes. For example, between 1989 and 1993 the police issued 1,758 cautions and 1,435 convictions to female children under the age of 18 in England and Wales. In the same period there were 46 cautions and 48 convictions of male children for offences relating to their involvement in 'prostitution'.[1] If local authorities responded at all, the response was for local authorities to bring these children into local authority care for being exposed to 'moral danger'

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

3.8 The Children Act 1989 (the "1989 Act") placed a new range of duties on local authorities and courts to place the welfare of the child at the centre of decision making. It set out a duty on local authorities to "*safeguard and promote the welfare of children within their area who are in need*" and a duty to make such enquiries as they consider necessary to decide whether to take any action to safeguard or promote the welfare of a child suffering, or likely to suffer, significant harm.[2]

3.9 In 1991, '*Working Together Under the Children Act 1989: A Guide to Arrangements for Inter-agency Co-operation for the Protection of Children from Abuse'* was published, consolidating guidance on procedures for the protection of children. It made clear the local authority's responsibility to identify children whose health and development would be impaired without support, and to recognise those in need of protection by being sexually, physically, or emotionally harmed.[3]

3.10 As I have noted, Telford's local authority, during the early to mid-1990s, was Shropshire County Council. Social care was generally delivered by an area team; child protection enquiries however were dealt with by a specialist team which would receive referrals and carry out initial investigation before handing over to area (later district) teams for ongoing management.

3.11 The child protection team was seen as the elite service and seat of expertise. It dealt with intra-familial abuse. Although the team was highly specialised, there was a perception that the elite nature deprived the district teams of expertise, and that provision was not joined up. In an attempt to deal with this perception, the teams were combined and redrawn and additionally the service, including the child protection side, received referrals from the public as well as from professionals. It was this structure that was inherited by Telford & Wrekin Council when it became a stand-alone ("unitary") authority in 1998.

3.12 The Inquiry has seen evidence which suggests that the new unitary authority's focus was on education, rather than social care:

"[Care – adult and children] – *really wasn't as sexy, it really wasn't seen as such a high priority as Education and Training. Education and training was very much the flagship.*"[4]

3.13 Furthermore, there was a lack of expertise and understanding:

"*it took a number of years* [following 1998] *for the council to understand what safeguarding was about*."[5]

3.14 There is evidence that CSE was happening in Telford in the 1990s and that the local authority (both before and after the establishment of the unitary authority) was aware of it; social workers were attending child protection case conferences with the police.

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[2] Children Act 1989 (legislation.gov.uk)
[3] Home Office, Department of Health, Department of Education and Science, and the Welsh Office (1991) '*Working together under the Children Act 1989: a guide to arrangements for inter-agency co-operation for the protection of children from abuse'*. Stationary Office
[4] [redacted] pgs 7-8
[5] [redacted] pg 35

3.15 Further, the Inquiry has seen evidence that in 1997/1998, youth workers providing school support and youth club services became concerned about children who were going missing at weekends, the suspicion being that they were being taken to Birmingham by older men. Other agencies were less engaged; the Inquiry has seen an account that:

"… *the police* [saw] *them as a nuisance, the care providers from the care home weren't interested, it was almost like it's their choice… if they want to go missing it's their choice."*[6]

3.16 The Inquiry heard that social care and the child protection system did not 'pick up on' CSE because *"the referral pathways weren't there for that sort of thing*".[7]

3.17 In this regard, it may also be a factor that lines of communication between the Youth Service and Children's Social Care were not properly established; the Inquiry has an account from a witness familiar with the interaction between the two:

"*We didn't share the same values, we didn't have the same culture, so we tended not to engage with them much, or them with us. So they kept their pocket of kids and we kept our pocket of kids."*[8]

3.18 The Inquiry heard that the limits of the old Shropshire child protection teams remained under the new authority, in that the focus was abuse within the family; abuse (including exploitation) dealt with outside the family was deemed "*stranger abuse*"[9] and was referred to the police; the role of Safeguarding in such cases was simply to make assessments for therapeutic support. This was not, of course, the role contemplated by the 1989 Act in respect of children at risk of serious harm.

3.19 The Inquiry heard the belief expressed "*social services wouldn't have had the power to intervene in such a* [extra-familial] *case*".[10] If that belief was held, it was plainly wrongly held and should have been corrected.

3.20 The Inquiry heard that the Head of Social Services role was not "*delivered well*"[11] and that social care managers felt "*besieged and under-confident"*.[12] The Inquiry has seen evidence of dispute between different geographical areas in social care and lack of cooperation. In the early 2000s, the Social Care department was said to be "*quite fragile... especially for children"*.[13] The Council scored extremely poorly on inspections, although improvements were recognised by 2003 and 2004.

3.21 Case studies show that where Safeguarding were involved children were often treated as if they had full agency; the approach was 'victim-blaming' with a focus on the children's behaviour rather than on the actions of perpetrators. The support provided by Safeguarding was reactive, and erratic, with continual drift and delay. There is evidence that child protection workers 'hid behind' protection of information with "*a well embedded culture of*

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6 [redacted] pg 3
7 [redacted] pg 20
8 [redacted] pg 4
9 [redacted] pg 5
10 [redacted] pg 17
11 [redacted] pg 5
12 [redacted] pg 8
13 [redacted] pg 5

confidentiality".[14] Of course, it remained the case that CSE or 'child prostitution' was not of itself seen as a qualifying factor for social care involvement and that no other provision existed for support of victims of CSE.

3.22 In 1999, '*Working Together to Safeguard Children: A Guide to Inter-Agency Working*'[15] was updated and reissued. It required Area Child Protection Committees ("ACPCs") to develop local policies and procedures for inter-agency work to protect children and to encourage effective working between services. The guidance highlighted 'child pornography', 'the internet' and 'children involved in prostitution' as matters of safeguarding concern, and required ACPCs to put in place local protocols on responding to 'children involved in prostitution'.

3.23 In 2000, the Department of Health published '*Safeguarding Children Involved in Prostitution*' guidance. This was mandatory guidance and emphasised the obligation to have in place a local protocol.

3.24 In terms of recognition of and response to sexual exploitation by the Council:

3.24.1 Following concerns raised by youth club workers in about 1997, a case was made to the ACPC for funding for a project to "*monitor and evaluate the numbers of children involved in or at risk of sexual exploitation*".[16] Funding was granted – four hours per week - for an awareness raising campaign in schools. That response and level of funding was to endure through to 2006.

3.24.2 Minutes from a Safety, Partnership, Arleston, College ("SPACE") meeting in November 1999 note "*sexual exploitation*" as an "*issue/concern*", as well as "*violence and aggression linked to cultural issues*".[17]

3.24.3 The Youth Service organised a Sexual Exploitation workshop in December 1999[18] and ran it again the following year.[19]

3.24.4 A Sexual Exploitation group began to meet; the Council cannot identify when it began. The meetings were poorly attended. The ACPC minutes for May 2003[20] show that an attempt to create a working group for a CSE action plan had failed.

3.24.5 The 2003/2004 ACPC Business Plan suggests that there was a Sexual Exploitation group "*working to draft a multi-agency protocol*"[21] although the obligation to have a protocol had been in place for a number of years.

3.24.6 The Family Assessment and Support Team ("FAST") was created to deal with "*behavioural*" issues.[22] It was largely staffed with family support workers, who

14 pg 24
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16 , pg 9
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19 pgs 7-9
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22 pg 3

encountered difficulties in attempting to refer suspected victims of CSE to social workers. The Inquiry heard:

"*I think we all worked in silo and I think where we had concerns about particular children I don't feel like those concerns were shared. In the sense that I would have a conversation with a social worker or with the duty team to say I'm really worried about. I don't think they'd acknowledge the level of worry and I don't really feel like I ever met a threshold to get action from a social worker or proactive action from a social worker."*[23]

3.24.7 Locality teams called "Clusters" were set up as groups of agencies and services that work together and support children and young people.[24] Social workers did not work within Clusters during this time period. Clusters were not intended as a safeguarding service or CSE response, but the evidence the Inquiry has seen shows that they were dealing with victims of CSE – and encountering the same difficulty in referring such children to Social Care. The Clusters were ultimately told by a senior figure in Safeguarding to stop sending safeguarding detailed accounts of exploitation by email, because the allegations could "*start a race riot*". [25]

3.25 The overall themes of this period are of an unwillingness on the part of Social Care to recognise CSE as qualifying a child for its attention; and, in those cases where it did become involved, its response was focused on victim behaviour. This view of CSE endured: in the early 2000s, attempts by FAST and later the Clusters to refer children suspected of being victims of CSE to Social Care were rebuffed. The CSE response came essentially from the Youth Service and was, during this time, limited to a four hour per week awareness raising programme. The ACPC appears to have seen its role around CSE to be strictly confined to providing training rather than, as required by national guidance, to inquire about actual trends and to seek to coordinate partner agencies to understand and disrupt the problem.

The National Landscape

3.26 In examining the Council's response to CSE, it was necessary for me to gain an understanding of the national landscape and policy framework. The Inquiry's social care expert, Jane Wiffin, carried out a comprehensive review of the policy framework regarding CSE covering a period of 25 years, during which there have been developing concerns and changes in the understanding of CSE.

The 1989 Act

3.27 In 1989, the Children Act was passed; this was a watershed moment in safeguarding the rights and welfare of children. It was aimed at making the law less confusing and easier to apply and was hailed by the then Lord Chancellor as "*the most comprehensive and far-reaching reform of child law which has come before parliament in living memory*".[26] The

[23] [redacted] pg 14
[24] [redacted]
[25] [redacted] pg 15
[26] [redacted] pg 32

1989 Act placed a range of new duties on local authorities and the courts to place the welfare of a child at the centre of decision making, to promote the welfare of children in need and to take reasonable steps to prevent ill treatment and neglect.

3.28 It is right that I consider the significance of the 1989 Act at the outset. Whilst child protection policy, practice and knowledge has developed enormously during the period of my Terms of Reference, the professional response to child welfare concerns have been covered throughout by the 1989 Act. The following analysis has been provided by the Inquiry's expert, Jane Wiffin.

3.29 This legislation made clear that in all decisions to be made "*the welfare of the child is paramount*".[27]

3.30 Section 17 of the 1989 Act placed a general duty on all local authorities to "*safeguard and promote the welfare of children within their area who are in need.*"[28] A "*child in need*" is a child who needs additional support from the local authority to meet their potential, for example in relation to their health or development. A section 17 assessment is conducted to identify the needs of the child and ensure that the family are given the appropriate support in enabling them to safeguard and promote the child's welfare.

3.31 The concept of actual or likely significant harm was also introduced by the 1989 Act and has remained in place.

3.32 Section 47(1) of the 1989 Act states:

"*Where a local authority… have reasonable cause to suspect that a child who lives, or is found, in the area is suffering, or is likely to suffer, significant harm, the authority shall make or cause to be made such enquiries, as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.*"

3.33 Section 31 of the 1989 Act makes clear that in making further decisions about the need for compulsory removal of children from their parents care the local authority must be satisfied that:

3.33.1 The child is suffering or is likely to suffer significant harm; and

3.33.2 The harm or likelihood of harm is attributable to a lack of adequate parental care or control.

3.34 The Adoption and Children Act 2002 broadened the definition of significant harm in the 1989 Act, providing that there was no absolute criteria on which to rely when judging what constitutes significant harm. I understand from the Inquiry's social care expert that consideration of the severity of ill-treatment may include:

3.34.1 The degree and extent of physical harm;

3.34.2 The duration and frequency of abuse or neglect;

[27] The Children Act 1989 Section 1(1)
[28] https://www.legislation.gov.uk/ukpga/1989/41/section/17

3.34.3 The extent of premeditation;

3.34.4 The degree of threats and coercion; and

3.34.5 Evidence of sadism, and bizarre or unusual elements in child sexual abuse.[29]

3.35 The reference to a lack of adequate parental care or control in section 31 has caused uncertainty about a robust and authoritative response to extra-familial harm. Exploitation can take place without parental knowledge or acquiescence, but the process of sexual exploitation often leads to a significant loss of parental control and this, properly interpreted, allows a local authority to form the view that there is a lack of parental care or control for the purposes of the 1989 Act.

'Working Together' Under the 1989 Act

3.36 '*Working Together Under the Children Act 1989: A Guide to Arrangements for Inter-agency Co-operation for the Protection of Children from Abuse*'[30] ("Working Together 1991", or, where referred to in this chapter to include all previous iterations, as "*Working Together*") was first published in 1991. This document consolidated previous guidance on procedures for the protection of children and made clear the local authority's responsibility to identify children whose health and development would be impaired without support, and recognise those in need of protection who were being sexually, physically, emotionally harmed and neglected, resulting in actual or likely significant harm. It recommended developments for making safeguarding more effective, including fulfilling the requirements of the 1989 Act, and using lessons learned from individual cases. It did not specifically address the needs or circumstances of so-called 'child prostitutes'.

3.37 While there have been many iterations of the *Working Together* guidance, the basic process has remained the same. It is the responsibility of professionals to notice that children are being harmed or needing to be safeguarded; this should be shared with the responsible local authority. The local authority must, based on the available information, decide between no action, action to support a child and their family or action to safeguard using strategy meetings, child protection enquiries and child protection planning. The criteria on which these decisions need to be made has not changed since 1989. It is difficult to reconcile proper consideration of the terms of the 1989 Act and the *Working Together* guidance with a judgment that a child subject to CSE is not suffering or likely to suffer significant harm or, at the very least, needing to be safeguarded.

The Protection of Children from Sexual Exploitation

3.38 The 1989 UN Convention on the Rights of the Child[31] (the "Convention") was intended to provide the basis for an international response to the sexual exploitation of children. The Convention, ratified by the UK in 1991, contained several articles of relevance to the

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[29] Recognition of Significant Harm - The Voice of the Child - Family Law Research

[30] Home Office, Department of Health, Department of Education and Science, and the Welsh Office (1991) '*Working together under the Children Act 1989: a guide to arrangements for inter-agency co-operation for the protection of children from abuse*'. Stationary Office

[31] https://www.unicef.org.uk/what-we-do/un-convention-child-rights

protection of children from sexual exploitation. Those articles required children to be protected from:

3.38.1 All forms of physical or mental violence, injury or abuse, including sexual abuse by parent(s), guardian(s) or caretaker (article 19);

3.38.2 Economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development (article 34);

3.38.3 The inducement or coercion of a child to engage in any unlawful sexual activity (article 34(a));

3.38.4 The exploitative use of children in prostitution or other unlawful sexual practices (article 34(b));

3.38.5 The exploitative use of children in pornographic performances and materials (article 34(c));

3.38.6 Article 35 states that *"parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of the sale of or traffic in children for any purpose or in any form"*;

3.38.7 The Convention protects the rights of children in conflict with the law, ensuring that *"no child shall be deprived of his or her liberty unlawfully or arbitrarily"* (article 37);

3.38.8 It provides for the 'physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse' (article 39); and

3.38.9 Finally, the Convention recognises the right of every accused child *"to be treated in a manner consistent with the promotion of the child's sense of dignity and worth ... and which considers the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society"* (article 40).

3.39 I have emphasised, as underlined above, article 34(b), which expressly mentions exploitation via 'child prostitution'.

3.40 In the mid-1990s the voluntary sector, led by the Children's Society, Barnardo's and the NSPCC challenged the criminalisation of children and campaigned for the concept of 'child prostitute' to be changed and for these children to be seen as being abused, and the 'pimps' and 'punters' to be seen as abusive adults. The arguments for this campaign were outlined in the 1996 Children's Society publication '*The Game's Up: Redefining Child Prostitution: Children Society*',[32] the 1998 Barnardo's publication '*Whose Daughter Next: Children Next? Children Abused Through Prostitution*'[33] and a further publication by the Children's Society in 1999 called '*One Way Street? Retrospectives on Child Prostitution*'.[34]

[32] Lee and O'Brien (1995) *'The games up: redefining child prostitution: Children Society'*
[33] Swann and McNeish (1998) Whose Daughter Next: Children Next? Children Abused Through Prostitution: Barnardo's
[34] Melrose, M (1999). One way street?: Retrospectives on childhood prostitution. London: The Children's Society

3.41 In 1997 the Association of Chief Police Officers ("ACPO") produced guidelines regarding the "*coercers, users and victims*"[35] of 'child prostitution' and these were successfully piloted before becoming ACPO national policy. The focus had moved to recognise that some children were vulnerable, but the guidelines emphasised using professional judgment about children's circumstances.

3.42 In October 1998, at the Asia-Europe Child Welfare conference, the UK Government re-affirmed its intention to develop a national plan, which would draw together the extensive work being done in the UK to address CSE.

3.43 In 1999, the Labour Government announced a target to eradicate child poverty by 2020. This was the point at which 'early intervention' developed as a distinct, joined up policy approach.

3.44 In December 1999, the Working Together 1991 guidance was replaced by the updated '*Working Together to Safeguard Children: A Guide to Inter-Agency Working 1999'* ("Working Together 1999") to safeguard and promote the welfare of children.[36] This set out Government guidance on inter-agency co-operation to protect and promote the welfare of children. It required local authorities to ensure the existence of ACPCs. The ACPC was described as an inter-agency forum for agreeing how the different services and professional groups should cooperate to safeguard children in their area, and for making sure that arrangements worked effectively to bring about good outcomes for children. The ACPCs specific responsibilities were to:

3.44.1 Develop local policies and procedures for inter-agency work to protect children;

3.44.2 Audit and evaluate how well local services work together to protect children;

3.44.3 Encourage and develop effective working between services and professionals;

3.44.4 Improve local working based on national and local experience and research;

3.44.5 Undertake case reviews in instances where a child dies or is seriously harmed;

3.44.6 Improve the quality of child protection work through inter-agency training; and

3.44.7 Raise awareness within the wider community of the need to safeguard children.

3.45 The scope of the responsibilities of the ACPC extended to:

3.45.1 Children abused or neglected within families, including those harmed in the context of domestic violence;

3.45.2 Children abused outside families by adults known to them;

3.45.3 Children abused and neglected by professional carers, within an institutional setting, or anywhere else where children are cared for away from home;

3.45.4 Children abused by strangers;

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[35] [redacted]

[36] *'Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children'*. Stationery Office, 1999

3.45.5 Children abused by other young children;

3.45.6 Young perpetrators of abuse;

3.45.7 'Children involved in prostitution'; and

3.45.8 Children who misuse drugs and alcohol.

Framework For The Assessment of Children In Need And Their Families

3.46 In 2000, the '*Framework For The Assessment of Children In Need And Their Families*'[37] guidance (the "Assessment Framework") was published. This built on and superseded earlier Department of Health guidance used by social workers for assessing and protecting children. The purpose of the Assessment Framework was to assist social work practitioners, in consultation with other agencies, to understand the child and family's situation more fully, once concerns about significant harm had been established following initial enquiries and assessment.

3.47 The Assessment Framework process provided that there would be an initial assessment of each child referred to social services with a request for services to be provided, within seven days of referral. Where necessary an in-depth assessment, led by social services but involving other agencies or independent professionals, would then follow within 35 working days.

3.48 This guidance highlighted the importance of local authority social services departments working with other local authority departments and health authorities to safeguard and promote the welfare of children. It was to be seen to contribute to integrated working and identified that early intervention was essential to support children and families before problems, either from within the family or because of external factors, which have an impact on parenting capacity and family life, escalate into crisis or abuse. It further highlighted that good joint working practices and an understanding at a local level was vital to the success of the early intervention agenda.

3.49 The Assessment Framework also provided safeguarding professionals with a systematic way of analysing, understanding and recording what is happening to children within their families and the wider context of the community in which they live, including consideration of whether the child being assessed is in need, whether the child is suffering or likely to suffer significant harm, what actions must be taken and which services would best meet the needs of the child and family.

3.50 The guidance identified that those children 'involved in prostitution' were a particularly vulnerable group who can be invisible to statutory agencies, their wellbeing overlooked, and planning and interventions for them not adequate. The core principles that underpinned the Assessment Framework were to:

3.50.1 Be child centred;

3.50.2 Be rooted in child development;

[37] https://webarchive.nationalarchives.gov.uk

3.50.3 Be ecological in their approach;

3.50.4 Ensure equality of opportunity;

3.50.5 Involve working with children and families;

3.50.6 Build on strengths as well as identify difficulties;

3.50.7 Be inter-agency in their approach to assessment and the provision of services;

3.50.8 Be a continuing process, not a single event;

3.50.9 Be carried out in parallel with other action and providing services; and

3.50.10 Be grounded in evidence-based knowledge.

Safeguarding Children Involved in Prostitution and the National Plan for Safeguarding Children from Commercial Exploitation

3.51 In May 2000, the Government introduced supplementary guidance to Working Together 1999 titled *'Safeguarding Children Involved in Prostitution'* (the "2000 Supplementary Guidance").[38] It made clear the need to read this guidance alongside the requirements of Working Together 1999. Although this guidance still described the concern as one of children 'involved in prostitution' (the emphasis is mine), it did at least outline that the children were primarily victims of abuse and that it was necessary to safeguard and promote their welfare, alongside investigating and prosecuting those who abused them and coerced them into 'prostitution'.

3.52 The 2000 Supplementary Guidance highlighted that where a professional believed that a child was 'involved in prostitution' and was at risk of significant harm then they should always refer those concerns to the local authority's social services team. Within this guidance there remained scope for children to be convicted of prostitution-related offences if they "*persistently*" returned to "*soliciting on the street*". The ACPCs were reminded of the need to develop a multi-agency protocol to address 'child prostitution' and for this to include:

3.52.1 Activity to understand the number of children 'involved in prostitution' in their area;

3.52.2 A clear outline of the processes to be followed when there were concerns about children 'involved in prostitution', including the links to existing safeguarding processes;

3.52.3 A focus on the importance of developing local support services including advice, counselling, sexual health and drawing on the expertise of the voluntary sector;

3.52.4 Provision of expertise to guide professional action; and

38 [redacted]

3.52.5 A consideration of the need for inter-disciplinary training and awareness raising.

3.53 This guidance was reviewed in 2001 and there was an increased emphasis on recognising the child as a victim of abuse and the need to address the behaviours of adult perpetrators.

3.54 In 2001, the '*National Plan for Safeguarding Children from Commercial Exploitation'* was published by the Department of Health and the Home Office.[39] It highlighted information about what was happening to address the needs of children impacted by commercial sexual exploitation. It highlighted that the 1989 Act was the main statutory framework for promoting and safeguarding the welfare of children in England and Wales. This plan highlighted that ACPCs should take an active role in coordinating the work of local agencies in investigating the sexual exploitation of children and ensuring that appropriate protective services were in place.

3.55 The Government White Paper, '*Protecting the Public*' in 2002[40], outlined the need to reform the law on sexual offences since it was said to be "*archaic, incoherent and discriminatory*" and spoke of the need for the protection of children from commercial sexual exploitation.

3.56 In 2002, Middlesex University and the NSPCC contributed to a National Children's Bureau publication on CSE.[41] The research highlighted the seriousness of the issue; the extensive harm CSE caused to children; and the complexity of reaching out to those impacted. There were wide ranging conclusions about the need for a more coordinated professional response and the role that the education sector could play.

3.57 Also in 2002, there was recognition by Staffordshire police of the extent of CSE and the harm to children; Operation Sorcerer was launched. This would be one of many such investigations over the next ten years. One of these was Operation Chalice ("Chalice"), which led to a number of successful convictions being brought in 2013 for sexual abuse and CSE in Telford. I deal with Chalice in detail later in this Report, within Chapter 5: The Policing of CSE in Telford.

3.58 The 2000 Supplementary Guidance was issued under the LASSO Act 1970[42]. It was published on 1 May 2000 and was to be followed unless there were exceptional reasons justifying a variation. It notes*:*

"It is important to recognise 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. Increased awareness and research has shown that the vast majority of children do not enter into prostitution willingly and that their involvement is indicative of coercion or desperation rather than choice."

3.59 The 2000 Supplementary Guidance offered this advice:

"The Government recognises that creating a successful exit strategy from prostitution for a child is not a simple process. It requires a careful, caring and concerted inter-agency

[39] https://childhub.org/en/child-protection-online-library/national-plan-safeguarding-children-commercial-sexual-exploitation
[40] https://webarchive.nationalarchives.gov.uk
[41] '*It's someone taking a part of you: A study of young women and sexual exploitation'*
[42] [redacted]

approach that may have to be sustained for a long period of time. The development of ACPO Guidelines and their successful application in pilot areas in Nottingham and Wolverhampton show how effective inter-agency working can be in dealing with this problem."

3.60 I have underlined Wolverhampton to illustrate that a near neighbour of Telford was held up as a successful example of inter-agency working.

3.61 The guidance continued:

"Where children are already involved in prostitution, the emphasis must to be to protect them from further abuse and to support them out of prostitution."

3.62 It spoke of the importance of the police, health professionals, youth workers and teachers being alive to the possibility of children becoming involved in prostitution. There was a reminder of the obligation under Working Together 1999 to have in place a local protocol on responding to children about whom there are prostitution concerns consistent with local protocols for safeguarding children and with the framework for assessment of children in need:

"It is essential to have these arrangements in place so that immediate and effective action can be taken when required to ensure the welfare and safety of children considered to be involved in prostitution and to initiate appropriate investigative action against those who may have coerced and abused them."

3.63 The positive obligation to make arrangements was expressed in this way:

"ACPCs should make arrangements to develop a protocol on children involved in prostitution and take responsibility for monitoring and reviewing its operation.

The ACPC should make arrangements to:

- *actively enquire into the extent to which children are involved in prostitution.*
- *develop a local protocol on children involved in prostitution, and to monitor and review the operation of the protocol.*
- *provide a local resource and source of expertise for those who have concerns that a child may be at risk of being drawn into prostitution or is being abused through prostitution."*

3.64 However, the 2000 Supplementary Guidance gave clear direction as to how services should respond:

"When a parent, professional, or another person contacts a social services department with concerns about a child's involvement in prostitution, the social services department should decide on its course of action within 24 hours.

Referrals, following an initial assessment [led by the social services department after no later than 7 working days – the emphasis is mine, with wording taken from elsewhere in the document]*, may lead to:*

no further action;

directly to the provision of services or other help - including from other agencies; and/or

to the initiation of s.47 enquiries.

… An initial assessment may indicate that a child is 'in need' as defined by s.17 of the Children Act 1989, but that there are no substantiated concerns that the child may be suffering, or at risk of suffering significant harm. In these circumstances, the Framework for the Assessment of Children in Need and their Families provides a framework for a fuller assessment of a child's health and development, and of the parents' capacity to respond to their child's needs.

… This core assessment can provide a sound evidence base for professional judgements on whether services would be helpful and, if so, what kind of help is most likely to bring about optimal outcomes for the child."

3.65 The 2000 Supplementary Guidance anticipated the concern that information sharing can engender and reminded readers:

"Working Together to Safeguard Children provides guidance on the sharing of information. It states that personal information about a child held by professionals and agencies is subject to a legal duty of confidence, and should not normally be disclosed without the consent of the subject. However, it stresses that the law permits the disclosure of confidential information necessary to safeguard a child or children."

3.66 It further stressed the significance of a child going missing:

"It is known from research that children looked after who run away are particularly at risk of sexual exploitation. Local authorities should monitor carefully the incidence of children looked after who go missing, particularly from residential care. Local authorities should have protocols in place with the police and other agencies on the action to be taken whenever a child goes missing and when she or he returns."

3.67 Practical direction was offered as to the use of non-social work solutions:

"Youth services are well placed to help children who may be at risk of involvement in prostitution. In some areas, such as Walsall, the Youth Service has played an important role in raising awareness amongst young people of the risks of being coerced into prostitution.

The new youth support service, Connexions, will have an important role to play in both helping prevent children from becoming involved in prostitution and in helping those already involved. Local protocols on children involved in prostitution will need to include the

Connexions Service. The Connexions service is designed to reduce barriers to learning, which involves ensuring that the needs of young people are recognised and acted upon.

Ultimately, this will improve the life chances of those at risk of social exclusion, such as through involvement in prostitution, during their teenage years. Connexions will provide a network of personal advisers who will be able to provide advice and support to these young people, as well as putting them in touch with appropriate specialist services. This may include, for example, arranging for them to have a mentor who can help raise their self-confidence and enable them to lead more independent and successful lives as adults."

Lord Laming

3.68 In January 2003, Lord Laming published his report on the Victoria Climbié Independent Inquiry[43], giving over one hundred recommendations for action. The Inquiry concluded that Victoria's death had been entirely preventable and identified systemic problems in areas within the safeguarding system, multi-agency working, the role of senior managers and their understanding of what was happening on the ground. It did not address CSE. However, it did bring about changes embodied in *Working Together*, which focused on information sharing and understanding the differences across section 17 and section 47 of the 1989 Act.

3.69 The most significant recommendation, so far as this Inquiry is concerned, was that the Department of Health should amalgamate the *Working Together* guidance and the Assessment Framework documents into one simplified document. The report stated that this document should tackle the following six aspects in a clear and practical way:

3.69.1 It must establish a 'common language' for use across all agencies to help those agencies to identify who they are concerned about, why they are concerned, who is best placed to respond to those concerns, and what outcome is being sought from any planned response;

3.69.2 It must disseminate a best practice approach by social services to receiving and managing information about children at the 'front door';

3.69.3 It must make clear in cases that fall short of an immediately identifiable section 47 label that the seeking or refusal of parental permission must not restrict the initial information gathering and sharing. This should, if necessary, include talking to the child;

3.69.4 It must prescribe a clear step-by-step guide on how to manage a case through either a section 17 or a section 47 track, with built-in systems for case monitoring and review;

3.69.5 It must replace the child protection register with a more effective system. Case conferences should remain, but the focus must no longer be on whether to

[43] The Victoria Climbie Inquiry: report of an inquiry by Lord Laming - GOV.UK (www.gov.uk)

register or not. Instead, the focus should be on establishing an agreed plan to safeguard and promote the welfare of the particular child; and

3.69.6 The new guidance should include some consistency in the application of both section 17 and section 47.

Every Child Matters

3.70 In 2003 the Green Paper '*Every Child Matters*'[44] was published. It constituted the Government's response to the findings and recommendations of Lord Laming's inquiry and represented the Government's recognition of the value of investing in prevention and early intervention. It aimed to achieve the end of disjointed services that failed to protect eight-year-old Victoria Climbié and aimed to achieve better outcomes for all children by making organisations that provide services to children work better together. The ambition was that Every Child Matters would bring about a root and branch reform of children's services at every level, with its main aims being that every child, whatever their background or circumstances, would have the support they needed to:

3.70.1 Be healthy;

3.70.2 Stay safe;

3.70.3 Enjoy and achieve;

3.70.4 Make a positive contribution; and

3.70.5 Achieve economic wellbeing.

3.71 Each of these aims was subject to a detailed framework whereby multi-agency partnerships work together to achieve the objectives of the initiative. Criticism had been raised in the past that professionals had failed to understand each other's roles or to work together effectively in a multi-disciplinary manner, leading to poor services for children and families. One of the primary objectives of Every Child Matters was to change this, stressing the importance of all professionals working with children being aware of the contribution that could be made by their own and each other's service and to plan and deliver their work with children accordingly. The preferred model for the integration of agencies was a 'children's trust'.

3.72 Every Child Matters also made wide ranging recommendations for change, but relevant here are:

3.72.1 Improving information collection and sharing: the Council's AWARE system was highlighted as an example of good practice because it enabled all professionals to access the same information system; this system provided a traffic light system which highlighted levels of concern.

3.72.2 Establishing a common assessment framework ("CAF") across services for all children, which is dealt with in further detail below. This was designed to be used in situations where there were concerns with how a child is progressing in any

[44] https://www.gov.uk/government/publications/every-child-matters

way (raised by the child, a parent or a professional), where the child's needs were unclear, where the child's needs were broader than a professional's own service could address or where it was thought that a common assessment framework would help to identify the child's needs.

3.72.3 Replacing ACPCs, which were described as not working well in some areas and had a low priority regarding safeguarding children. ACPCs were to be replaced by Local Safeguarding Children's Boards ("LSCBs"). It was expected that these would bring together all relevant local partners:

"... *to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and to ensure the effectiveness of what is done by each such person or body for those purposes.*"

3.72.4 The Government's stated aim was that there would be one person in charge locally with the responsibility for improving children's lives. Local authorities were asked to create the post of Director of Children's Services, accountable for both local authority education and children's social services and also that there would be a lead council member for children.

3.72.5 Nationally, there was to be a Children's Commissioner and Minister for Children, Young People and Families in the Department for Education and Employment to coordinate policies across government.

3.73 These recommendations were all later mandated by the Children Act 2004.[45]

Children's Trusts

3.74 In 2003, the Secretary of State for Health proposed that children's trusts should be established locally, to bring health and social care of children under one management structure.

3.75 The Every Child Matters Green Paper defined the "*Children's Trust*" as normally sitting within the local authority, reporting to elected members, with "*a single planning and commissioning function supported by pooled budgets*".[46] The plan was that this would in turn drive forward "*the integration of frontline service provision*", the expectation being that "*localities… develop a change programme for implementing the* [Children's Trust] *framework*".

3.76 The Children Act 2004 followed, providing the legal basis for Every Child Matters and requiring the setting up of partnership arrangements to promote cooperation, improve wellbeing and to assess, plan and commission services that deliver better outcomes for children. A 'Children's Trust' was defined as a local area partnership, led by the local authority, and bringing together the key local agencies – some of which were under a statutory "*duty to co-operate*" – to improve children's wellbeing through integrated services

[45] https://www.legislation.gov.uk/ukpga/2004/31/contents
[46] [redacted]

focused on delivering the five Every Child Matters outcomes. The Children's Trust was seen as a thematic partnership within the Local Strategic Partnership – the multi-agency partnership operating at local level and bringing together public, private, community and voluntary sectors to work together more effectively to promote better outcomes for local people.

3.77 Every Child Matters' Children's Trust arrangements were said to have four essential components:

3.77.1 Professionals to be enabled and encouraged to work together in more integrated front-line services, built around the needs of children;

3.77.2 Common processes designed to create and underpin joint working;

3.77.3 A planning and commissioning framework which brought together agencies' planning, supported as appropriate by the pooling of resources, and ensuring key priorities are identified and addressed; and

3.77.4 Strong inter-agency governance arrangements, in which shared ownership was coupled with clear accountability.

The Bichard Inquiry

3.78 In 2004 the Bichard Inquiry was published.[47] This was a public inquiry into child protection following the murder of two girls in Soham by their school caretaker, Ian Huntley. The relevant findings to this review of sexual exploitation were the failure by the police and children's services to identify grooming behaviour, alongside a failure to take the issue of underage sexual activity by adults with children seriously. The Bichard Inquiry produced a number of recommendations, including that:

3.78.1 The Government should reaffirm the guidance in *Working Together*, so that the police are notified as soon as possible when a criminal offence has been committed, or is suspected of having been committed, against a child – unless there are exceptional reasons not to do so;

3.78.2 The Integrated Children's System should record those cases where a decision is taken not to refer to the police;

3.78.3 The Commission for Social Care Inspection, as part of any social services inspection, should review whether decisions not to inform the police have been properly taken; and

3.78.4 National guidance should be produced to inform the decision as to whether to notify the police. It was highlighted that this guidance could usefully draw upon the criteria included in a local protocol being developed by Sheffield Social Services (and brought to the attention of the Inquiry). Within this, the decision as to whether to notify the police would take account of:

3.78.4.1 Age or power imbalances;

3.78.4.2 Overt aggression;

[47] https://dera.ioe.ac.uk/6394/1/report.pdf

3.78.4.3 Coercion or bribery;

3.78.4.4 The misuse of substances as a disinhibitory;

3.78.4.5 Whether the child's own behaviour, because of the misuse of substances, places him/her at risk so that he/she is unable to make an informed choice about any activity;

3.78.4.6 Whether any attempts to secure secrecy have been made by the sexual partner, beyond what would be considered usual in a teenage relationship;

3.78.4.7 Whether the sexual partner is known by one of the agencies (which presupposes those checks will be made with the police);

3.78.4.8 Whether the child denies, minimises or accepts concerns; and

3.78.4.9 Whether the methods used are consistent with grooming.

Connexions

3.79 As I will explain in further detail below, one organisation that played a role in the Council's response to CSE was Connexions. It has therefore been appropriate me to understand more about this service, which was launched by the Government in April 2001. Its stated aim was to ensure "*a smooth transition from compulsory schooling to post-16 learning*"[48] and to the world of work. Connexions replaced the careers service and aimed to change the way that children were supported during their transition to adulthood, through encouraging them to stay in education and training until the age of 19.

3.80 There was a focus on supporting children with a "*coherence across current service boundaries, so that someone has an overview of the whole of a young person's needs*".[49]

3.81 The Connexions service was based on eight key principles, which included raising aspirations, taking account of the views of children and partnership working between agencies.[50]

3.82 The Government's decision to set up this new service was based on research which concluded that:

3.82.1 There were inadequacies in the current support system for young people, which meant that many were "*falling through the gap*";

3.82.2 Young people still lacked the career and decision making skills they needed to make effective career, course or job choices, and many lacked the confidence to seek help; and

[48] The Connexions Service in England – infed.org:
[49] The Connexions Service in England – infed.org:
[50] DfEE (2000) *Connexions* http://imsed.org/mobi/the-connexions-service-in-england/

3.82.3 Although young people had more choice post-16, they did not feel they had sufficient information about opportunities to help prepare them for independent living.

3.83 The Department for Education and Employment provided grant funding to local partnerships, which included a wide range of agencies providing help to young people, the aim being to provide a single integrated youth support service. Partnerships commonly included, for example, social services, youth offending, youth services and career service teams.

3.84 Initial specified caseload numbers for individual personal advisers was 10 to 20 people requiring "*integrated and specialist support*", 250 people requiring "*in-depth support*", and 800 people requiring "*general support*". This model drew criticism, particularly when resources overall appeared inadequate to meet the needs. It was noted that there was a dilemma over the balance between Connexions as a service that was targeted at children at risk and Connexions as a wider service for all children who wished to use it.

3.85 By 2006 there was significant concern about Connexions[51] and there was recognition that there remained a basic problem with the way in which Connexions was established as both a "*universal and a targeted*"[52] service. The impact of the Connexions strategy on youth work was unpopular in some sectors as it, amongst other criticism, had undermined the informal educational character of youth work.

3.86 Later, the guidance in Working Together 2006[53] (which I discuss further below) suggested that Connexions should work closely with other agencies concerned with child safety and welfare and, from 1 April 2008, responsibility for providing Connexions services was transferred to local authorities in each area. Documents show that from 2007, Connexions was known locally as Connexions4Youth. The local authorities were able to shape the Connexions service to fit their own planning priorities, with Working Together 2010 (again, discussed later in this chapter)[54] providing some further guidance as to what the Connexions service should provide.

District Authority

3.87 Telford & Wrekin sits within the historic county of Shropshire. Before the unitary authority came into existence in 1998, there was a county council, to which I have referred, and a district authority, created in 1974 as Wrekin District Council. The Terms of Reference for this Inquiry start from 1989 and it has therefore been necessary to examine the incidents of CSE and the response of the county and district authorities during this time.

3.88 It is important to highlight that there have been difficulties in obtaining both witness and documentary evidence from this time period. As has been referred to already in Chapter 1: Background to the Inquiry, the Inquiry was told by Shropshire Council that it no longer held a number of the documents requested. This is understandable due to the passage of time

[51] http://imsed.org/mobi/the-connexions-service-in-england/
[52] The Connexions Service in England – infed.org:
[53] [redacted] pg 17
[54] [redacted] pg 52

and the retention policies for local authorities. This lack of evidence is a difficulty that a number of other inquiries have suffered. However it has, as a result, been more difficult for me to reach meaningful conclusions for this earlier period of time.

3.89 What is known is that Shropshire County Council, as it then was, was split into four areas dealing with social care: Telford & Wrekin, Shrewsbury, North and South Shropshire. Originally, each area had a team with senior social workers, social workers and social work assistants. There were specialist teams within the area offices including Children's Services. From 1989 onwards a unit known formally as the "*special unit*" (informally as "*the A-Team*")[55] was the 'front door' service - the initial point of contact for child protection related enquiries received by the local authority. Later there were two special units, one for Telford alone, each of which was overseen by a Head of Child Protection.[56] A special unit would carry out an initial investigation before handing the case over to one of the area teams for ongoing management.[57]

3.90 Evidence provided to the Inquiry is that in Telford, from 1991 to 1997, there was a child protection team and district team structure. The district social work teams in Madeley, Wellington, Dawley and Oakengates dealt with issues of neglect and emotional abuse. The child protection team dealt with familial abuse only and was seen as the elite service and seat of expertise (the emphasis in the following quote being from the witness):

"If you had aspirations to become a manager you really had to have done a year or two in the Child Protection team… there was a sense that we were the crème de la crème... we were all designated as <u>*senior*</u> *social workers... we also had our pay enhanced. I think that's the sort of thing which breeds a certain amount of, I don't know, low-level resentment…. We were* [the ones] *to determine, if you will, what kind of work we would send to the district teams when we felt the child protection task was completed...* [the district teams] *were also very short-staffed."*[58]

3.91 Concern about the perceived elitism of the child protection team system was echoed by another senior officer in child protection:[59]

"… *there was a concern that those specialist teams, … were quite elite and that had* [an] *adverse impact on our other social work teams and colleagues that they were less aware and less knowledgeable so there was a move, over time, to remove those specialist teams and see child protection as a continuum as a child in need and they'd be part of assessment teams but not a specialist structure...."*[60]

3.92 The Inquiry understands that there was a realisation that the system, encompassing a high status child protection team and a lower-status set of district social work teams, was not desirable or sustainable, and that a decision was taken that the Wrekin area was going to be divided into North and South. It was decided that each division would have an initial assessment team (referred to in some documentation as an initial response team) with

55 [redacted] pg 5
56 [redacted] pg 26
57 [redacted] pg 5
58 [redacted] pgs 7-8
59 [redacted]
60 [redacted] pg 26

three social workers, and a case management team with three senior social workers. This compacted the five original teams into four and was, the Inquiry was told, intended to sweep away the old resentments. Additionally the service, including the child protection side, was open to the public, whereas the previous system had relied on referrals. It was thought that the restructure:

"… *challenged the elitism of the old child protection team.*"[61]

3.93 The Inquiry heard that this structure endured following the creation of the unitary authority.

3.94 As to the approach to what we would now regard as CSE cases, evidence given to the Inquiry was that the child protection teams would deal solely with familial abuse. Abuse perpetrated by people outside the family unit was deemed "*stranger abuse*" and:

"*Those were always discussed and usually referred to the police for action and our role, in those circumstances, was to make assessments of the need for support for a therapeutic input.*"[62]

3.95 This is, if accurate, a remarkable failure; as already noted, the duty under the 1989 Act is not simply to make assessments of the need for therapeutic support, but to consider whether the child is suffering from serious harm and if so, to follow the procedures set out in the 1989 Act and the *Working Together* guidance.

3.96 The Inquiry heard evidence from Council witnesses who were of the view that there were simply no reports of gang grooming or boyfriend model type CSE in the 1990s. However, a senior employee of Shropshire County Council, as it was then known, told the Inquiry that they recall reports and concerns about "*young people absconding and engaging in (suspected) risky activities*". They went on to describe how difficult it was to:

"… *address such patterns of behaviour. Usually, they would be young people already in our care so already with a complex and challenging background. Often their carers and social workers would be highlighting their worries and stating, in effect, "we can't contain them, we can't control then, we can't keep them safe". On more than one occasion* [the Council] *would have been asked to sanction an application for secure unit placement just simply to provide controls and perhaps to disrupt the damaging patterns of behaviour and links with risk adults /groups.*"[63]

3.97 The Inquiry also considered witness evidence that had there been such CSE-type reports, they would have been referred to West Mercia Police ("WMP") "*because social services wouldn't have had the power to intervene in such a case".*[64]

3.98 During the Maxwellisation process I heard a more nuanced account of this: that while referrals to the police would have been "*expected and requested*", the police could refer cases back where incidents were "*reflective of wider welfare concerns for a young person*".[65]

61 [redacted] pg 24
62 [redacted] pg 5
63 [redacted]
64 [redacted] pg 17
65 [redacted]

I have not, though, seen evidence of referral back. Further, I regard it as surprising that there would not have been action during a police investigation.

3.99 The evidence gathered by the Inquiry shows that CSE was indeed happening during the early period of its Terms of Reference, examples of which are as follows:

3.99.1 A child protection case conference report dated mid-1997 which records that an 11 year old child was "*placing* [themselves] *at risk of possible significant abuse from unknown adults, which may include sexual abuse, drug misuse, child prostitution etc".* They were *"in moral danger and* [had] *not been willing to engage with any workers who have had involvement with* [them]*, i.e. Social Workers, Police Officers, Residential Workers."*[66] The child's name was placed on the Child Protection Register under the category of neglect

3.99.2 A psychiatrist's report dated early 1998 provides the following description of a 15-year-old child:

"[Their] *current behaviours i.e. sexual promiscuity, possible prostitution and drug abuse would all seem to fit with the picture of a* [child] *with very low self worth who periodically gets depressed and periodically attempts to harm* [themself] *in various ways, some of which bring* [them] *to the attention of people like myself, others of which, e.g. the drug abuse, do not*".[67]

3.99.3 Concerns about this child "*selling* [their] *body*" are raised in a Safeguarding committee report.[68] There are a number of further references to Shropshire Safeguarding' concerns about this child and in late 1997 secure placement appears to have been considered.[69]

3.99.4 Further, in 1999, Lucy Lowe came to the attention of agencies and concerns were raised by her school that Lucy was "*attempting to sell drugs to pupils*" and involved in *"prostitution by young girls from the school*".[70] The only action taken by the Council was to write to Lucy's family to "*offer help*". I deal with the case of Lucy Lowe in much greater detail in Chapter 8: Case Studies.

3.100 In what seems to be an acceptance that the threshold for intervention was regarded inflexibly, after 1 April 1998, and often applied by non-qualified staff, the Inquiry heard:

"*I think we didn't pick up on CSE because the referral pathways weren't there for that sort of thing. The duty officer in the CP team – who was very rarely a qualified social worker – was crucial in referrals. It was someone who could think fast and type fast. They would discuss it with whichever senior social worker or team leader was on, but it's not a sound way of putting together complex pieces of information."*[71]

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66 [redacted] pgs 267-269
67 [redacted]
68 [redacted]
69 [redacted]
70 [redacted] pg 1
71 [redacted] pg 21

3.101 I understand this to be further indication that the child protection statutory requirements and onward referral was not a primary consideration for the child protection professionals who encountered CSE. So, despite there being evidence that children were being harmed through 'prostitution', this was not seen as inevitably a matter for statutory child protection processes.

3.102 Another factor was that families were reluctant to make reports to Children's Services as:

"*The perception of social workers is that they are people who take your kids away. That endures, even to this day, so there was a disincentive for some people, for family members to say 'I need to record this'.*"[72]

3.103 The Inquiry understands[73] that, during the 1990s, Telford was home to an innovative project directed at children who were potential '*perpetrators'* of sexual abuse. It was run by a youth justice team worker with practitioners from across social care and child protection. Its approach became known as the 'Shropshire Model', and was adopted by a number of local authorities. The features of this that are of relevance are:

3.103.1 First, that the Council found funds for a coordinator and administrative support although: *"Telford and Shropshire always seemed a bit 'strapped for cash' (Telford particularly)"*[74]; and

3.103.2 Second, that it began essentially as an interest group and its continued existence appears to have been dependent upon its two founders:

"*As is the way with specialist projects, the specialist knowledge that was being derived became concentrated within two people's roles rather than throughout a practice network, and something may have been lost.*"[75]

3.104 This pattern of official response being born from individual officers' concerns, was replicated in the response to CSE. It appears that the earliest such response came from another "*interest group*" around Stirchley, where the Inquiry heard that, in 1997/1998, youth workers providing school support and youth club services became concerned about children who were going missing at weekends, the suspicion being that they were being taken to Birmingham by older men.[76] Witnesses with knowledge of the situation told the Inquiry that when concerns were raised with authority figures that there was no provision for these children.

3.105 A request for information from both the Council and Shropshire Council about the Stirchley Project by the Inquiry yielded no results however the Inquiry was told that:

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[72] pg 22
[73] pg 6
[74] pg 6
[75] pg 6
[76] pg 3

"… it was a stigmatisation towards young people in care…. they were just seen as… "there's nothing we can do, we can't keep them in, if they wanna go, they'll go"."[77]

3.106 Further, the Inquiry understands that, in CSE terms, it was believed to be "*the start of something at the time*".[78] Around this time, a number of youth workers raised their concerns with a line manager, later then visiting a Barnardo's Project in Birmingham and commissioning the Barnardo's team to deliver a day's conference in Telford, to raise the issue of CSE locally. The existence of the Birmingham Project shows that CSE was not nationally unknown at the time; indeed, the Inquiry has heard from others about other authorities' and services' specialist provision around victims of sexual exploitation,[79] and since the mid-1990s the voluntary sector had been campaigning for the criminalisation of children and the concept of 'child prostitute' to be changed.

3.107 The above is further supported by evidence to the Inquiry that the youth workers' perception was that there was not a good working relationship between Youth Services and Safeguarding.

3.108 The issue was potentially further compounded at the time by a lack of resources. As well as the suggestion (above) that Shropshire and Telford always seemed "*strapped for cash*",[80] the Inquiry heard the view that Shropshire viewed Telford as requiring a disproportionate level of resources[81] and that:

"There was a sense that Telford was the poor relation before it became unitary. For example, I had never seen my divisional manager at Donnington though he only worked 17 miles away at the Shirehall in Shrewsbury. We were out of sight and out of mind."[82]

Telford & Wrekin – the Creation of a Unitary Authority

3.109 Telford & Wrekin Council was created in 1998 when Wrekin District Council became a unitary authority. The Inquiry heard that prior to the implementation of the legislation creating the unitary authority, there had been a number of arguments between the two Councils as to the appropriateness of the structural split. I heard that Shropshire County Council argued against the creation of the unitary authority and considered that would be the worst of all possible structural outcomes.[83]

3.110 The Inquiry heard that Telford was very different, culturally and economically, from the rest of Shropshire.[84] The Inquiry understands that the town:

"… had five old market towns, Dawley, Wellington, Oakengates, and Newport, they were very distinct market towns with their own identity, and then they were overlaid by the development of Telford New Town, sprawling new estates and inward migration. So you

77 [redacted] pg 4
78 [redacted] pg 21
79 [redacted] pg 38
80 [redacted] pg 6
81 [redacted] pg 12
82 [redacted] pg 13
83 [redacted]
84 [redacted] pg 7

had, imposed on these old structures, a very dislocated, rapidly growing mobile new population, many people who came from poor socio-economic backgrounds from the Black Country and Birmingham, put into all these newly built estates with their links to their wider family support networks broken. But what Telford didn't have was any sort of centre, or heart, it had a shopping centre but there was no social or cultural centre in the heart of Telford. It had old challenges and new challenges, coming together."[85]

3.111 Other witnesses told the Inquiry:

"*Looking back, reflecting on my experiences in Telford and also comparing Shropshire with Telford, Telford always felt 'the poor relative'. It was a small local authority and resources seemed much tighter than in Shropshire. It was small and therefore people knew each other, and there was a real sense of "we're all in this together". However, I think most people were doing at least two or three jobs or at least had two or three roles within their substantive posts and I would probably say the same about myself at the time."*[86]

"It lacks a centre, other than a shopping centre. We used to talk about it all the time when I was there. How do you create an identity for Telford as a place when it's built around a shopping centre that somebody else owns? And how do you create civic identity? How do you create a central locus?"[87]

3.112 The Inquiry heard that the rationale for seeking unitary authority status for the Wrekin District, which was accepted by the Government in 1997, was predicated on the borough having a distinct identity to the rest of Shropshire shaped by the Telford New Town. This presented opportunities and challenges that were strikingly different to the rest of the county – the demise of heavy industry, deprivation, stalled housing growth, and educational attainment significantly below the national average.

3.113 At this time, it was thought that Telford had more in common with an inner-city authority than with the rural landscape and economy of the rest of Shropshire. Shropshire County Council did not have the impetus or ability to address the challenges that Telford faced.[88]

3.114 Upon the establishment of the unitary authority, the Council took responsibility for Children and Adult Social Services and Education.[89] It is worth noting that the Council had three Chief Executives in the three years following the establishment of the unitary authority.

3.115 The new council was seen to be ambitious. The Inquiry heard that:

"*Telford & Wrekin Council has led the way on lots of things. They are and have been an innovative Council. When I came to Shropshire and I had the choice at one point in time of working in either Telford, where there's lots of pockets of deprivation, or Shrewsbury which,*

85 [redacted] pg 8
86 [redacted] pg 12
87 [redacted] pg 26
88 [redacted]
89 [redacted] pg 8

bluntly is full of the twin-set and pearl brigade and it was really hard in Shrewsbury to get innovative projects off the ground. Do you know what, it was a very, very different feel."[90]

"[it] *was keen to create and indeed did gain a great reputation regionally and nationally for 'punching above its weight'. We were always piloting or trailblazing something."*[91]

3.116 One witness to the Inquiry, previously a senior figure at the Council, explained that, although both the local authorities in the Shropshire area wanted to "*make their mark*", it was Telford & Wrekin, as a newly formed council, "*who was perhaps keen to show that it was making a success of its independence*".[92] The ambition showed itself particularly in its education provision:

"*We* [set] *out a clear and distinct vision, of what we wanted the new Local Education Authority to look like… We secured the complete commitment of all the local schools in Telford and from a very early stage, the commitment of the police and health services, the post-16 sector, towards a common vision. The White Paper which we published in 1997, it had five ambitions clearly set out which were:*

- *raising education and achievement;*
- *alleviating educational disadvantage (narrowing the gap);*
- *a coherent approach to Early Years;*
- *a coherent approach to post- 16 and lifelong learning; and*
- *putting schools at the heart of their communities.*

… and interestingly the phrase at 'the heart of their communities'… became one of the future Labour Government principles… David Blunkett (Sec of State for Education) picked it up and so it's now commonly referred to… We believed that education and the work between services was the key to social economic and regeneration and community cohesion. For a place like Telford, as I've just described it, those principles were very important because it was as much about social and economic regeneration and community cohesion for this disjointed and diverse locality."[93]

3.117 The new unitary authority was not universally welcomed, however:

"When local government reorganisation was proposed, all of the schools in Telford at the time were very unhappy and resistant to change, they wanted to stay with Shropshire. There was a complete mix of schools, the old grant maintained schools, comprehensive schools, grammar schools, secondary modern schools, there was Thomas Telford as a city technology college, it had every kind of mix of school that you could think, it was a

90 [redacted] pg 13
91 [redacted] pg 8
92 [redacted] pg 27
93 [redacted] pgs 9-10

microcosm of the British secondary education system. But very unhappy schools, they didn't want local government reorganisation, they didn't want to be part of Telford."[94]

3.118 The Inquiry also heard the view that Telford & Wrekin may have been over-ambitious. Its population was then about 160,000. Though it was not unique at that time in seeking unitary status with that level of population, current guidelines now suggest that a new unitary would not be considered with a population of less than 300,000 – in part because of the experiences of small unitary authorities from the 1990s.[95]

3.119 Being classed as, what one witness described as an "*upper tier*"[96] council, the new unitary authority was responsible not only for education but for statutory social care; a senior officer in post at the time told the Inquiry that the challenges of this may have been under-estimated,[97] and another involved in the very early days suggested:

"*Care – adult and children – really wasn't as sexy, it really wasn't seen as such a high priority as Education and Training. Education and training was very much the flagship."*[98]

3.120 Further, the Inquiry heard the view that:

"Telford the place, especially the new town itself, is a much more challenging area than might be supposed. The levels of deprivation are significant though not as bad as other parts of the West Midlands conurbation. More so, there are severe challenges to how the town was designed, built and populated as one of the post war "overspill" new towns.

One feature of that from my professional perspective at the time was that many of the vulnerable families we worked with were displaced from their previous networks, lacking in the presence of extended families who had been left behind and with new community networks which felt as fragile as the poorly designed town. Being poor or vulnerable is not easy in any place, but I would argue being poor or vulnerable in Telford had particular challenges."

3.121 The same witness took the view that during the early days of the unitary authority:

"*… for understandable reasons, the political and officer leadership of the council was generally more concerned with their "place building" responsibilities which they understood better as former district leaders, than their "people" duties, like social services; and to my mind, the more vulnerable people of Telford lived in relatively under-developed and fractured communities because of the recent and poor physical design of the place."*[99]

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94 [redacted] pg 9
95 [redacted] pg 4
96 [redacted] pg 4
97 [redacted] pg 4
98 [redacted] pg 8
99 [redacted] pg 4

Safeguarding

3.122 As I have explained above, upon becoming a unitary council, Telford & Wrekin assumed financial and legal responsibility for social care services including safeguarding.

3.123 The Inquiry heard evidence that "*it took a number of years* [following 1998] *for the council to understand what safeguarding was about*"[100] and was told also that in terms of safeguarding, "*Telford wasn't able initially to necessarily attract some of the best people from Shropshire*".[101] I have seen evidence to suggest that this is perhaps not surprising, as larger authorities find it easier in comparison to smaller local authorities to recruit high calibre of staff. While the commitment to Social Services was present on the part of the Chief Executive, the Council and the members for Children's Social Care, as a result of recruitment problems they did "*not have all the tools*".[102] There was perceived to be an early bias towards Adult Social Care within the Social Care directorship.

3.124 The Inquiry heard different perspectives on joint work between the councils after the division; so far as education was concerned, it heard that while in many newly spun off unitary authorities:

"… *services were literally ripped apart and ripped asunder, so you did lose the best of that corporate organisational memory. But we did completely the opposite. We made sure that those services that best operated on the economies of scale, were secured through the joint arrangements, and* [we made] *sure that it wasn't just a continuation of more of the same, because that would not have suited Telford. But that we retained the economies of scale and expertise, particularly for vulnerable children, whilst making sure that both the different needs of Telford and Shropshire as, a rural shire and a new town were fully met.*"[103]

3.125 While on the social care side, the Inquiry was told:

"… *after the division of what was originally Shropshire Council into two, with the Telford and Wrekin area gaining independence, there was a resistance to working together on joint initiatives.*"[104]

3.126 The Inquiry further heard some evidence of an initial friction at councillor and even at Chief Executive level, but also that the relationship improved. It is important to note, however, that those who were employed by Shropshire County Council at the time of the establishment of the unitary authority and up to 2008, have not recognised this reference to friction and have described a professional and collaborative working relationship following the creation of the unitary authority,[105] but there is some support for both initial difficulty and later improvements in Ofsted's April 2001 inspection of Shropshire's Local Education Authority: in referring to the quality of leadership given by the corporate director and senior managers, the inspection noted that "*despite initial resistance to the separation of Telford and Wrekin from Shropshire, continuing joint arrangements have been seamlessly*

100 [redacted] pg 35
101 [redacted] pg 15
102 [redacted] pg 15
103 [redacted] pg 17
104 [redacted] pg 26
105 [redacted]

implemented."[106] Whether there was in fact resistance there plainly was some joint working, though the Inquiry has seen evidence that Shropshire in particular would question its return on investment in joint initiatives, thinking that – for example in Youth Offending - Telford received better value for its investment.[107]

3.127 A senior officer within Social Care at the time of the establishment of the unitary authority told the Inquiry:[108]

"*Certainly there was a narrative in Telford when I was there which was that Shropshire had kind of tried to ensure they were favoured by the process of dislocation in terms of staffing and in terms of the quality of managers. And that was, there was no burning platform issue in that regard but there was always a sense of almost organisational resentment as to whether or not Shropshire had been fair in the distribution of resources, both around the quantum of resources and the quality of the resources… the deal had been financially less good for Telford as the new unitary authority than they'd expected and that played into the then hugely complicated and still hugely complicated ways in which various forms of funding methodology were brought to bear upon how the council was funded.*"[109]

3.128 While this narrative may have had currency at the time within Telford & Wrekin, the Inquiry has seen other material which tends to suggest that the disaggregation of previously combined budgets was agreed by officers from both councils, working together.[110]

3.129 Evidence provided to the Inquiry was that while education was being funded significantly from central government, and with it the innovations already referred to, the picture was quite different in respect of children's social services. At this stage – pre-2004 – there were separate Directors of Education and Social Care and it was not until the Director of Children's Services role, created by the Children Act 2004 and filled in 2005, to cover both Education and Children's Social Care that the central government "*windfall*" money could be "*pooled*".[111]

3.130 The Inquiry understands that relationships between Social Care and Education were "*somewhat strained*" during this period, at least from the perspective of the Social Care department and that this was because:

"*… in comparison to social care, the education department in Telford was strong and well established and was led extremely well... In comparison, children's social care was not well regarded by the Council. This was especially exemplified in that the new sources of funding towards supporting vulnerable children from the second Blair administration, especially Children's Fund and Sure Start, were routed in Telford through education rather than social care essentially because there was more confidence in that department.*"[112]

[106] https://files.ofsted.gov.uk/v1/file/2755716
[107] [redacted] pgs 26-27
[108] [redacted]
[109] [redacted] pg 28, pg 43
[110] [redacted]
[111] [redacted] pg 30
[112] [redacted] pg 8

3.131 I am persuaded that the Children's Fund and Sure Start monies were routed through Education in Telford rather than through Social Care because of a lack of confidence in the Social Care department.

3.132 The Inquiry also received evidence that, Social Care managers felt "*besieged and under-confident*".[113]

3.133 It is apparent that there was also a lack of joined up working within Social Care. The Inquiry has had sight of minutes of a strategy meeting held in late 1998, at which there was a discussion relating to specific CSE victims/survivors, one of whom was aged 13 and possibly pregnant. It was noted that:

"… *there appears to be a lack of liaison between the North and South Wrekin Social Services Teams and there is the issue of why there is no representation from the South to offer information in respect of the young person residing in that area.*"[114]

3.134 The minutes go on to record that the manager with responsibility for the case had been invited to the meeting but had declined to attend and that others present at the meeting were therefore "*unable to comment as to how far their investigations have proceeded*".[115] The WMP representative present also expressed concern in the meeting about the lack of liaison between the North and South Wrekin Social Services Teams.[116]

3.135 At a follow up strategy meeting held later that month, at which again there was no attendance or update from the team in question, one of the participants:

"… *stressed emphatically the necessity for liaison with South Wrekin Case Management Team as a matter of urgency in order to ascertain where the situation stands at present.*"[117]

3.136 A member of the resource team agreed, stating that 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.*"[118]

3.137 It was confirmed at the meeting that they would be writing to the South Wrekin team as a result, stating that the participants at the meeting felt strongly that feedback on the cases under discussion and further information, however minimal, needed to be forthcoming, "*to help decide how best we steer this meeting to… ensure the safety of these girls*".[119]

3.138 The seriousness of this situation was made clear to all attendees, noting that:

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113 [redacted] pg 8
114 [redacted] pgs 136-137
115 [redacted] pg 137
116 [redacted] pg 136
117 [redacted] pg 191
118 [redacted] pg 196
119 [redacted] pg 196

"… *the meeting recorded the grave concerns voiced today and unanimously felt the urgency to realise the seriousness of the situation surrounding the girls.*"[120]

3.139 The Inquiry has seen evidence which demonstrates that this tension between North and South Wrekin led to failures in information sharing, including with WMP, in respect of the Council's response to children known to the Inquiry as victims/survivors of CSE. I deal with this in greater detail below and in Chapter 5: The Policing of CSE in Telford.

3.140 By December 2000, the division in social services provision between North and South had ended and there was, as a result, a single initial assessment team. The system whereby a duty officer would take calls for new work only was amended, with a 'Helpdesk'[121] put in place to direct social workers to calls for work on new and open cases.[122] This appears to be a continuation of the work begun years before to make child protection more uniform and more accessible generally.

3.141 There was a change in senior management in Social Care within a few years of the unitary authority being created. The new incumbent's previous experience was as a social worker, including working in children's residential settings.[123] The Inquiry heard the view expressed that there was a fundamental structural flaw in the management of Social Care and Children's Services - namely the presence of a number of managers who reported to the Director – which meant that:

"… *the most senior children's specialist in the department was at third tier and lacked authority to represent highly demanding services to the Council. That flaw was a serious one even if the generic Head of Social Services role was being delivered well. It was not.*"[124]

3.142 The department was said in the early 2000s to be "*quite fragile... especially for children"*. There were five outstanding case reviews, a "*very significant indicator of poor performance*". Though the Council had passed a Joint Area Review ("JAR") in 2001 it had done so relying on its performance in Adult Social Services. In 2002, the Social Services Inspectorate ("SSI") introduced its first annual performance based national league table[125]; Telford was very close to performing so badly as to require special measures.

3.143 The Inquiry heard that there were in the early 2000s a "*litany of significant concerns*"[126] about Children's Social Care involving:

- *"Routine practice*
- *Staffing levels*
- *Competence of front line staff and managers*

120 [redacted], pg 196
121 [redacted] pg 24
122 [redacted] pg 6
123 [redacted] pg 3
124 [redacted] pg 5
125 [redacted] pgs 5-6
126 [redacted] pg 6

- *The effectiveness of the "front door" or referral system*
- *Poor quality recording practices*
- *Poor information systems."*

3.144 Although subsequent inspections showed some improvement (the SSI rating improving from one star to two stars in 2003 and 2004, with improvements in Children's Social Care noted), all these concerns were to be recurrent themes throughout the Inquiry's Terms of Reference.

3.145 In short, there were not enough people, and those who were there were not good enough at taking referrals, dealing with referrals, recording what happened in respect of referrals and sharing that information.

3.146 The Inquiry has also seen evidence, in ACPC minutes dated 11 May 2004, of staffing problems during this early period.[127] The Helpdesk itself was unsuccessful, with "*masses of unprocessed referrals*".[128] Further, there was a national shortage of qualified social workers, which had been reflected locally. At one stage the vacancy rate was 22% and a problem of unallocated cases had arisen. Child protection reviews were being delayed. At the time of the above-mentioned meeting the vacancy rate was under 10%, but the vacancies had been filled by "*talented... but unqualified*"[129] staff. The Inquiry heard:

"*… we couldn't get Social Workers… it's also about the quality of social workers… there was a real fashion for becoming newly qualified and then going to an agency to work because it was very good, very well paid, but people had no, absolutely no, experience."*[130]

3.147 The Inquiry understands that the Council's focus at the time was very much on dealing with the costs of children in care, in order to release funding for early intervention work, which was of course a political priority at the time by virtue of Every Child Matters. This reduced the funding available for child protection work. Senior officers in Safeguarding perceived a lack of awareness among councillors of children's social care issues and Safeguarding and also that elected members regarded Safeguarding as a problem area, taking away funding from the traditional district council spending areas, to which many councillors had been used in pre-unitary days.[131]

3.148 Another witness put it more directly, stating that children who need specialist placements *"can have a major impact upon the funding profile of a relatively small service",* but reinforced:

"… we never hesitated to use really strong interventions for young people including the use of secure accommodation… I can think of no time using money as a reason not to intervene

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128 pg 7
129
130 pg 16
131 pg 38

in those circumstances. The most difficult period in the history of the department, at no time did we let money dictate the way in which we intervened for individual children."[132]

3.149 As noted in the National Landscape section of this chapter, in July 2003 the Corporate Director of Social Care presented the report regarding the recommendations of the Victoria Climbié Inquiry authored by Lord Laming, using an audit framework produced by the Department of Health. This was a requirement of the SSI. There were seven standards, and the Council was invited to rate whether recommendations had been addressed and to rate progress.

3.150 The Council rated itself as three (out of four) meaning that it considered its progress to be satisfactory. One of the standards that was rated included referral processes, and in the Council's assessment it was acknowledged there had been delays caused by the introduction of a new computer system. The report issued at the time noted that there had been historic concerns about social work assessment processes (the Assessment Framework introduced in 2000), including their quality and timeliness. This was reported to be being addressed by increasing the number of social workers and managers, with further training, improved supervision and workload management processes also in place. Some progress was noted as being made on having a chronology on each child's file, which was deemed to be hampered by a lack of qualified and experienced social workers. There were concerns within the assessment about the inadequacy of the training budget and the ability to release staff to attend any training.[133]

3.151 Of course all these issues would have had an impact on the response to CSE but, as will be explained in further detail below, at this stage, CSE was largely being discussed by the Youth Development Service and Connexions. It is unclear how Safeguarding and the pressures on them as a service were being discussed in the context of CSE.

Structures within the Council with Responsibility for CSE

3.152 During this relevant period, a number of groups were in existence which have been said to have had responsibility for dealing with and responding to CSE, or what would now be called CSE. These were:

3.152.1 The Community Safety Partnership ("CSP");

3.152.2 The Children & Young People's Safeguarding Partnership ("CYPSP"), which later became the Children's Trust Board ("CTB");

3.152.3 The ACPC; and, latterly

3.152.4 The Sexual Exploitation subgroup (which will be dealt with separately).

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132 [redacted] pgs 45-46
133 [redacted]

3.153 Later documents suggest that the CSP was linked to the LSCB, the successor of the ACPC. Lack of documentation from this earlier period means that the governance structure between the CSP and the ACPC is unclear.

Community Safety Partnership Board

3.154 The Crime and Disorder Act 1998 placed a legal requirement on local authorities to establish a CSP. Section 16 placed a legal duty on the responsible authorities to work together to tackle and reduce crime and disorder, including anti-social behaviour, domestic abuse, substance misuse, reduce re-offending and reducing fear of crime. The CSP received funding from the Home Office and the Police & Crime Commissioner ("PCC").

3.155 One of the CSP's purposes, according to the Council's CSE strategy document of 2017 to 2020, was to undertake all actions possible to tackle CSE and to safeguard children experiencing and/or at risk from this form of child abuse.[134]

3.156 Documents seen by the Inquiry show that the CSP has been in existence in Telford from 1998 and was still active in 2020. However, the Inquiry has seen no documents from, or reference to, the CSP during its earlier period and I am therefore driven to the conclusion that whatever its intended function, it did nothing with respect to CSE.

Children & Young Person's Strategic Partnership Board

3.157 The Inquiry understands that the CYPSP was created in 1999.[135] It had a wide remit, covering all aspects of Safeguarding planning, not just child protection. The CYPSP included the directors of education, health, social care as well as representatives of the Primary Care Trust ("PCT"), WMP, the Youth Offending Service, schools and colleges, the voluntary sector and the CSP.

3.158 Early ambitions of the CYPSP included the Information Referral and Tracking system, ("IRT"), said to comprise multi-agency working designed to promote the Every Child Matters agenda[136] and intended to provide a shared database accessible to all services and agencies who might intervene in a child's life and, in respect of intervention, a single multi-agency assessment and joint training for all those who worked with children. Further, the concept of a key professional or lead worker was introduced, because:

"… *you could share information and data on children's needs but unless you actually made sure that you did something about it, it came to nothing.*"[137]

3.159 Evidence provided to the Inquiry indicates that the concept of the CYPSP was a success to the extent that it became the nationally adopted model for CTBs[138] and that the CYPSP acted as the CTB in Telford.[139]

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135 pg 17
136 pgs 6, 49
137 pg 28
138 pg 26
139 pg 19

3.160 Documents suggest that the CYPSP remained "*actively*" in place in 2005, comprising the chairs of five "*outcome groups*" – one of which was the LSCB Executive group.[140] The Inquiry has seen no evidence to suggest what activity this group actively engaged in.

Area Child Protection Committee ("ACPC")

3.161 As I explained in the National Landscape section for this time period, Working Together 1999 set out Government guidance on inter-agency co-operation to protect and promote the welfare of children, and required local authorities to establish ACPCs. The ACPC was described as an inter-agency forum for agreeing how the different services and professional groups should cooperate to safeguard children in their area, and for making sure that arrangements worked effectively to bring about good outcomes for children.

3.162 The earliest material the Inquiry has seen relating to Telford's ACPC is from 1999. Despite the Inquiry's best efforts in making targeted requests to stakeholders, very limited documentation has been disclosed to the Inquiry in relation to the ACPC, so analysis of its activity is necessarily limited. This has been extremely disappointing given the evidence shared with the Inquiry by witnesses about the important role the ACPC played in the Council's early response to CSE.[141] One witness found it incredible that neither the Council nor WMP have been able to retrieve ACPC minutes, which they described as being fundamental to the Inquiry's understanding of the issue and the way in which it was processed.[142]

3.163 The Inquiry understands that one of the ACPC's key functions was to agree safeguarding procedures in line with statutory guidance, that all partners worked to. The Inquiry also understands that the ACPC initally appointed people to conduct Serious Case Reviews ("SCRs") and to coordinate individual agency reviews, but did not do much development work.[143]

3.164 In the provisions of Working Together 1999 and the later 2000 Supplementary Guidance, there was an obligation on ACPCs to "*actively enquire into the extent to which there is a local problem*". It is unclear what mechanisms were put in place to achieve this. Further, whilst the 2000 Supplementary Guidance highlighted the importance of developing local support services including advice, counselling, sexual health and drawing on the expertise of the voluntary sector, there is a lack of clarity as to whether, and if so how, this was done in Telford.

3.165 Analysis carried out by the Inquiry of the case study individuals, which is detailed in Chapter 8: Case Studies of this Report, also shows that there were disputes about who was responsible for service provision for victims of CSE at this time.

140 [redacted] pg 32
141 [redacted]
142 [redacted] pg 4
143 [redacted] pgs 15-16

3.166 The ACPC itself was initially chaired by the Head of Children's Services. In 2001, the structure was revised and the remit of the group extended to include more subgroups, including Youth Services.[144]

3.167 There was a local protocol put in place between the CYPSP and the ACPC implementing a direct reporting line.[145]

Early Multi-Agency Working

Early examples: Children A, B and G

3.168 The earliest evidence of multi-agency working the Inquiry has seen in relation to specific CSE cases is detailed in the case study analyses of Children A, B and G[146], which can be found in Chapter 5: The Policing of CSE in Telford.

3.169 These cases date back to the late 1990s and it is important to note that the cases were 'live' before the creation of the unitary authority. However, the cases were still open from 1998 and continued to be dealt with by the Council. The Inquiry's expert witness, Jane Wiffin, regards the files as revealing in terms of the poor information sharing and poor adherence to the *Working Together* practices of this period. Further, she notes that the cases bear striking similarities to one another and show not only that the children were not receiving the appropriate assistance and support, but also that attitudes of the time to victims of this crime were wanting in the extreme.

3.170 Whilst this chapter does not propose to repeat the findings set out in Chapter 5: The Policing of CSE in Telford, some of the issues specific to the Safeguarding element, and particularly the social workers' response to, and engagement with, these children, merit further consideration at this point, before the extent to which Safeguarding was working with other agencies can be analysed.

3.170.1 Looking at common themes from the three cases, it is clear that in each case, even though the individuals concerned are 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.

3.170.2 There is an element of victim-blaming, with the children considered at risk because of their own actions. There is a failure by those in authority to see what is happening as exploitation rather than consensual, and there was little intervention or attempt to prevent the exploitation.

3.170.3 Support provided by Safeguarding 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 – i.e. no missing episodes. Once the missing episodes recommenced and WMP became involved once more, there

[144] [redacted] pgs 7, 16
[145] [redacted] pg 17
[146] So named in accordance with the chronology of the Report and the main case studies discussed in Chapter 8: Case Studies.

was an apparent resourcing issue in Safeguarding which meant there was no support forthcoming, even after disclosure and admissions were then made by the child. Subsequent support was obstructed because of social workers failing to attend meetings or not liaising appropriately and when rapes were reported by the child, the social worker did not attend the interview. The child, now a 'high risk' child, was without a social worker for a further five months.

3.170.4 There were clear incidences of significant harm across the children's timelines and a number of incidents which should have led to child protection action, but these were simply not responded to.

3.170.5 The reaction by Safeguarding 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 behind the behaviour.

3.170.6 Despite corporate parenting guidance being in place, even before the introduction of the '*Quality Protects*' programme in 1999, which made clear that councils were corporate parents, there is evidence that the children were effectively abandoned by the Council.

3.170.7 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 should have happened.

3.170.8 This is mirrored in a lack of formal representation by professionals at meetings and in record keeping, meaning that files and data is 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.

3.170.9 There is evidence of continual drift and delay and indeed even apathy on the part of social workers.

3.171 It is clear to see from this brief summary that there were gaps in Safeguarding practices, and it is therefore perhaps unsurprising that this is further evidence in the ability to work with other organisations. The failure to attend multi-agency meetings and lack of liaison with even different social services areas of Telford has already been touched upon. The Inquiry has seen reference to a dispute between social services areas, which led to the South Social Services Team failing to attend strategy meetings or engage with WMP about a case with which they had involvement. It goes without saying that this would have had implications for the care of that child and that these practices would also have impacted on the quality of the support for others.

Referrals and multi-agency meetings

3.172 In terms of referrals, it appears that the usual form of referral was from Safeguarding to WMP:

"… *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.*"[147]

3.173 Above all, the impression from the evidence is that information sharing was taking place effectively, but informally – the situation up until 1997 (and therefore before the creation of the unitary authority) was summed up in this way by a member of the child protection team:

"Our team was located in the police house which was part and parcel of the police station and the police had a couple of rooms… That was useful because it meant that we were able to make and sustain good relationships with the police operationally, I think one of the issues here is probably difficulties in the strategic approach, but as workers, as operational workers, we could have discussions more or less straight away and when we wanted with colleagues in the police service."[148]

3.174 Of course, the child protection team was disbanded, as has already been noted, to promote a more uniform service and to counter feelings of elitism; a consequence of the scattering of the team to geographical teams was to end the closeness of child protection social workers and police officers, and with it the ease of informal information sharing.

3.175 The Inquiry has heard less about the degree to which the Council would receive referrals from WMP, though has had sight of material from 2000 which suggests that WMP referred the parents of a victim/survivor of CSE to Safeguarding for the purpose of obtaining counselling for the child.[149]

3.176 It is clear from the evidence the Inquiry has seen, however, that WMP was involved with the Council (both prior to and following the creation of the unitary authority) in multi-agency meetings in relation to child protection from 1990 onwards. Attendees at those meetings included representatives of health and education services and there were discussions around 'child prostitution' or sexual exploitation.

3.177 I have seen documents, including minutes of a strategy meeting held in November 1998 (following the creation of the unitary authority), where there were discussions around a number of children's involvement in "*child prostitution*", with concerns being raised.[150] Representatives at these meetings included a member of the Council's Initial Response Team, a social worker, a WMP officer, a member of the Housing team and from a third sector organisation. The minutes stress the importance that information is shared contemporaneously with all agencies concerned.

Multi-agency training

3.178 As I have explained above, by this time criticisms had been raised that professionals had failed to understand each other's roles or to work together effectively and the Every Child

147 [redacted] pg 6
148 [redacted]
149 [redacted]
150 [redacted] pg 220

Matters Green Paper, published in 2003,[151] aimed to encourage organisations that provided services together to work more collaboratively.

3.179 In 2002, the ACPC agreed that there was a need for a designated trainer for multi-agency child protection training. This was jointly funded by the PCT, WMP, Connexions, the probation service, and the Council's Education and Safeguarding teams. A similar joint funding agreement was put in place for an ACPC administrator, though the PCT did not contribute to this post.[152]

3.180 I have seen later ACPC minutes indicating joint training exercises.[153] This training was delivered by Sara Swann MBE, who had been the National Lead for Child Prostitution with Barnardo's. I have referred to Ms Swann's role in multi-agency response to CSE in Chapter 2: Nature, Patterns and Prevalence of CSE in Telford. I heard that this multi-agency training day was delivered by Ms Swann to the Council after it was requested and arranged by a youth worker who had a keen interest in the issue of CSE and was very pro-active in championing the Council's response to CSE.

3.181 The Council has not provided any material or information about this training, but the Inquiry has been able to source copies of the training material.[154] The training was clearly designed to explore and challenge perceptions and attitudes to the CSE issue; an update on national policy was provided, including government guidance and new sexual offences legislation and delegates gained an understanding of how practice relates to local protocols, as well as recognising alerting risk factors and warning signs of vulnerability and involvement. The training stressed the important role that ACPCs played in the response to CSE. ACPCs were able to actively enquire in to the extent of children subjected to CSE and provide a local resource and a source of expertise. It is worth emphasising this point; these important messages were being delivered to the Council as early as 2004.

3.182 The training noted that in all cases, consideration should be given to calling an early strategy meeting to establish the exact nature of the concerns, to share and clarify information, to agree how the case should be managed, and to make recommendations to address the concerns. It is important to bear in mind the importance placed on strategy meetings as I come on to consider the Council's response to CSE.

3.183 It is not clear from information provided to the Inquiry which bodies participated in the training, and in particular whether WMP participated. The Inquiry understands that there was no follow up action with Ms Swann and that the training session itself was just a single day.

3.184 At a meeting of the ACPC on 2 October 2003,[155] concerns were expressed that there was:

"… *information that some people have and others don't, and that information/linkages doesn't get lost that could become very relevant should another referral be made. We need*

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to be able to link names in should anything else come up. IRT could potentially assist with this."

3.185 There was plainly a feeling that, so far as information sharing was concerned, officers felt uncertain: *"Whilst there may be criticism about sharing information, if something went wrong and we had held information, there would be more criticism."*[156]

3.186 A senior figure within Safeguarding at the time reflected on this:

"I think sometimes professional child protection workers do hide behind the protection of information issues too strongly, but until the 2004 legislation, there was no cover for doing otherwise."[157]

3.187 Another senior Council official echoed the viewpoint that social workers: *"have a well embedded culture of confidentiality and trust, so sharing sensitive information about an individual child would be hard for them to achieve".* The difficulty with police intelligence being shared was also mentioned.[158]

Common Assessment Framework ("CAF")

3.188 As set out above, in 2003, Every Child Matters introduced the CAF. The CAF for children was a standardised approach to undertaking an assessment of a child's additional needs and identifying how best to meet those needs. The CAF was a key part of delivering integrated frontline services focused on children's needs and strengths. It was to be used by practitioners across the children's workforce in England. There was an expectation that every local authority would identify a lead professional with responsibility for ensuring information was collected and shared across services for children, covering special educational needs, Connexions, Youth Offending Teams, health and social services.

3.189 The aim was for basic information to follow the child to reduce duplication.[159] I understand that the CAF was intended to be used for children with additional needs which may not be complex or severe enough to require statutory intervention and that it was intended to introduce a more holistic assessment of the needs of the child. The overarching aim of this is that it would help identify the needs of a child earlier and therefore enable earlier intervention to prevent the needs of a child escalating.[160] One witness explained it as making one single comprehensive assessment of children's needs "*rather than the separate plethora of assessments that existed*".[161]

3.190 The CAF was described as a process which included initial information gathering through to undertaking the assessment analysing it and developing a plan. The initial action plan would identify the immediate actions that those present at the assessment would be recommended to take (including the child and family). The CAF was entirely voluntary. Professionals were required to discuss their concerns with the child and/or their parent or

156 [redacted]
157 [redacted] pg 102
158 [redacted] pg 24-26
159 [redacted] pg 14
160 [redacted] pg 30
161 [redacted] pg 27

carer before completing. This came to be seen as requiring the parent or carer to give consent to a CAF.

3.191 Despite the emphasis being on multi-agency working and a coordinated approach to supporting the child, evidence provided to the Inquiry is that a number of agencies did not 'buy into' the CAF and were reluctant to act as a lead professional.[162]

3.192 One witness spoke about the unintended consequences of the CAF, which was that it unearthed a lot of need. The emphasis was on early intervention and this prompted an increase in referrals to the Safeguarding team,[163] which was already stretched.

Team Around the Child ("TAC")

3.193 Where concerns were identified within a CAF, but not enough to warrant statutory intervention, a TAC was set up to bring agencies together and provide the necessary support for the child. Again, a lead professional would be appointed who would usually be the person with the best relationship with the child and family.

3.194 I have not seen any evidence of a social worker being appointed as a lead professional and the impression from the evidence gathered is that social workers were not fully engaged in the CAF/TAC processes. One witness told me that whilst there was an ambition to involve social workers in the CAF/TAC, that was not the case in practice. When a referral was made to the Safeguarding team, this would usually trigger the traditional child protection procedures, which were entirely separate from the CAF/TAC. The consequence of this was that the TAC support fell away. Whilst there was a desire to have a continuous flow of information between social workers and other agencies, with one single system and process, the Inquiry understands that this was never fully achieved.[164]

The AWARE system

3.195 As I explained above, the Every Child Matters agenda from 2003 made a number of recommendations for change, including improving information collection and sharing and the Council's AWARE system was highlighted as an example of good practice (the emphasis in the below quote is mine):

"*In many parts of the country, local authorities are developing innovative solutions to information sharing. In some areas, these are based on the use of technology to enable professionals to register early concerns about a child's needs, as in Telford & Wrekin's AWARE project, and through the Connexions Customer Information System.*"[165]

3.196 The AWARE system provided a traffic light system which highlighted levels of concern and enabled all professionals to access the same information system. It was intended to provide a 'who's who' of all those involved with the child from each agency. NHS numbers were to be used for the pilot and the sharing of information was to be proactive rather than reactive.

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162 [redacted] pg 6
163 [redacted] pg 16
164 [redacted] pgs 12-13
165 [redacted] pg 58

3.197 In the ACPC Business Plan 2003/2004, dated May 2003,[166] the development of the AWARE programme was listed on the actions proposed to be taken as part of achieving the "*to ensure that children are protected from emotional, physical and sexual abuse and neglect*" objective of the '*Quality Protects*' Government initiative.

3.198 I have seen reference to AWARE as a "*current pilot*"[167] in 2003, but have seen no other reference to it in later documents or indeed any evidence of how or if it was used in practice by Council staff and agencies.

Information Referral and Tracking ("IRT")

3.199 The IRT was another example of multi-agency working designed to promote the Every Child Matters agenda[168] and intended to be based around a forthcoming IT system designed to overcome information sharing problems. It involved the creation of a large-scale, countrywide mechanism for finding means of flagging children where there may be concerns and having an electronic means of agencies being able to see those flags, share information and build a bigger picture around the child.

3.200 According to the Council's Corporate Submission:

"… under the borough's old system, known as Aware, a child's name, address and date of birth was logged and made available to education welfare, health services and the police. Different colours on screen indicated each agency's level of involvement with a particular child. IRT, meanwhile, involves more agencies, such as Connexions, Sure Start, the voluntary sector and youth offending teams, and stores more information such as school and GP details."[169]

3.201 The Inquiry understands that this involved developing and embedding the CAF and TAC processes.

3.202 Another Council officer with familiarity with the IRT pilot gave more detail in describing the work:

"[the] *stance for Telford and Wrekin and Shropshire was not to rely solely on an IT system as the main way in which you identify children who may need additional support, you can use flags but there had to be practice that was accompanied by bringing professional judgement. The flags can be indicators but there had to be systems and processes that were professionally based that enabled professionals to talk to each other to then properly share information and then, of course, there needed to be protocols that enabled the sharing of that information across the agencies. So that was the substance of the work which was then around what protocols were required, did we need to have in place to share information that was about, not just about children at the point at which they were at risk but emerging concerns that might lead to further concerns down the line so this was about*

166 [redacted] pgs 8, 11
167 [redacted]
168 [redacted] pgs 6, 49
169 [redacted] pg 9

beginning to have a method whereby you could identify children much earlier that might need support or a family that might need support.

… the Common Assessment came quite quickly into this piece of work because it became very clear from the national work and the local, sharing a concern was not enough there needed to be a shared understanding across different professionals of what needs were, having descriptors of what those needs might mean, having a shared language, and therefore, developing some shared systems and processes by which a collection of professionals, across the system relevant to a family both outside of the local authority and within the local authority could come together in a coordinated way before matters needed a social work intervention."[170]

3.203 The Inquiry also heard that:

"*We were... hoping and planning to use this NHS unique identifier number and registration, which would have meant that we could then start to use our intelligence from an information sharing point of view, as a single record and thereby greatly assist integration. At the time we were doing this, we were trying to use 'non-sensitive data' from a range of databases. The ultimate aim through the work of the IRT trailblazer of course, would be to gain permission from government to use more sensitive and vulnerable data to share (through correct permissions), in order to intervene in circumstances of concern etc. Obviously, one of the biggest challenges was around the confidentiality of data sharing protocols but this was a general challenge for all of the trailblazers nationally as well.*"[171]

3.204 Scepticism about the information technology solution was justified; the Inquiry heard:

"*Like* [all] *big IT projects from central government, they spend years working on them and they never actually come to fruition and actually it never did come to fruition as a government centrally led IT implementation programme.*"[172]

3.205 Other witnesses were more direct about IRT:

"*IRT is fine, except it assumes that somebody else is always doing the work, whereas what we thought the issue is that you've got to hold a case and stay accountable for the case.*"[173]

3.206 The Inquiry also heard that, at the eleventh hour, the Government "*pulled the plug*" on the initiative and that was the end of IRT. Keen for the goodwill and joint planning not to go to waste, those involved in the IRT scheme developed a group which they called the 'Badger Set'.[174]

3.207 The informal group (named after the village in which they met) were working to co-locate services to provide multi-agency response. A witness explained:

[170] [redacted] pgs 6-7
[171] [redacted] pg 1
[172] [redacted] pg 7
[173] [redacted] pg 96
[174] [redacted] pg 11

"*They weren't the high-level acute services like social care, so we were thinking that we could start with services that operate at a lower level of need as a starting point. It was recognised that this was a journey. You're turning an oil tanker. You can't do it overnight. Let's start with those services such as educational welfare, behaviour support, learning support, primary mental health workers, early years etc, where applicable. Then try to get these services to work well together and hopefully over time we may be able to get more acute services such as social care workers etc to get involved.*"[175]

3.208 The newly co-located services would operate in five "Clusters" and staff members were seconded from participating agencies to serve as a Cluster Manager or Integrated Service Manager ("ISM").[176] The Clusters are dealt with in further detail below.

3.209 I understand that the Council won a number of accolades including a Beacon awareness award for the CAF, IRT and TAC practices.[177]

Family Assessment and Support Team ("FAST")

3.210 The FAST was intended to comprise social workers and family support workers; at the outset it had nine of the latter and just one (of an intended three) of the former. A witness involved in the team recalls difficulty recruiting social workers and that the social worker assigned to the FAST, having trained in a different country, had "*inaccurate information and inappropriate practices and she was unable to fulfil her role in supporting the unqualified Family Support Workers; they were in fact supporting her*".[178]

3.211 The theory was that FAST would receive referrals from the Initial Assessment Team where the Initial Assessment Team's assessment had shown family support needs including behavioural difficulties or non-attendance at school.[179] The Initial Assessment Team would hold cases for four months[180] and the question arose as to what should happen if an officer in FAST identified issues which, in their view, required Safeguarding intervention; one such officer, a social worker herself, was told that there was no mechanism for referral back to Initial Assessment or onto Safeguarding following the initial conclusion that the issue was behavioural. Only a significant subsequent event could trigger a reassessment, despite the fact that these initial assessments were often superficial and considered only the behavioural "*presenting problem*" and not any other vulnerability such as exploitation.[181]

3.212 The same witness considered this in the context of the loss of the specialist teams that had existed in the Shropshire days:

"*I think what you lose is, you no longer have a team and a police team that are both invested in looking for, as well as responding to, abuse so when you make it more generic,*

175 [redacted] pg 12
176 [redacted] pg 13
177 [redacted] pg 11
178 [redacted] pg 3
179 [redacted] pg 3
180 [redacted] pg 6
181 [redacted] pgs 3-4

you become more reactive. That changes the nature of people's understanding and levels of confidence [to deal with the issue].*"*[182]

3.213 Evidence gathered by the Inquiry includes children suspected of being exploited being re-referred to the Initial Assessment Team for further assessment but being rebuffed[183] and that there was a lack of professional respect, where the Safeguarding team regarded the FAST team as "*only family support workers*".[184]

3.214 The Inquiry heard:

"*I think we all worked in silo and I think where we had concerns about particular children I don't feel like those concerns were shared. In the sense that I would have a conversation with a social worker or with the duty team to say I'm really worried about* [a child]. *I don't think they'd acknowledge the level of worry and I don't really feel like I ever met a threshold to get action from a social worker or proactive action from a social worker."*[185]

3.215 The FAST team did have access to Safeguarding records,[186] an issue that will become important in the context of the Council's later response to CSE.

Overview

3.216 These were all processes intended to bring agencies together at an earlier intervention point to support young children and their families. Despite the emphasis on early intervention, victims and survivors who have provided evidence to this Inquiry have spoken of low level intelligence being missed. Furthermore the evidence suggests that the old lines of demarcation between Safeguarding and Early Intervention were still rigidly enforced.

Early Awareness of CSE

3.217 In its Corporate Submission, the Council has stated that it:

"… *first became aware of what is now known as Child Sexual Exploitation in 1999 through work of the then Youth Development Service. Responding to this challenge to protect those most at risk and to support victims has remained an essential focus of the Council and its partners."*[187]

3.218 This does not accord with other documentary and witness evidence which suggests that the Council's effective response did not come until much later.

3.219 The Inquiry heard from witnesses that:

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182 [redacted] pg 27
183 [redacted] pg 10
184 [redacted] pg 25
185 [redacted] pg 14
186 [redacted] pg 26
187 [redacted] pg 3

"*I think I was aware that* [CSE] *was going on but I... wasn't involved in* [addressing] *any of it. I think generally we would have been made aware that it was going on because of the nature of the job, we would have known…*

I think at that time the attitude was that it was a lifestyle choice. These girls had all chosen to go with, "bad boys" because of the excitement .. and that may have been true to some extent. But it wasn't until later on when attitudes did start to change that we realised they weren't actual prostitutes… that was midway 2006/7 perhaps."[188]

3.220 Another witness, a member of the ACPC and its successor, the LSCB, told the Inquiry:

"I collated it on what information I had, but it was very, it was all hearsay, it was all hearsay and rumours and I think that was, that reflects a lot of the very early work, it was rumours and hearsay and a comment from here then that built that underpinning sense of something was happening but we're not sure what."[189]

3.221 A manager in the Safeguarding team recalls:

"*Around the Asian community… people would say we seem to be getting a lot of sexual abuse within an Asian community… from a social care point of view… there'd be lots of indicators what now are absolutely screaming red flags that you look at and look at some of the old files and think 'for goodness sake how on earth did we not see that'… children going missing or parents making contact saying about not being able to keep their child in… it was seen as teenagers and behaviours.*"[190]

3.222 A senior social worker in the 2000s offered this view:

"*… between 2002 and probably 2008, we were getting a lot of teenagers, girls around 14 onwards where things were going wrong at school they were dropping out of school, they were falling out with parents, parents were saying they were beyond parental control, they were being described as runaways. A lot of the time there seemed to be a friendship with an older female about an 18 year old. It seemed to be something, parents were saying well you know they've got his older friend who keeps giving them fags or gives them drink or whatever but it was, it seemed more the parents were reporting this right, reporting they were out of parental control and were asking us to accommodate them… the focus was on the relationship between the family and the girl.*"[191]

3.223 A longstanding senior officer in Safeguarding also told the Inquiry:

"*I think professionals were encouraged to see those symptoms as behaviours unless they made the connection with exploitation, and a lot of focus there was on familial abuse and institutional abuse rather than abuse outside of the family.*"[192]

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188 [redacted] pgs 6-7
189 [redacted] pg 7
190 [redacted] pg 20
191 [redacted] pg 10
192 [redacted] pg 27

3.224 The Inquiry has seen a file of intelligence material, comprising of four reports prepared by WMP and dating back to the late 1990s. It is apparent from this historic material, which has been referred to as the 'D2276 material', that there was relevant information in the possession of WMP tending to show that there was a significant CSE problem in Telford from the mid to late 1990s. I deal with this in detail at Chapter 5: The Policing of CSE in Telford.

3.225 Those reports themselves do not suggest a routine referral of every intelligence report to the Council – nor do I suggest that should be the case, as children were not identifiable in every case. The third 1999 intelligence report (as referred to in Chapter 5: The Policing of CSE in Telford) in particular does, however, name individual children and while the distribution within WMP is clear there is no indication that the information was passed to the Council.

3.226 WMP has admitted that it has not been able to detect any coordinated response to the CSE issues raised in the 1999 reports, but it is apparent from the case studies I have set out in Chapter 5: The Policing of CSE in Telford that, as early as the mid-1990s, some of the children known to WMP were also known to Safeguarding as being subject to exploitative behaviour.

3.227 A senior Council official and member of the ACPC remembers CSE was discussed at the ACPC during this period, due to feedback received from youth workers, who had expressed concerns about children engaging in "*risky behaviour*"[193] – taken to mean sexual activity with much older men. The same witness recalls that youth workers were particularly good at encouraging children to disclose information, as they were more approachable and were not perceived as being in a position of authority as a social worker might be. They managed to avoid the stigma surrounding this role. Furthermore, youth workers were able to develop long term relationships, deemed to be essential to building sufficient trust and confidence, with children often not seeing themselves as victims.

3.228 The witness expressed the further view that it is only through working with an individual over a long period that they may begin to recognise the behaviour under discussion for what it is and that it can take months, if not years, for this to happen; whereas social workers traditionally have a much shorter-term role in an individual's life and therefore are not always as able to make this same connection with the child.[194]

3.229 The ACPC Business Plan for 2003/4, produced in May 2003,[195] noted that the main committee of the ACPC had five subgroups, one of which related to sexual exploitation. The expectation was that the group would be chaired by a member of the ACPC and would provide regular updates on the work of the group to the ACPC. Although there appeared to be regular updates, there was no focus on progress and tracking of agreed tasks. This was to be a common theme that I will return to throughout this chapter.

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193 pg 2
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The Sexual Exploitation subgroup

3.230 The Council's Corporate Submission cannot identify when the Sexual Exploitation subgroup came into existence but notes that it existed in 2002;[196] this may have been a project or temporary group.

3.231 ACPC minutes dated May 2003 show that an attempt to create a working group for a CSE action plan had failed,[197] and one witness relates that a regular Sexual Exploitation working group was set up in late 2003.[198] It is plain that at about 2003 Sexual Exploitation meetings were taking place.

3.232 The same ACPC minutes note that there were two cases of sexual exploitation:

"… *where those involved are afraid to report it. Two strategy meetings have been held and both are now active in terms of being pursued by police and social care. This is a big issue for schools and* [the attendee speaking] *would be keen for schools to get hold of it and take it forward in terms of policy and planning."*[199]

Neighbourhood Action Team

3.233 The Inquiry received certain documents covering the period 1999 to 2006 relating to the Neighbourhood Action Team, SPACE and the T&W Collaborative Team for Children and Young People. They are incomplete, but were disclosed to the Inquiry by an individual and comprise material which the Inquiry had not seen from the Council or any another source and demonstrate that these local level bodies had awareness of CSE or concerns about children during this early period.

3.234 A history of Council provision for children appeared in a minute of the Neighbourhood Action Team dated 2 May 2000:

"History of Children and Young Persons Unit: Telford & Wrekin Council set up a number of Playschemes 10 - 12 years ago, this expanded and became the Children & Young People's Unit.; the Unit now also provide After School Provision and School Holiday Scheme's. 'Children's right to play is valued', and allows children to learn 'social skills'. 'Crucial Crew' - training up to NVQ Level 1 & 2 of lunch time supervisors/play leaders in encouraging play instead of 'policing' the playground/area, dealing with bullying, child safety and protection issues. Age Groups covered are 5 - 11 years and the Youth group 11 - 14 years. Support training for workers with Youth groups is also provided."[200]

3.235 Crucial Crew was an engagement programme with local schools. WMP and the LSCB were involved in delivering these training programmes, for example, educating children about what a trusted adult was, to school children.[201]

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198 pg 41
199 pg 4
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201 pg 33

3.236 An officer within the Youth Development Service[202] gave some further detail, indicating that the Shropshire Youth Association, which was set up in 1988, was essentially a body that managed the voluntary sector. When Telford was created as a unitary authority, it sought a different, in-house approach, which it called the Youth Development Service.[203]

3.237 Documents from 1999 detail the introduction of the Neighbourhood Action Teams.[204] It is apparent that these teams were intended to formalise multi-agency working to address the needs of the areas they served; and equally apparent from a progress report in October 1999 that the attempt was met with some suspicion:

"There is still not a clear understanding of the nature or purpose of 'Neighbourhood Action Teams' — this is not to say that the concept of partnership working is not understood and accepted, but the specific term is seen by some people, especially those not within the Health Service, T&WC or the Police as a new idea which has not been properly introduced, publicised or explained. Some see it as an imposition or an implication that they are being 'told what to do' by an outside body such as 'the council' without proper consultation and agreement. Some outside and independent agencies are keen on the idea and want to co-operate as much as possible, but the level of understanding and commitment still varies, even within the three main agencies. This poses a problem for some of those trying to 'make it happen', as they find themselves in the position of trying to sell an idea they may understand only imperfectly themselves, and not having any authority to persuade others to make a commitment to take part."[205]

3.238 Inevitably, there was dispute over group names: *"Acceptance of the term 'Neighbourhood Action Team' varies, but is becoming the norm in at least some areas"*.[206]

3.239 The Inquiry made a targeted request for information from the Council for further documents about the Neighbourhood Action Team. The Inquiry was informed by the Council that the Neighbourhood Action Teams were not set up for the purpose of responding to CSE within the borough. The teams were intended to respond to issues relating to specific neighbourhoods and could include things such as anti-social behaviour, crime and community safety matters. This appears to me to be a description of a group ideally placed to identify concerns about children and to share those concerns with partner agencies.

SPACE

3.240 One of the groups established during this period settled for the title 'SPACE' (Safety, Partnership, Arleston, College). In a report dated 11 August 1999, it noted:

"*There isn't an established line of communication between the agencies who reported the problems and the youth service (ASB). This should be developed and investigated as part of an action plan."*[207]

202 [redacted] pg 6
203 [redacted] pg 7
204 [redacted]
205 [redacted] pg 1
206 [redacted] pg 1
207 [redacted]

3.241 The Inquiry has not seen the action plan.

3.242 On 1 October 1999 the minutes[208] of SPACE note:

"*The group has been concentrating on the issue of how to conduct research into local needs — there is likely to be close co-operation with H.A.P.P.1. (Hadley NAT) on research, and some people have undertaken training in focus group work. Focus groups have been conducted with Dawley Road Neighbourhood Watch, Monday over 50s Social Club, Millfield Residents Association and Guides*."

3.243 SPACE appears to have seen significant issues regarding children. The same report notes:

"Contraceptive advice is a problem — many questioned the confidentiality when doctors knew their parents. In other areas, some youth workers have a specific brief around the health of young people. The youth worker goes out to the young people on an informal basis through schools, youth clubs, outreach and detached work, or a drop-in at the health centre. This builds trust and links between the young people and the health centre.

Recommendation: That a worker should be employed to develop this work with young people. This could be funded through a number of agencies or a bid to the National Lottery."

3.244 On 17 November 1999, in a meeting at which WMP were represented, it noted "*sexual exploitation"* as being an *"issue/concern",* as well as *"violence and aggression linked to cultural issues*".[209] This is a very early use of the term "sexual exploitation"; there is no detail here as to what had been seen or reported so that it was now regarded as an issue or concern.

3.245 On 9 March 2000, a SPACE meeting minuted:[210]

"Police to contact [Name]*, Youth Service, Telford & Wrekin Council, regarding personal safety issues for young people. Comments from young people at an annual youth conference, although not specifically named as safety issues, but an underlying concern particularly in reference to buses and taxis."*

3.246 A handwritten note on the document suggests, without more detail, that "*initiatives already in place*".[211]

3.247 On 17 July 2001, SPACE remarked on the lack of youth workers in the area and noted that a scheme called Young Persons Support, which began in south Telford, was being expanded to the northern area and that there was a drive to recruit volunteers to serve as befrienders to children between the ages of nine and 16.[212]

208 [redacted]
209 [redacted]
210 [redacted] pg 2
211 [redacted]
212 [redacted]

3.248 The next SPACE meeting notes the Inquiry has seen date from 2005/2006; there is no mention of CSE.

3.249 The documents relevant to SPACE were provided to the Inquiry by an individual. The Inquiry made a targeted request for any documents held by the Council relevant to this group but were informed that, despite extensive searches, the Council could not identify any documents for this group and had no knowledge of its existence which suggests that the Council had no involvement or interaction with the group, which is surprising given its apparent remit of the group.

The T&W Collaborative Team for Children and Young People

3.250 The T&W Collaborative Team for Children and Young People was a group which appears to have been part of the Council's health responsibilities.[213] However, when the Inquiry made a request for information about this group, the Council was only able to locate a copy of the group's Terms of Reference which set out the group's purpose as:

"[To] *discuss, consider, comment, exchange information on service provisions and developments for Children & Families within the Telford & Wrekin area."*[214]

3.251 In minutes dated 6 December 1999 it appears:

"*In relation to Sexual Exploitation the Youth Service have organised a workshop on Saturday 11th December 1999, 10am-4pm at Furnace Lane Youth Club, Trench. Cost £5."*[215]

3.252 The Inquiry understands that the same workshop was run again on 21 July 2000 at Stirchley Youth Project, using the learning from Barnardo's, again at a cost of £5 or free to Youth Service staff.[216]

3.253 As is clear from documents provided to the Inquiry, one of the concerns of the group was teenage pregnancy. This followed a Social Exclusion Unit's report in 1999 and the subsequent formation of the national Teenage Pregnancy Unit, which allocated funds to Shropshire Health Authority aimed at "*tackling teenage pregnancies and supporting young parents*".[217]

3.254 The Collaborative Team's 4 September 2000 minutes note "*Teenage Pregnancy Coordinator for Shropshire Health Authority would be taking up post in November 2000.*[218] At this stage the Council had a teenage pregnancy support officer; she attended the meeting, and the minutes continue:

"The point was made that the data relating to teenage pregnancies was old. The need for data analysis was highlighted on two counts. Firstly, a question was raised of whether there

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213 [redacted]
214 [redacted]
215 [redacted] pg 2
216 [redacted] pgs 4, 16
217 [redacted]
218 [redacted] pg 3

were any clusters which might relate to the areas covered by the NATs and, secondly, the police asked for any data because of the problem of young single mothers in clusters creating what was described as a 'honeypot of crime'."

3.255 There is no explanation what was meant by the police suggestion that clusters of teenage mothers create a "*honeypot of crime*" – whether this was recognition that teenage pregnancy can be an indicator of CSE or whether pregnant teenagers were regarded as prolific criminals.

3.256 The Children and Families Collaborative Reference Group, appears to have been the strategic group to the Collaborative Team for Children and Young People's operational aspect. On 9 December 2002 it received a report from an individual described as '*T&W Youth – Sexual Exploitation Project'*. He gave a presentation in which he spoke of the work of the Project, part of an ACPC subgroup, as "*running workshops and submitting a statistical return*".[219]

3.257 The evidence relating to these groups underlines that CSE was not unheard of at the turn of the century. Evidence provided to the Inquiry confirms that individuals were concerned about children being sexually exploited; as I have noted elsewhere, there was concern in the local press; these neighbourhood level groups noted the problem. What is not clear is that there was any mechanism by which these concerns could be reported, or guidance as to whom they should be reported.

Sexual Exploitation Project

3.258 According to the Council's Corporate Submission, the Youth Development Service identified the need for a Sexual Exploitation Project in 1999.[220]

3.259 It is clear from evidence obtained by the Inquiry that the need was identified earlier, in or about 1997, by a youth club worker. The case was made to the ACPC for funding. As a result:

"[A] *project was established by the service to "monitor and evaluate the numbers of children involved in or at risk of sexual exploitation" through the allocation of a worker in the Council's Youth Development Service for 4 hours a week. The project worked to raise awareness of child exploitation through, in particular, education services."*[221]

3.260 The Inquiry has heard that this issue was identified through youth clubs and schools, with one youth worker witness noting that:

"*… they confided in you and it was these young people that were starting to tell me about young people going from the care home… there were young people who came to the secondary school, but not to the youth club, and were starting to go missing at the weekends."*[222]

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221 pg 9
222 pg 3

3.261 Members of Council staff involved in this work told the Inquiry:[223]

"I can recall doing some work in two particular secondary schools… This work was effectively the forerunner of the CATE project. We did work in both of those schools and again it was initially work with young people who weren't necessarily achieving, but where a school had picked up from conversation with young people whereby they were concerned that they were being more open in their conversations about sex and sexual activity than they should be for their age. So we were asked if we would develop some projects that were, and again it was probably at the time on the back of the teenage pregnancy work that we'd been doing for a number of years, but it was really about trying to keep young women safe and preventing them getting pregnant.

But it was probably about that time, early 2000s, where we probably began to become suspicious that this just wasn't young girls, teenage girls, who had found the joy of sex, that actually it was something a bit more serious and negative, if you like, in terms of what they were becoming involved in.

Early CATE work would have been with young women from those schools and then others referred by other young women we were working with and from other agencies. Some of this would have been awareness-raising about what 'grooming' looks like - the classic - attention of older men, gifts, rides in cars attention/'affection' shown, etc. Confirmation from young women that this was taking place would have led to CATE being set up as a Youth Service Project."

3.262 The Council has indicated that no information is available as to how the need for four hours was established nor is any data available from this Project.[224] The Inquiry has heard from a witness,[225] who told the Inquiry something different about its genesis:

"*… my understanding was it was only going to be a training project and it was from there that I learned that* [a youth worker] *and other youth workers had identified the problem.*

… [They were] *a youth worker managing a youth club. Shropshire Youth Service had failed an Ofsted inspection in 1998. But* [the] *youth club brief in Telford was to do outreach work which was contrary to what the youth service then was.*

This project wasn't a normal project for Youth Service. The historic bit of how the Youth Service became involved goes back to the 1990s. There was a group of youth workers, [who] *identified that young people in Telford seemed to be exhibiting behaviour which was not normal in the sense that they were going off unaccountably and coming back. There was, unfortunately no record of any youth worker working with these young people, this was an identified problem which was put to the service manager for a small part-time couple of hours a week project. I don't think the Youth Service quite knew what the project was going to develop into or how it developed but we had to have lots and lots and lots of interesting discussion to what we could do. With a small project and a perceived need we went ahead with really awareness training, well we developed awareness training packages,*

[223] [redacted] pg 11
[224] [redacted]
[225] [redacted] pgs 3, 7

we developed loads and loads of interesting training which we then shared with young people in youth clubs, not many youth clubs I will admit, and we went into some schools and talked to parents at parents evening…."

3.263 At a Sexual Exploitation meeting[226] on 21 November 2005, the Youth Service worker engaged in CSE work explained that the sexual exploitation work was only funded for four hours a week, and that much of this was taken up by running the sexual exploitation course.[227] The Inquiry has been provided with evidence that while an attempt had been made to require the Youth Service worker to monitor and evaluate numbers of children subjected to CSE, it had not been possible within the time allowance.[228] The school pilots were being prepared, and there was to be a new Personal, Social, Health and Economic, or 'PSHE', advisory service within the borough from April 2006.

3.264 The meeting conceded that sexual exploitation was not receiving sufficient prominence and that the "*former group*" should be resurrected. It is not clear to what the "*former group"* refers. When asked about the former group, no witnesses the Inquiry spoke to could recall it, but stated variously:

"I guess what I remember is lots of toing and froing around, and lots of talk about it but very little action being taken and I wonder if the LSCB was frustrated at the level of inactivity and they wanted something to happen but they didn't know what they needed to happen if that makes sense."[229]

"There was a consciousness that we needed to get to where we are now, but actually that wasn't happening." [230]

Youth Development Service

3.265 As I have explained, the need for a sexual exploitation project and the delivery of this Project was first delivered through the Youth Development Service, rather than Safeguarding. Indeed, a report dated 2006 describes how the Youth Service led the way locally in taking action to raise awareness and work towards addressing this problem.[231]

3.266 The Youth Development Service, or Youth Service as it is often referred to,[232] sat under the Education funding structure[233] and was the responsibility of the Director of Education & Culture, reporting to the Head of Leisure, Culture and Community Learning (this role was renamed in 2002 to Head of Children and Young People Services).[234]

3.267 In the late 1990s the Youth Service consisted of between seven and ten staff, delivering youth work, which included running evening youth clubs and working with secondary

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227 pg 2
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229 pg 27
230 pg 32
231 pg 1
232 pg 4
233 pg 14
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schools.[235] This information has been collated from documentary and witness evidence. The Council was asked to confirm the governance structure of the Youth Service and to confirm who the individuals working within the Youth Service were during this period, but informed the Inquiry that it had not been able to locate a definitive structure for this service at this time.

3.268 Despite the key role played by the Youth Service during this early period in tackling CSE, the Inquiry heard that there was not a good working relationship between the Youth Service and Safeguarding.

3.269 Evidence provided to the Inquiry indicates that the Youth Service led on the sexual exploitation work because of their specific skill set. The Inquiry heard that they were seen as being more approachable and were not perceived to be in a position of authority, as perhaps a social worker might be. The nature of this crime means that children often do not see themselves as victims, and it is only through working with individuals over a long period of time and building a relationship that the behaviour under discussion might be recognised.[236] Whilst the youth workers' ability to build relationships and encourage disclosure from children must not be undermined, I am not persuaded that the decision for the Council's response to be driven through the Youth Service was a conscious decision. It was simply a consequence of the fact that those who worked within the Youth Service had a particular interest in this area of work and were keen to deliver a response to the problem that they had perceived.

3.270 Although funding for the Sexual Exploitation Project was provided by the ACPC,[237] funding details of the Youth Service itself are unclear. The Inquiry heard that it had:

"*… no funds to do anything…* [it] *wasn't funded to give money to young people or to make provision for young people, it could only do that by identifying the problem* [to] *the partner what was needed and hope that they would pick up on what was going on.*"[238]

3.271 At the same time as the Sexual Exploitation Project was formed, the ACPC Training Coordinator created a CSE awareness raising course which was provided to statutory and voluntary agencies, however the Inquiry did not receive any further information about how many courses there were, what was covered or who attended.

Sexual Exploitation meetings

3.272 As I have noted, the evidence suggests that Sexual Exploitation meetings were taking place in 2003. The Inquiry has seen no minutes of earlier such meetings. One youth worker told the Inquiry that the early Sexual Exploitation meetings largely featured decision makers rather than practitioners, and were focused on policies and procedures rather than what was happening at street level:

[235] [redacted] pg 18
[236] [redacted]
[237] [redacted] pg 4
[238] [redacted] pg 8

"*I felt we needed people at the meetings who maybe were identifying some of the issues, so whether that was more practitioner led meetings… because it was about what was happening on the ground.*"[239]

3.273 From the evidence the Inquiry has seen it would be fair to say that there was general confusion – which persisted over time - about what was operational delivery and what was strategic. This is an early example of absence of practitioner experience at CSE planning meetings, in what was to be a persistent feature of the Council's response.

3.274 On 9 May 2003 a Sexual Exploitation meeting took place[240] to discuss the case of a child from Wellington who had been introduced by a friend to a group of Asian men and groomed by them before being raped. The meeting was chaired by the Inclusion and Support Services manager and attendees included representatives from community safety, WMP, Safeguarding and the teenage pregnancy support officer. The meeting was told that "*girls involved are passed around the group of men but... nothing is exchanged for this*".

3.275 The only logical explanation for this comment is that it was thought to remove the case from the category of 'prostitution'. The 2000 Supplementary Guidance was reviewed in 2001 and placed increased emphasis on recognising children as victims of abuse.[241] It was agreed that agencies would review the child's circumstances and that WMP would consider surveillance of the Asian males. There was a wider discussion of the role of the CSE group including the need for training, awareness raising, mapping and ensuring there were strategic links between organisations.

3.276 A teenage pregnancy support officer was present at this meeting. In 2005 a "*spike*" in teenage pregnancy was observed. A senior officer in Safeguarding[242] said of this "*spike*" that:

"*I don't believe that* [teenage pregnancy] *was ever linked to child sexual exploitation as a reason for it being an indicator to track, it was more of an indicator about education and economic wellbeing and life chances… I don't believe at the time that was an indicator… that would help agencies identify... CSE within that context.*"[243]

3.277 When the same officer was asked about a feeling on the part of victims and survivors that signs ("*low level intelligence*") had been missed, they replied, "*I think victims and survivors would be right to say that*".[244]

3.278 This was not the only witness who told the Inquiry that no link was made between CSE and teenage pregnancy.[245] Teenage pregnancy was treated as a health concern or an indicator of education or economic wellbeing, rather than a potential indicator of serious safeguarding concerns.

239 [redacted] pg 25
240 [redacted]
241 [redacted]
242 [redacted]
243 [redacted] pg 43
244 [redacted] pg 24
245 [redacted]

3.279 WMP's contribution at this meeting held on 9 May 2003 was a focused question about where the men lived – a particular street was mentioned – and the observation that this sort of situation had occurred before. WMP had previously visited a local school about this issue, but the children in question would only refer to the men as their boyfriends. It was said that something should be done in local schools at an early age to help prevention, and that more information needed to be sought on how the group of men operate. No current issues were identified for Safeguarding intervention, notwithstanding the plainest evidence of ongoing sexual exploitation of identified victims. I deal with this meeting from a WMP perspective in Chapter 5: The Policing of CSE in Telford.

3.280 At an ACPC meeting on 11 November 2003,[246] the Youth Service representative[247] noted that there had been one Sexual Exploitation meeting since the last ACPC but that it had not been well attended. The action plan was still not drafted.[248]

3.281 As has been explained above, the 2000 Supplementary Guidance reminded authorities of the obligation under Working Together 1999 to have a local protocol on responding to children about whom there were 'prostitution' concerns.

3.282 I have seen a local protocol.[249] It was produced by the Youth Development Service on behalf of the LSCB in 2006,[250] in line with the requirements of the above supplementary guidance.[251] It is not clear whether there was an earlier version or indeed the reason for the delay in producing this. The protocol followed the requirements of the guidance and made clear that CSE was a form of child abuse. There was an outline of the pathway and intervention model, and required lead officers to champion the needs and circumstances of those affected by CSE in each ACPC model.

3.283 While the 2003/2004 ACPC Business Plan's[252] 'Links to Key Strategies and Plans' did not include any relating to sexual exploitation, the document noted that a sexual exploitation policy <u>had been</u> (my emphasis both here and in the quote) drafted and continued:

"This [Sexual Exploitation] *group <u>is working to draft</u> a multi-agency protocol and to provide training for staff who are, or may be, involved with young people who become sexually exploited through prostitution."*

3.284 It may be, therefore, that although a protocol was foreshadowed in 2003 it was not realised until 2006.

3.285 So far as the drafting of the protocol was concerned, the Inquiry was told:

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251 https://dera.ioe.ac.uk/9329/1/00689-2009BKT-EN.pdf
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"*We wrote a protocol… it was just a putting together of other people's work really… it was a concoction of three protocols, one from the north of England, one from Camden and one from Nottingham... We also worked quite closely with NSPCC and Barnardo's.*"[253]

3.286 Those involved in working with victims/survivors of CSE and senior members of Safeguarding who have provided evidence to the Inquiry could not recall having seen this document.[254] This suggests to me that the creation of the protocol was nothing more than fulfilling a perceived obligation and was not in fact used in practice.[255] No information was provided to the Inquiry about how the protocol was launched, monitored or the expectations of each agency.

3.287 The protocol itself refers to a "*policy/protocol*" that was produced between Social Services and WMP and updated in 2000. The Inquiry requested a copy of this from the Council. Despite extensive searches, this earlier document could not be located.

3.288 In November 2006, a proposal was taken by Barnardo's to the LSCB Executive group to review the current Sexual Exploitation Project, to further develop its work, and costings were provided. This did not go ahead. No information was provided to the Inquiry about why the bid was sought and why it was not pursued.

Conclusions

3.289 There can be no doubt on the evidence I have heard that the signs of CSE were apparent to anyone prepared to recognise them during this period.[256] However, while some individuals plainly recognised the problem, the structures in place did not serve child victims of CSE well.

3.290 The Shropshire Safeguarding structures enforced a rigid hierarchy between child protection and district teams, which led to an inflexible approach which was ill-equipped to deal with CSE. Although there was a restructure designed to make the approach to child protection recognise a "*continuum of need*"[257] this appears not to have been successful. I derive this conclusion from the fact that I see no evidence that anything was done.

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

3.292 There was informal information sharing between the Council and WMP from an early stage, though the restructure in 1997 removed the physical closeness of specialist child protection senior social workers and police officers dealing with child cases.

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[253] [redacted] pg 3
[254] [redacted] pg 12, [redacted], pg 43, [redacted], pg 30
[255] [redacted]
[256] [redacted] pg 3, [redacted] pg 33, [redacted]
[257] [redacted] pg 19

3.293 While it is clear that Safeguarding were involved with children where the section 47 threshold was thought to be met, it is less clear that the decisions as to the threshold were made properly in CSE cases, or that there was any effective Council response to cases thought to fall below that threshold.

3.294 In the move to a unitary authority the focus was on building a strong Education department and the structures associated with education provision. There is no sign of parallel enthusiasm for, or interest in, Safeguarding. The early days of child protection were marred by a lack of focus and resources.

3.295 Further, the new unitary authority lacked political experience in developing social services including children's social services; and there was a lack of strong professional expertise – at management and at practitioner level - in the Council's Safeguarding provision in the very early days.

3.296 Decisions as to resources and priority were rested ultimately with elected representatives as budget-holders. The evidence I have seen shows an enthusiasm for building structures without thought as to how those structures may operate to produce positive outcomes, or even how they would interact with each other.

3.297 I have seen no evidence that the change to a unitary authority brought a different approach to cooperation between Safeguarding and other services in respect of CSE – or at all. Safeguarding remained siloed, and tightly drawn. Attempts at innovation and openness – such as the Helpdesk – initially foundered for lack of funding.

3.298 The response of the ACPC appears – on admittedly scant documentation – to have been minimal.

3.299 While it was reported to ACPC this was a "*big issue for schools*"[258] there is little evidence of coordinated response and no response involving dealing with child victims of CSE. The Youth Development Service allocated a worker for four hours per week, with a plainly unachievable brief, not only to produce training materials and deliver training to schools but also to evaluate and monitor prevalence of CSE.[259]

3.300 Attempts in the early 2000s to set up sexual exploitation policy meetings failed for lack of engagement.[260]

3.301 The ACPC appears not to have recognised the issues of children going 'missing' as an indicator and its relevance to CSE, despite the references to this in the national guidance and the prevalence of missing episodes in the histories of children exploited locally.

3.302 Similarly, the ACPC appears not to have recognised teenage pregnancy as an indicator and despite a well-documented "*spike*"[261] in 2005 was content with an instruction not to refer

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259 pg 2
260 pg 27, pg 38, , pg 22,
261 pg 14

teenage mothers to the Initial Assessment team, obviously regarding pregnancy as a lifestyle choice at any age, or a health issue, rather than a safeguarding issue.

3.303 As a result the ACPC appears to have seen its role as to CSE to be strictly confined to providing training rather than, as required by national guidance, to inquire about actual trends and to seek to coordinate partner agencies to understand and disrupt the problem.

2004 to 2012

Key Developments

3.304 The Children Act 2004 mandated the creation of LSCBs to replace ACPCs; and to appoint a Director of Children's Services to oversee all aspects of provision for children, bringing together education and social care provision.

3.305 The LSCB's role included the obligation to develop policies and procedures for safeguarding and promoting the welfare of children in the authority, including policies and procedures in relation to the action to be taken where there are concerns about a child's safety or welfare, and thresholds for intervention.

3.306 In the Council, the LSCB was described as "*big and unwieldy*".[262] A more detailed account received by the Inquiry was that "[y]*ou would have 20 or 30 members and it became increasingly difficult to manage or to ensure that people were involved and engaged*".[263]

3.307 The Inquiry heard evidence that the LSCB was not effective, with one description being: "*we were going round in circles all the time. We're ticking a box but we're not actually doing any work*".[264] Evidence was also given that LSCB engagement with the issues for discussion, outside the meeting itself, was discouraged – the independently-chaired LSCB was at least initially reliant on the Council-chaired LSCB Executive group for its information, and the Inquiry saw evidence that LSCB members' attendance at Sexual Exploitation subgroup meetings was resisted.

3.308 In 2006, the Government reissued the Working Together guidance (now, "Working Together 2006"); the new iteration made clear that where children were identified as being either 'involved in prostitution' or were at risk of being drawn into 'prostitution' this should always trigger the agreed local safeguarding procedures. At this stage, it is difficult to identify what those were.

3.309 Concerns about the Safeguarding response to CSE remained. The Inquiry received this account:

"*My team were making referrals to the Helpdesk at social care about concerns that they had, again, not using that word 'exploitation' because we didn't have that language. They were concerned about something that they couldn't put their finger on in the community that was attracting young people and making them behave in a risky way… We never felt*

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262 [redacted] pg 38
263 [redacted] pg 20
264 [redacted] pg 38

as though we particularly got anywhere… it seemed that the information that we were sharing, we were worried about, didn't necessarily go anywhere."[265]

3.310 The Inquiry has evidence of continuing Sexual Exploitation meetings; regrettably, the minutes of the 18 October 2005 meeting note that the group's function "*is still unclear*".[266] The provision for sexual exploitation work remained at four hours per week.

3.311 In 2006, the Sexual Exploitation group was renamed the CATE subgroup with a remit to develop local policies, procedures and responses. The Inquiry has read that the aim was "*probably trying to make it broader than the Youth Service team and pushing it more to being a standalone team than part of the Youth Service".*[267]

3.312 In 2006, the CATE subgroup received a report from a delegate who had attended a national course and proposed an active sexual exploitation response, based on a scheme set up in Walsall. The proposals faltered for lack of funding. In late 2007, the group heard that two Connexions (essentially a rebranded Youth Service) workers had been allocated time to deal with sexual exploitation. The Inquiry was told that the workers had a youth service background as "*the work didn't always fit into safeguarding procedures, it was very youth work orientated – more about building trusted relationships*".[268] This was known as the 'CATE Project' initially, before later the 'CATE Team', and was in fact less a new provision and more formalisation of the support that certain youth workers were already informally offering victims/survivors of CSE.

3.313 The Inquiry heard that cost was a factor in determining which agency would make provision:

"*Connexions for Youth staff don't cost as much as social workers. So, it almost felt a little bit like we were back to being resource-led and if we're being resource-led the option to do this as cheaply as possible seemed to be the better option at the time."*[269]

3.314 Despite the positive step of the inception of a team, there remained a lack of focus on establishing or evaluating what the CSE work hoped to achieve or whether these were the right outcomes and, most importantly, what difference they made. Moreover, the CATE Team's existence was not well known:

"*… we knew there was a CATE team but it was a bit cloak and dagger, it was all very confidential and it wasn't really, we didn't know who they working with and it was quite a select kind of team if you like. Agencies outside of the CATE team weren't fully aware of their role. I don't remember there being any information shared regarding their purpose or referral routes."*[270]

3.315 In 2007, the 'CATE Pathway group' was established with a stated aim to "*develop and oversee the implementation of an agreed model of protection and support for young people*

265 [redacted] pg 10
266 [redacted]
267 [redacted] pg 41
268 [redacted] pg 10
269 [redacted] pg 40
270 [redacted] pg 16

identified through the CATE project";[271] this is, of course, essentially the same remit as the CATE subgroup – the creation of which I discuss in more detail below – and an early example of the duplication and overlap of oversight groups that was to be an enduring feature over the next decade.

3.316 It is important to note that although there had been "*a debate as to whether individual cases should be dealt with within Child Protection Services*"[272], the CATE system was not a safeguarding response in accordance with the 1989 Act. It was not until late 2008 that a formal referral process was agreed containing the possibility of reference to children's Safeguarding.

3.317 The role of a CATE practitioner was not defined and the CATE Team's way of working was very much informed by the youth work experience of its practitioners. This was hands-on work, providing a 24 hours per day, seven days per week on-call service to children finding themselves in difficult situations, even on occasion travelling to pick a young person up from an unfamiliar town or environment, the young person having been taken there by their perpetrator. The CATE practitioners appear to have acted instinctively and often in response to emergency situations, at some personal risk.

3.318 In 2007 the 'Senior Officers' Coordination group' was established, comprising representatives of the Council, WMP and health authorities, in response to "*growing evidence of organised, co-ordinated sexual exploitation of children in the borough*".[273] WMP reported to the group the concerns that would lead to Chalice and noted this had been "*going on for years*".[274]

3.319 The CATE Team initially dealt with children who were over 13 years old; the Inquiry heard that the explanation for children aged 13 and under not being referred to CATE was unclear (and indeed, there is confusion within some of the documents), though thought perhaps to have derived from the fact that funding for the Youth Service was intended to be directed at children between 13 and 19 years old.

3.320 Demand on the CATE Team was very high. There was a CATE meeting on 25 June 2008[275] at which it was reported that the team was supporting five children, although I have seen evidence to suggest that the true figure was in fact higher. I understand that there was absence within the team and the CATE Team manager – who was managing 30 other Connexions4Youth staff – was undertaking practitioner work.[276] There was no capacity for preventative work in schools. A report in September 2008 noted that the team had insufficient staff. The Inquiry heard:

"[The case was made] *numerous times to increase the staffing for the CATE team but without actually it being new money, we were stopping something to put money into CATE*

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272 pgs 2-3
273 pg 17
274 pg 4
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276 pg 7

and by that time I think we'd cut things so drastically there probably wasn't a lot else to cut."[277]

3.321 By 2009 the CATE Team had lost staff and amounted to a single practitioner who was moved to WMP accommodation to assist with Chalice. A report acknowledged that the CATE Team had insufficient resources to deal with need and asked that the LSCB undertake work to determine the extent of sexual exploitation and to provide resources to deal adequately with it; I have seen no evidence that work was done or resources provided. Ultimately, Connexions4Youth continued its temporary funding for another year though in a significant move, the Director of Children's Services appointed a senior practitioner from Safeguarding to manage the CATE Team.

3.322 This formal joining of CATE and Safeguarding appears to have been positive; the Inquiry heard from a practitioner in Safeguarding that having exposure to CATE allowed a better understanding of CSE "[i]*t's almost like these blinkers went and I so got it*".[278] Nevertheless, the union did not produce an alignment of processes or reconciliation of terminology: at this stage the CATE process was using many terms (for example, "strategy meeting") that suggested, but did not equate to, a *Working Together* process.

3.323 The new management did not mean that CATE's funding was secure; in 2010 the CATE subgroup was still seeking "*sustainable funding*"[279] despite the fact that the Children and Young People 'Priority Plan' of 14 June 2010 noted that a priority was to "*improve support to those subject to sexual exploitation and reduce the number of those at risk (CATE)*".[280]

3.324 The Council had expressed an early interest in European funding: the DAPHNE Project would "*support* […] *the current workstream on CATE*"[281] and additionally provide resources for a CSE Training Coordinator. Despite some enthusiasm for the bid and a significant amount of preparatory work it was not pursued, for reasons that are not clear. The Inquiry has noted throughout the review of the CATE Team and indeed the Council's other CSE provision that third party funding was often discussed but almost never pursued.

3.325 The Council began a restructuring process in 2010; a confidential memorandum of January 2011 explained the rationale:

"… *to be honest and realistic in what we can and can't do. We can't do everything that we would like to do nor are we the only organisation available locally to offer support. And in the current financial climate with reducing levels of public service funding from the Government, we will need to prioritise and focus on the things that matter most."*[282]

3.326 It appears that CSE was not one of the "*things that matter most*"; the document did not mention it. So far as CATE was concerned, the service was to be provided by family support workers under Cohesion, a targeted support service. The existing CATE practitioners were

277 [redacted] pg 52
278 [redacted] pg 23
279 [redacted]
280 [redacted]
281 [redacted]
282 [redacted], pg 3

to have no role. Shockingly, there had been no liaison with the chair of the LSCB as to the restructure proposals.

3.327 This proposal sparked protest among the CATE Team and the Council relented to the extent that it allowed a single CATE practitioner to remain, as a team of one, expected to support the victims/survivors in the ongoing Chalice trials, to work with other existing cases, and to train a new cohort of practitioners within Cohesion. CATE's time in Cohesion was to prove difficult, but there was perhaps one positive; the Inquiry heard:

"… *under the new structure the CATE team went across into the newly formed Cohesion service…up to that point it wasn't in base budgets at all, it was a project.*"[283]

3.328 The dominant theme from this time period is a reluctance on the part of the Council to fund a CSE response at all, notwithstanding the increasing national awareness of the problem and guidance requiring procedures and processes to be put in place. Safeguarding still did not regard CSE as its problem. The CATE Team was never a safeguarding – i.e. a response in accordance with the 1989 Act/*Working Together* guidance – it was a formalisation of work which had been done on an ad-hoc basis by youth workers. Further, its funding from Connexions4youth was not new money or a sustainable solution. The CATE work placed heavy demands on its practitioners and very nearly broke under the weight of these demands, falling to a single practitioner during 2009 before, finally, Safeguarding took over management. Even then the CATE Team was not safe, and by 2012 CATE was on the verge of erasure; it is difficult not to see the 'mainstreaming' proposals as evidence that there was a failure on the part of those planning the restructure to understand the nature of the skilled work done by the CATE Project members, or its importance to children in Telford.

3.329 This era also encompassed the birth and early years of the LSCB. It was, from the start – too big; isolated by the Council (deliberately, in my view) from information and decision making; poorly resourced and effectively powerless. It is astonishing that the CATE Project was born without LSCB involvement and that CATE's intended demise in the restructure was not discussed with the LSCB chair.

The National Landscape

The Children Act 2004

3.330 The Children Act 2004 provided the legal backbone for an ongoing programme of reform. It reinforced that all people and organisations working with children have a responsibility to help safeguard children and promote their welfare. Section 10 required each local authority to decide to promote cooperation between the authority, each of the authority's relevant partners, and such other persons or bodies who exercise functions or are engaged in activities in relation to children in the local authority's area, as the authority considers appropriate. The arrangements were required to be focused on improving the wellbeing of children in the authority's area – which includes protection from harm and neglect alongside other outcomes. Section 11 placed duties on a range of organisations and individuals to ensure that their functions, and any services that they contract out to others, were discharged about the need to safeguard and promote the welfare of children. Section 12

[283] [redacted] pg 55

allowed further secondary legislation and statutory guidance to be made with respect to setting up databases or indexes that contain basic information about children to help professionals in working together to provide early support to children and their families.

3.331 The Children Act 2004 placed a statutory duty on all local authorities to establish LSCBs, to replace the non-statutory ACPCs.

3.332 Furthermore, the Children Act 2004 mandated the creation of the Director of Children's Services ("DCS") role, the holder being responsible for a local authority's education and social services provision in so far as those services were provided to children.

Local Safeguarding Children Board ("LSCB")

3.333 LSCBs were charged with drawing all the relevant partner agencies together to work cooperatively to improve safeguarding outcomes for children and to hold those agencies to account in respect of this work. The scope of LSCBs' role included safeguarding and promoting the welfare of children, aiming to identify and prevent maltreatment, impairment of health or development, and ensuring children would grow up in circumstances consistent with safe and effective care.

3.334 The core objectives of the LSCB were set out in the Children Act 2004 and Working Together 2006 and associated regulations[284] as follows:

3.334.1 To developing policies and procedures for safeguarding and promoting the welfare of children in the authority, including policies and procedures in relation to the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

3.334.2 The provision of appropriate and effective safeguarding training for professionals;

3.334.3 Investigation of allegations concerning persons who work with children;

3.334.4 Communicating to persons and bodies in the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done, and encouraging them to do so;

3.334.5 Monitoring and evaluating the effectiveness of what is done by the authority and their LSCB partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

3.334.6 Participating in the planning of services for children in the local authority;

3.334.7 Undertaking reviews of serious cases and advising the authority and their LSCB partners on lessons to be learned;

[284] The Local Safeguarding Children Boards Regulations 2006, Statutory Instrument no. 2006/90

3.334.8 Agreeing inter-agency procedures for section 47 enquiries, and developing local protocols on key issues of concern such as:

3.334.8.1 Children abused through prostitution;

3.334.8.2 Children living with domestic violence, substance abuse, or parental mental illness;

3.334.8.3 Female genital mutilation ("FGM");

3.334.8.4 Forced marriage;

3.334.8.5 Children missing from school;

3.334.8.6 Children who may have been trafficked; and

3.334.8.7 Safeguarding looked after children who are away from home;

3.334.9 Communicating to people and bodies in the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done, and encouraging them to do so; and

3.334.10 Monitoring and evaluating the effectiveness of what is done by the local authority and LSCB partners, individually and collectively, to safeguard and promote the welfare of children and advise them on ways to improve.

3.335 The Chair of the LSCB had a crucial role in making certain that the LSCB operated effectively and secured an independent voice for the LSCB. As such it was necessary for the Chair to be of sufficient standing and expertise to command the respect and support of all partners, to act objectively and distinguish their role as LSCB Chair from any day-to-day role – for example, as an employee of the local authority.

3.336 The '*Youth Matters*' Green Paper in 2005 set out a vision of integrated youth support services to help all young people achieve the five Every Child Matters outcome through coherent, young person-centred delivery of information, advice and guidance, support, development opportunities and positive activities.

3.337 It was planned that integrated youth support services should be in place throughout England by 2008. A guide to targeted youth support was published in 2007 under the Every Child Matters banner. This guide offered a framework to inform the design and implementation of targeted youth support in each local area, drawing on the experience of 14 targeted youth support pathfinder areas. This document did not set requirements on local authorities, schools or other agencies, but was intended to offer practical help in reforming targeted youth support, to improve outcomes for young people.

3.338 This was intended for young people who would not meet the traditional thresholds for statutory or specialist services, but who, without help, were at future risk of further problems such as substance misuse, youth offending, teenage pregnancy and homelessness. This was noted as being likely to include young people who experience a

combination of factors, including persistent absence or exclusion from school, behavioural problems, low self-efficacy, attitudes which condone risky behaviours and poor family support/support networks, among others.

Working Together to Safeguard Children 2006

3.339 As previously mentioned, in 2006 the Government reissued the *Working Together* guidance ("Working Together 2006").[285] The importance and process of inter-agency working to safeguarding children was further outlined. The importance of addressing the safeguarding needs of "*children abused through prostitution*" through reference to the Sexual Offences Act 2003 was outlined. There was also a focus on the prosecution of those who abused, exploited children through 'prostitution' and those who incited, arranged and caused child 'prostitution'.

3.340 The guidance made clear that where children were identified as being either 'involved in prostitution' or were at risk of being drawn into 'prostitution' this should always trigger the agreed local safeguarding procedures, with the dual aim of keeping children/young people safe, from harm and to ensure adults who harmed were brought to justice. The 2000 Supplementary Guidance remained unchanged. There was a section addressing concerns highlighted by Bichard in 2003, on the possible harm caused to children by underage sexual activity, making clear the existing legal framework and asking professionals to take this seriously.

3.341 In 2007, further supplementary guidance to Working Together 2006 was issued, regarding safeguarding children who may have been trafficked (the "2007 Trafficking Guidance").[286] This guidance was intended to support those working with children to identify and respond to trafficked children, including those trafficked for sexual exploitation both into, and within, the UK. The guidance reiterated the use of existing safeguarding procedures. LSCBs were asked to consider whether they should have inter-agency strategies and protocols in place for the early identification and notification to the relevant agencies of potential trafficking victims and that LSCBs should maintain close links with the community groups and have a strategy in place for raising awareness within the local community of the possibility that children are being trafficked and potentially sexually exploited.

3.342 In June 2008 the Government commissioned the University of Bedfordshire[287] to undertake a scoping exercise to review the progress being made by LSCBs to implement existing guidance, to assess the extent to which action had been taken against the perpetrators of sexual exploitation (the University of Bedfordshire used this language despite the lack of a shift from 'prostitution' in government guidance), to report on emerging good practice and highlight the current barriers and challenges to keeping this group of children/young people safe. This concluded that there were concerns about the implementation of the existing guidance and the lack of awareness of CSE amongst professionals.

3.343 In 2009, further supplementary guidance to Working Together 2006 was issued again in England and Wales, titled '*Safeguarding Children and Young People from Sexual*

[285] http://www.familieslink.co.uk/download/june07/working%20together%202006.pdf
[286]
[287] Jago S, Arocha L, Brodie I, Melrose M, Pearce J and Warrington C (2011) *What's Going on to Safeguard Children and Young People from Sexual Exploitation? How local partnerships respond to child sexual exploitation.* Luton: University of Bedfordshire.

Exploitation' (the "2009 Sexual Exploitation Guidance").[288] This was a comprehensive document that moved the discussion away from 'child prostitution', and all that this implied, and focused on CSE as child abuse. The guidance provided a definition:

"*Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g., food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) because of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example, being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.*"

3.344 This guidance sets out key principles including the need for a child centred approach; a focus on prevention; early identification and effective safeguarding; and the disruption of perpetrators and their prosecution. The importance of the use of existing safeguarding procedures and the need for joint working was emphasised. It included information about CSE and its impact on children; the roles and responsibilities of professionals; and advice about dealing with individual cases. The needs of children were highlighted, as well as those of their families.

3.345 The guidance also makes clear the key role that LSCBs should play. They were asked to consider CSE in their local needs assessment and where they found it to be a significant issue the LSCB was required to ensure that it was regarded as a priority by the Children's Trust. The LSCB also was asked to:

3.345.1 Develop specific procedures for CSE in partnership with partner agencies; ensuring they were making a significant difference to children/young people;

3.345.2 Put in place systems to track and monitor cases of CSE and understand the local landscape to meet need;

3.345.3 Provide appropriate training; and

3.345.4 Consider SCRs regarding CSE.

Children and Young People's Plan

3.346 From 2006, local authorities were required to have a Children and Young People's Plan. It was intended to be a key document which covered, in one place, all services for children, young people and families within a single strategic and overarching vision for the local area.

[288] Department for Children, Schools and Families (2009) '*Safeguarding Children and Young People from Sexual Exploitation'*. HMSO: London.

The CTB was accountable for overseeing the delivery of the Children and Young People's Plan and, from April 2010, it became a statutory duty for local authorities to have regard to its plan in exercising its functions.

Lord Laming – 'Baby P'

3.347 Following the death of 'Baby P', the Secretary of State for Children, Schools and Families commissioned Lord Laming to provide an urgent report on the progress being made across the country to implement effective arrangements for safeguarding children. The start of the report, published in March 2009,[289] outlines headline messages:

3.347.1 The Secretaries of State for Health, Justice, the Home Office and Children, Schools and Families must collaborate in the setting of explicit strategic priorities for the protection of children and young people for each of the key frontline services and ensure sufficient resources are in place to deliver these priorities;

3.347.2 The Secretary of State for Children, Schools and Families must immediately address the inadequacy of the training and supply of frontline social workers;

3.347.3 The Secretary of State for Health must immediately address the wariness of staff throughout the health services to engage with child protection work; and

3.347.4 The Home Secretary must urgently address the adequacy of the resources devoted to police child protection teams, the specialist training of these staff, the vacancy rates, the status of this work and the quality of service provided.

3.348 Lord Laming highlighted continuing problems with inter-agency working, information sharing and feedback when referrals of harm are made by different agencies. There remained confusion about the use of Working Together 2006. There was still a focus on children's services being responsible for safeguarding and a poor sense of this being everybody's responsibility. There were inconsistencies in multi-agency attendance at core group meetings, reviews and casework decisions.

3.349 There was an emphasis on:

3.349.1 Leadership and accountability;

3.349.2 Walking in the shoes of children - understanding things from their perspective – child centred practice:

"*Every professional coming into contact with a child in whatever context should be clear that it is not acceptable to do nothing when a child may be in need of help. It is important that the social work relationship, in particular, is not misunderstood as being a relationship for the benefit of the parents or for the relationship itself, rather than a focussed intervention to protect the child and promote their welfare*";

[289] The_Protection_of_Children_in_England.pdf (publishing.service.gov.uk)

3.349.3 Focusing too much on parents' needs;

3.349.4 The importance of early intervention. Laming made the point that early intervention should not be seen as something that only applies to babies and toddlers. Teenagers who are starting to disengage from school or show signs of anti-social behaviour also benefit from preventative and early help and support. Schools, youth workers and other professionals should be aware of the signs and know how best to respond;

3.349.5 The importance of the 'front door':

"*A key factor in identifying children and young people who need help is ensuring services are designed to encourage contact from members of the public, parents and children and young people as well as by other agencies*";

3.349.6 Laming further stated that if safeguarding children is everybody's responsibility, then everybody should know how, and who, to contact if they are concerned about a child. All service providers should look critically at how they receive referrals, the point known as their 'front door'. In local authorities where callers are directed to call centres that handle a wide range of local authority business, the local authority must ensure that any call relating to the protection of a child is quickly transferred to a trained person with immediate access to an experienced social worker allocated to work with that team for more complex or high-risk referrals;

3.349.7 Improving assessments:

"*Fundamental to establishing the extent of a child's need is a child centred, sensitive and comprehensive assessment. Assessment should involve gathering a full understanding of what is happening to a child in the context of their family circumstances and the wider community, using a variety of sources of information. It must, therefore, be a joint or parallel assessment with all professionals concerned for the child's safety and welfare. Time needs to be spent making sense of this information involving the family where appropriate*";

3.349.8 A continuum of support for children:

"*… the term 'threshold' has been increasingly used amongst professionals in children's services and their partner agencies. Thresholds are an attempt to limit access to services either because of finance or staffing constraints. Thresholds have no statutory basis and are not part of the Framework for the Assessment of Children in Need and their Families. Despite this, concerns have been raised from across the full range of services contributing to this report that thresholds, which act as gateways to restrict services for children, are inconsistent, and are too high*";

3.349.9 Training and recruitment of social workers, inspection processes and the processes of SCRs:

"*There is a clear need for a determined focus on improvement of practice in child protection across all the agencies that support children. New ways should be created to share good practice and learn lessons when things go wrong*"; and

3.349.10 LSCB arrangements and funding for safeguarding and court proceedings.

3.350 There were 58 recommendations on all of these areas. The relevant ones to safeguarding practice are:

3.350.1 Recommendation 11. The Department for Children, Schools and Families should revise *Working Together* to set out clear expectations at all points where concerns about a child's safety are received, ensuring intake/duty teams have sufficient training and expertise to take referrals and that staff have immediate, on-site support available from an experienced social worker. Local authorities should take appropriate action to implement these changes.

3.350.2 Recommendation 13. Children's Trusts must ensure that all assessments of need for children and their families include evidence from all the professionals involved in their lives, take account of case histories and significant events (including previous assessments) and above all must include direct contact with the child.

3.350.3 Recommendation 14. Local authorities must ensure that 'Children in Need', as defined by section 17 of the 1989 Act, have early access to effective specialist services and support to meet their needs.

3.350.4 Recommendation 15. The Social Work Task Force should establish guidelines on guaranteed supervision time for social workers that may vary depending on experience.

3.350.5 Recommendation 16. The Department for Children, Schools and Families should revise *Working Together* to set out the elements of high quality supervision focused on case planning, constructive challenge and professional development.

3.350.6 Recommendation 19. The Department for Children, Schools and Families must strengthen *Working Together*, and Children's Trusts must take appropriate action to ensure: all referrals to children's services from other professionals lead to an initial assessment, including direct involvement with the child and their family, and the direct engagement with, and feedback to, the referring professional; core group meetings, reviews and casework decisions include all the professionals involved with the child, particularly police, health, youth services and education colleagues. Records must be kept which must include the written views of those who cannot make such meetings; and formal procedures must be in place for managing a conflict of opinions between professionals from different services over the safety of a child.

3.351 *Working Together*[290] was revised in 2010 ("Working Together 2010"), prompted by the Laming report. This outlined the safeguarding responsibilities of all agencies. There was a brief section on CSE and a reminder of the responsibilities contained in the 2009 Sexual Exploitation Guidance and of the fact that children who are sexually exploited are the victims of child sexual abuse, and their needs require careful assessment. They are likely to be in need of welfare services and – in many cases – protection under the 1989 Act. It also highlighted the role of the LSCB to ensure that there was appropriate training and supervision of those responsible for safeguarding children.

3.352 In January 2011 Barnardo's published '*Puppet on a String; the urgent need to cut children free from sexual exploitation'*.[291] This expressed concern that CSE was not being considered as a national child protection issue and children at risk or experiencing CSE were not being identified; the report called on the Secretary of State for Education to take responsibility and set out a clear plan of action for all agencies to raise awareness to improve early identification of CSE, improve statutory responses and the provision of services, improve the evidence and improve prosecution procedures.

3.353 In October 2011 the University of Bedfordshire, in partnership with the National Working Group for Sexually Exploited Children and Young People ("NWG"),[292] produced a publication[293] which reviewed the response of LSCBs to the 2009 Sexual Exploitation Guidance. They found that only a quarter of LSCBs had implemented the guidance; there remained a lack of awareness raising and prosecution of perpetrators. They noted problems with data collection and therefore a lack of a strategic response to needs. This had led to pockets of good practice by individual champions or incident-led practice where there had been a child death, and no strategic response. Their conclusion was that despite some examples of innovative practice, LSCBs were failing to safeguard children from CSE.

The Munro Report

3.354 In June 2010, the Secretary of State for Education asked Eileen Munro to conduct an independent review of child protection in England. In 2011 Munro produced her final report. The context was a perceptible steep rise in referrals (11% in the 2009/2010 year) since the publicity around the death of Baby P. It was noted that managing this high rate of referrals had become so problematic that it was seriously affecting all other aspects of social work. '*The Munro Review of Child Protection: Final Report A child-centred system'*[294] does not mention CSE.

3.355 Munro saw the central question as '*what helps professionals make the best judgments they can to protect a vulnerable child?*'. The final report set out proposals for reform which are intended:

[290] https://www.workingtogetheronline.co.uk/documents/wt_2010.PDF
[291] Barnardo's (2011) *'Puppet on a string: The urgent need to cut children free from sexual exploitation'* https://www.basw.co.uk/resources/puppet-string
[292] https://www.nwgnetwork.org/the-work-we-do/
[293] Jago, S et al (2011) '*What's going on to safeguard children and young people from sexual exploitation? How local partnerships respond to child sexual exploitation'*
[294] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf

"… *to create the conditions that enable professionals to make the best judgments about the help to give to children, young people and families. This involves moving from a system that has become over-bureaucratised and focused on compliance to one that values and develops professional expertise and is focused on the safety and welfare of children and young people.*"

3.356 The focus of this report is on social workers being able to exercise professional judgment, to be freed from bureaucracy and overall less prescription in the safeguarding process. The Government was asked to revise both the statutory guidance, *Working Together* and the Assessment Framework and their associated policies and to remove initial and core assessments, replacing them with single assessment and guide timescales.

3.357 In 2011 the Government published its response to '*The Munro Review of Child Protection'.*[295] The Government accepted most recommendations, including in principal Recommendation 10 which stated that the Government should place a duty on local authorities and statutory partners to secure the sufficient provision of local early help services for children and families.

3.358 In the same year the Government published the '*Tackling Child Sexual Abuse Action Plan'.*[296] This action plan drew on recent publications about CSE, as well as the recent Munro review into child protection.[297] The plan reinforced the important role that LSCBs played at the centre of local multi-agency arrangements including:

3.358.1 Improving data collection (the University of Bedfordshire had produced a data monitoring tool);

3.358.2 Promoting and actioning mapping of need in the local area and putting in place systems and processes to monitor ongoing prevalence and response;

3.358.3 Developing an effective local strategy ensuring that coordinated multi-agency response was in place (based on data) and to consider developing a working group/subgroup; and

3.358.4 Providing training and making it a priority.

3.359 The action plan asked children's services and health task and finish groups to consider why agencies were not responding to CSE, and that NWG[298] would provide support. The need for all agencies to support victims/survivors and their families after sexual exploitation was highlighted. This plan proposed the re-issue of the 2009 Sexual Exploitation Guidance and the production of a step-by-step guide for front line professionals on what to do if they worked with a child who was a victim/survivor of CSE.

[295]https://webarchive.nationalarchives.gov.uk/ukgwa/20130104032606mp_/http://media.education.gov.uk/assets/files/pdf/g/government%20response%20to%20munro%20-%20final.pdf
[296]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/180867/DFE-00246-2011.pdf
[297]https://www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system#:~:text=Report%20setting%20out%20reform%20proposals,children%2C%20young%20people%20and%20families.
[298] https://www.nwgnetwork.org/the-work-we-do/

Safeguarding

Staffing Issues

3.360 In 2005, the Director of Education became the DCS.[299] The Inquiry heard that, by this stage, Safeguarding was:

"*… in a very reasonable state... but there was still work to be done.*"[300]

3.361 In 2008 the Council appointed a new DCS, whose background was in education. There had been what some witnesses called a lengthy "*interregnum*" (meaning 'pause') when the post was vacant; a sense of strategic direction was thought to be missing.[301]

3.362 It is clear from evidence provided to the Inquiry that the Safeguarding service had been depleted of its leadership because of absences through illness. There was only one senior manager in Safeguarding at the time in 2008/2009. The extreme shortage of senior staff meant that the department was in very poor shape, as identified in the JAR (which is dealt with below), and the leadership role was seen as unattractive as the stress the service was under was well-known regionally. The Inquiry understands that one recruit to the Council's Safeguarding team at the time had been aware that the department was struggling, from time spent at Shropshire Council, but did not appreciate how "*dire*" the situation was.[302]

3.363 The Inquiry heard further that Telford "*was not an area in which social workers were choosing to work*".[303] Telford was known to have complex social care issues thought not to be unusual for a new town, particularly one into which fractured families had moved.

3.364 The new DCS did not last. In late 2009, the Council appointed an interim DCS from within existing staff. The system was known not to be operating at an "*optimum level*";[304] an extra £1 million in funds was secured and the Inquiry was provided with evidence that the Council's political leadership was supportive in that regard. However the extra funds were largely necessary to satisfy a large agency staff bill and a notable increase in the number of cases being dealt with. As a result, plans to integrate social workers into the Clusters were initially stymied because there were insufficient social workers in the core service and budget holders would not accommodate further recruitment for that purpose.

3.365 The Inquiry heard from a senior social worker:

"*I can remember a lot of staff discontent and a lot of agency staff… and I can remember that supervisions weren't being held regularly... Most teams were not having their monthly regular supervision, I think... I think the morale at that level, I don't think it was just at social worker level, I think the morale at team manager level wasn't good at that time…*

[299] [redacted] pg 34
[300] [redacted] pg 34
[301] [redacted] pg 5
[302] [redacted] pg 5
[303] [redacted] pg 4
[304] [redacted] pg 6

We were a lot lower paid than our neighbouring authorities and a lot of people were sort of arguing that we'd got higher caseloads, that we were being paid less… a lot of people left and went to neighbouring authorities."[305]

3.366 A senior official told the Inquiry:

"… *there was concern about the number of looked after children; you know, it seemed to be that the number of looked after children was a concern because of the expense... I'm not pinning that on any individual particularly but there was certainly sometimes an impression from the administration that there was concern about how much looked after children cost."*[306]

3.367 Another senior official told the Inquiry: *"Children's Social Services was generally seen as a "problem area"".*[307] By this the witness meant that it was her impression that:

"… it was felt by those in authority that a lot of money was already being channelled into this area, particularly into the issues which arose from the many looked-after children in the Council's care. This "took away" from the traditional district council spend, a number of the unitary authority councillors coming from the original district council."

Ofsted assessment - 2008

3.368 Ofsted has carried out a number of inspections of the Council during the period of my Terms of Reference. The Inquiry understands that Ofsted has focused on and significantly developed its learning and understanding of the nature and impact of CSE during this period. Its frameworks and methodology for inspections have developed in response to the growing understanding in the sector about CSE, and Ofsted now carries out inspections known as Inspecting Local Authority Children's Services ("ILACS") introduced in January 2018, which include a closer examination of a local authority's response to CSE.[308]

3.369 Between the period 1 April 2007 to 31 March 2008, Ofsted carried out a performance assessment of services for children in the Council. Inspectors made judgments based on the following scale: '*outstanding/excellent*'; '*good*'; '*adequate*'; and '*inadequate*'. The letter was shared with the DCS in January 2009.[309] There was no reference within this report to the Council's response to CSE, but it provides a helpful insight into the overall effectiveness of children's services which was found to be '*adequate*'. Capacity pressures within Children's Social Care teams was found to be a weakness and area for development. The contribution of services to improving outcomes for children and young people in terms of "Staying Safe", one of the five Every Child Matters outcomes, was found to be 'adequate'. There was outstanding multi-agency preventative and family support services delivered through local Clusters using TAC and CAF processes. However, an important weakness and areas for development included the percentage of initial assessments completed on time which was found to be below statistical neighbours and the fact that the LSCB did not focus sufficiently

305 [redacted] pgs 32-33
306 [redacted] pg 11
307 [redacted] pg 13
308 [redacted]
309 [redacted]

on performance management information. The level of teenage pregnancy in Telford had reduced, although it still remained above geographical neighbours.

Joint Assessment Review ("JAR") 2008

3.370 A JAR of the Council took place in May 2008.[310] JARs are conducted under arrangements made by Her Majesty's Chief Inspectorate of Schools, under the requirements of section 20 of the Children Act 2004.[311] Section 20(3) of the Children Act 2004 states that:

"[The] *purpose of a review under this section is to evaluate the extent to which, taken together, the children's services being reviewed improved the well-being of children and relevant young persons (and in particular to evaluate how those services work together to improve their well-being)*."

3.371 Within this JAR, a decision was made by Ofsted to carry out an additional inspection of the youth services provision.[312] The JAR inspection team included inspectorates from Ofsted, the Healthcare Commission, the Audit Commission, HM Inspectorate of Constabulary, HM Inspectorate of Prisons and HM Inspectorate of Probation.[313]

3.372 The JAR focused on the experience of children, and set out to describe the extent to which they were healthy, safe, enjoy and achieving, making a positive contribution and were well prepared to secure economic wellbeing (the five outcomes in '*Every Child Matters'* 2003). In doing so, the JAR also examined a range of other agencies. In particular, judgments were made on how services work together to improve outcomes for children and young people.[314]

3.373 The JAR was published on 9 September 2008. Some of the detail of the main findings of the 2008 JAR were as follows:[315]

3.373.1 A major strength was found to be the multi-agency preventive and family support services delivered through local Clusters using TAC and CAF processes;

3.373.2 An important weakness and area for development was found to be the capacity pressures within Children's Social Care teams. I note this was a problem which had existed since the Council's inception and which was to continue;

3.373.3 The contribution of services to improving outcomes for children and young people in the 'Staying Safe' outcome – shortly, Safeguarding - were found to be "*adequate*".[316] The Council's analysis of its strengths and areas for development in this area omitted a number of important weaknesses which had been identified in relation to safeguarding the most vulnerable children. The JAR commented that although appropriate action protects children at risk from harm,

310 [redacted]
311 [redacted] pg 5
312 [redacted] pgs 34-35
313 [redacted] pg 6
314 [redacted] pg 5
315 [redacted] pgs 5-6
316 [redacted] pgs 11-12

the quality of practice in social care services is variable, which means that not all children received timely and purposeful support and that as a result were not being safeguarded sufficiently well;

3.373.4 Although the contribution of local services to improving outcomes for looked after children and young people was rated as "*good",* it was noted that care plans varied in quality;

3.373.5 The quality of the partners' strategy for addressing teenage conception rates and providing support for young parents was rated as "*adequate*". Young people were said to be well supported, however it was stated that the work of partners has not had sufficient impact on reducing the high teenage pregnancy rate; and

3.373.6 Service management was said to be "*good*" with good capacity to improve further. Quality assurance and performance management arrangements in particular were found not to be strong.

3.373.7 The following recommendations were made for immediate action;[317]

3.373.7.1 For the partnership to ensure that an appropriate way is found for the successful dissemination of the findings of the report to children and young people in the area and also reduce the high levels of absence from school by looked after children; and

3.373.7.2 For the local authority to ensure that all cases are allocated promptly, care plans are of a high standard and the actions in them are progressed in a timely way. Also to establish a systematic and comprehensive approach to case file monitoring to ensure continuous improvement in social work practice.

3.373.8 The following recommendations were identified as needing to be actioned within the next six months:

3.373.8.1 For the local partnership to establish consistent quality assurance and performance management arrangements, to provide an objective knowledge of all service areas and to better identify areas for improvement across the partnership;

3.373.8.2 Also to review capacity in Children's Social Care to ensure that the needs of children are being met effectively and further reduce the rate of teenage conception by ensuring resources are targeted effectively in the areas of greatest need and on vulnerable groups; and

3.373.8.3 Finally to increase the use of performance data to evaluate the impact of the inclusion strategy and drive improvement.

[317] [redacted] pgs 7-8

3.374 In addition to the above, some comments were made in relation to the various areas of the report. Weaknesses in relation to local services for children at risk, or requiring safeguarding were identified as being:[318]

3.374.1 Deficiencies in the arrangements for case allocation and capacity problems for the case management teams. Also no systematic processes to collate information about the quality of practice and drive improvements in this respect.[319] One witness told the Inquiry that the service had been through a very difficult period because of the lack of director after the DCS left and the replacement not being appointed for some time (as has been explained above);

3.374.2 Also, although the section relating to looked after children was regarded as "*good*", the report highlighted that the quality of care plans was variable and that there were inadequate performance management systems;[320] and

3.374.3 Again, service management was rated as good, although it was noted that there was a lack of high quality information to inform performance management in some service areas. Also that there were capacity pressures in Children's Social Care teams.[321]

3.374.4 The comment was also made that:

"[the] *lack of a substantive Director of Children's Services for a substantial period of time, together with the recent loss of two experienced Heads of Service, has given other officers good opportunities for professional development. However, the overall impact has been to stretch leadership and management capacity in the portfolio close to the limit of its reserves."*[322]

3.375 In terms of Youth Services, the overall grading was "*good*", with strengths listed as being that most youth work is good or better and is delivered by workers who are well qualified, motivated, experienced and respected by children. Also that youth work provision is flexible and responsive and that the integration of Youth Development and Connexions4Youth services is progressing well.[323] I note that there was no reference to the role the Youth Development Service was playing in the Council's response to CSE. This is an indication of the importance afforded to the issue nationally at this time.

3.376 However, recommended areas for development included improving the overall quality and availability of accommodation and ICT, establishing a management information system which meets the needs of an integrated service and improving the quality assurance of professional practice.[324]

318 [redacted] pg 9
319 [redacted] pg 9
320 [redacted] pg 5, pg 13
321 [redacted] pg 23
322 [redacted] pg 25
323 [redacted] pg 30
324 [redacted] pg 30

3.377 Overall, the gradings were as follows:[325]

3.377.1 Safeguarding – "*adequate*";

3.377.2 Looked after children – "*good";*

3.377.3 Learning difficulties and/or disabilities – "*good*";

3.377.4 Service management – "*good"; and*

3.377.5 Capacity to improve – "*good*".

3.378 The Inquiry heard that the finding of Safeguarding being "*adequate*" had quite a significant impact on the service. The Head of Service was said to be very disappointed.[326]

3.379 I understand from evidence gathered by the Inquiry that the recommendations from the JAR 2008 report were incorporated into the Children and Young People's Plan,[327] published by the CTB. In the Children and Young People's Plan, the action plan for the 'Staying Safe' subgroup had ten priorities; one of these was to support those subject to CSE and reduce the number of young people at risk of CSE. Specifically, CSE became an LSCB priority.[328] The notes of this priority suggest that the pilot project was underway but that systems to log referrals and monitor outcomes were not yet in place. Objectives from the JAR were also incorporated into LSCB annual planning.

Structures within the Council with responsibility for CSE

3.380 During this period there was a plethora of groups which all appeared to have some responsibility for CSE. Piecing together the roles and governance structure of these various groups and committees has been an immensely difficult job. The absence of full suites of minutes, the persistent renaming and restructuring of the various groups, and the conflict between the information provided in the Council's Corporate Submission and the documents disclosed to the Inquiry have all contributed to this challenge.

3.381 In an effort to illustrate the various structures that were in place, this section of the chapter is intended to provide an overview of the groups in place and an analysis of the roles they played in the Council's response to CSE.

3.382 In summary, and based on the information the Inquiry has seen, the groups in existence during this period which have been of relevance to my Terms of Reference were:

3.382.1 LSCB;

3.382.2 LSCB Steering group, later known as the LSCB Executive;

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325 [redacted] pg 7
326 [redacted]
327 [redacted]
328 [redacted] pg 23

3.382.3 CTB which evolved from the CYPSP;

3.382.4 Sexual Exploitation group which was renamed the CATE subgroup;

3.382.5 Senior Officers' Coordination group;

3.382.6 CSE Pathway subgroup[329], a strategic group with objectives to collect data, develop learning in multi-agency response and to see that "*strategically through the LSCB and Community Safety Partnership preventative services are developed that have holistic approach to tackle CSE in Telford and Wrekin*"[330];

3.382.7 CATE Care Pathway[331] group (".. *to assist in the ongoing smooth running of the CATE Care Pathway*"[332]); before, the "*CATE Pathway*",[333] and later, the "*CATE Pathways*" group"[334];

3.382.8 The Gold, also known as CATE Gold[335], subgroup, set up to complement Chalice (which I deal with later in my report);

3.382.9 Missing Children (which I deal with later in my report);

3.382.10 Missing Persons (which I deal with later in my report); and

3.382.11 The Change for Children Partnership Board, an operational group of the Mini Local Safeguarding Partnership Board.

3.383 I should note at this point that, in its Maxwellisation response, the Council advised that a benchmarking exercise was undertaken in 2013, which looked at a sample group of ten other safeguarding children's boards and showed that, of these, the number of subgroups ranged from ten to three with the average being 5.6. It noted that having five subgroups was therefore below the average. Further, that this review led to the dissolution of the Executive, although it was not known at this point that this would later be replaced by the Quality, Performance and Operations subgroup ("QPO"). Further, it is the Council's position that the terms of reference for each subgroup also demonstrate a clear framework for each, without any overlap. All statutory objectives and functions were apparently allocated singly and uniquely to individual groups and that lack of overlap was purportedly built into the structure. The Council is of the view that these terms of reference provided clarity of purpose and that the structure enabled groups to be adaptive and responsive to changing circumstances; new terms of reference were developed and formally approved where circumstances dictated this was necessary. As I will show, I do not agree that the above approach was a productive or efficient one or that it avoided overlap and duplication of effort.

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Telford & Wrekin's LSCB

3.384 On 14 September 2004,[336] the ACPC prepared for the creation of the LSCB which it defined as the subgroup for the 'Staying Safe' outcome of Every Child Matters. The LSCB is also noted as being the 'Staying Safe' arm of the Local Safeguarding Partnership, also called the Strategic Partnership Board.[337]

3.385 The functions of the LSCB were similar to those of the ACPCs. However the statutory requirement of partner agencies to cooperate in the establishment and operation of the LSCBs was new.[338]

3.386 The Inquiry heard evidence that representation on the LSCB itself was a problem. There were:

"… *some challenges in relation to ensuring that senior staff attended the actual LSCB meetings themselves, as they would often delegate this task, sending more junior representatives in their place.*"[339]

3.387 The LSCB issued a commentary on the draft guidance Working Together 2005 in October 2005.[340] It "*strongly agreed*" with the proposition that:

"… *government should attempt to set out clearer policy for professionals – especially in field of protecting sexually active children from harm and abuse*" and further noted, "*if we are going to look at Safeguarding agenda holistically this needs to be recognised in key roles and appropriate funding to create posts to support this*". Money was a problem: "*We already struggle to provide child protection training to all who require it: to broaden this to the wider safeguarding agenda will require a significant investment.*"

3.388 The Local Safeguarding Children Board's Regulations 2006 require LSCBs to appoint a chair.[341] During the period 2004 to 2012 there were three chairs of the LSCB. In the earliest days this position was filled by a Council officer, it being noted at a meeting of the Steering group "*this can not be an independent chair as there would be budget implications*".[342]

3.389 The first independent chair was appointed from (and funded by) the charitable sector in early January 2006.[343] His tenure lasted three years. I heard of the LSCB how:

"*Initially* [it] *started off as maybe a group of 10 or 12 people sitting around a table then, as more and more people were co-opted onto them, they became almost like mini conferences. You would have 20 or 30 members and it became increasingly difficult to manage to ensure that people were involved and engaged.*"[344]

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337 pg 12, pg 11
338 Explanatory note to the Local Safeguarding Children Boards Regulations 2006.
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341 https://www.legislation.gov.uk/uksi/2006/90/regulation/4/made
342 pg 3
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344 pg 20

3.390 The LSCB itself was described as "*top heavy*" with as many as 30 people per meeting, compared to one witness's view of an optimal 15.[345]

3.391 The Inquiry heard a perception that the LSCB was still in a "*start-up phase*" and that funding was difficult:

"*People's awareness of these new duties and responsibilities was initially about trying to ensure there were resources to do the job. I remember endless wrangles about how we would fund the activities of the Board, who should contribute, which agencies wanted to be part of it; some wanted a seat at the table but they didn't want to support the work by paying for it, so those discussions went on just too long. They took up too much board time really, and the political machinations*."[346]

3.392 This was to prove a constant theme throughout the lifetime of the LSCB.

3.393 The Inquiry heard further that the first independent chair was to some extent at the mercy of the Council itself, in terms of information available. Witnesses told the Inquiry that he had to rely on others to obtain it and further that he lacked experience to seek out the information of his own accord.[347]

3.394 There would be a Sexual Exploitation subgroup of the LSCB. The Sexual Exploitation subgroup had not yet met but requested a change in name because of difficulties with email filtering. The protocol document was under consideration by a task group.

3.395 An independent member of the LSCB told the Inquiry that their attendance at Sexual Exploitation subgroup meetings and their efforts to speak directly to the Sexual Exploitation Project/team were resisted by some at the Council. They perceived a reluctance on the part of senior personnel, at Assistant Director/Director level, to allow them to get too close to the detail.[348] The same person could not recollect the funding of CSE response ever being a significant issue at the LSCB – which is remarkable given the changes that occurred during their tenure in the last years of the 2000s and beginning of the 2010s and the key role LSCBs were expected to play according to the supplementary guidance to Working Together 2006.

3.396 That CSE was under the radar of the LSCB is confirmed by the evidence the Inquiry heard from an earlier independent member of the LSCB in its first iteration, who admitted to very little awareness of how the CSE response began, although it was during their time on the LSCB.

3.397 The Inquiry heard from another witness familiar with the LSCB itself who said that the power lay not in the Chair but in the LSCB manager, a Council official.[349]

345 pg 11
346 pg 21
347 pg 9
348 pg 15
349 pg 42

3.398 A longstanding member of the ACPC and LSCB[350] said of the LSCB:

"… *it was big and unwieldy and actually quite often you'd go…to the next meeting you'd sit around a table and think I've not seen half these people sitting round this table before, and so actually there was a lot of repetition… we were going round in circles all the time. We're ticking a box but we're not actually doing any work.*"[351]

LSCB Steering Group

3.399 According to the Council's Corporate Submission, the LSCB Steering group, later known as the LSCB Executive Committee, was set up in 2004 and was accountable to both the LSCB and CTB. The Inquiry has been told by the Council that the Executive was formed "*to drive the business of the growing LSCB*".[352]

3.400 On 14 December 2004, the LSCB Steering group met for the first time.[353] Its declared aims were to include "*Keep*[ing] *Child Protection issues along with the Staying Safe issues*". Staffing was raised, particularly the post of the seconded training officer (transferred from the ACPC) whose secondment was due to end in April 2006. This was a concern, as training needs had increased and were likely to continue to do so. There had been no strategy for funding the ACPC. It was noted that this had been a major issue in the past: it was suggested that the LSCB be funded by "*rerouting from different budgets*".

3.401 An update on a Staying Safe action plan[354] notes in respect of the aim that children are "*safe from maltreatment, neglect, violence and sexual exploitation*" that there is "*ongoing tracking of PIs* [(performance indicators)] – *PIs agreed for all sub aims... Meeting re CP* [(child protection)] *and clusters took place on 30 September*", though it is not apparent what the performance indicators were in respect of sexual exploitation, nor what was the subject or result of the meeting between the Clusters and child protection.

3.402 The Steering group met again on 9 February 2005.[355] Lack of funds was again noted as a risk. As to sexual exploitation, the volume of work was described as "*incredible*". In order to deal with it there was "*a need to collapse as many meetings as possible*"; the LSCB's role was primarily about policies and procedures, and duplication should be kept to a minimum. Despite this plainly sensible plea to reduce bureaucracy, it was decided in the meeting that early priorities should be:

3.402.1 To re-invent the policies and procedures, and this may mean re-establishing the policies and procedures group;

3.402.2 For the first six months to update and make accessible the policy and procedures across the LSCB; and

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351 pg 37
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3.402.3 To set up a practitioners forum.

3.403 On 8 March 2005 the Steering group noted[356] that the number of unallocated cases in child protection was significantly reduced because of new appointments and returns from illness. It was agreed that a priority outcome for the LSCB would be "*to reduce the number of children suffering from maltreatment, neglect, violence and sexual exploitation"* and on 26 April the group[357] agreed that training should "*stick to*" the remit of child protection within the safe from maltreatment, neglect, violence and sexual exploitation aim.

3.404 It was also noted that reviewing officers would "*welcome discussion regarding the appropriateness of registration* *__when it is the child's own behaviour that places them at risk__*" (my emphasis) in the context of there being "*growing issues on the older girls*".

3.405 On 5 October 2005 the Steering group[358] considered the structures and function of the LSCB itself. Already it was noted that the difficulties with the LSCB were "*partly due to* [its] *size and inconsistency of representatives attending*". The link between an over-large group and the failure of senior people to attend does not seem to have been recognised.

3.406 The Steering group resolved that the LSCB needed to be separate from the Children and Young Persons Strategy board with different membership. It noted that the LSCB currently received information only from the Steering group. There needed to be a "*job description*" or Terms of Reference for the LSCB, and an independent chair. The appointment of an independent chair would cause "*budget implications*" and as a result the LSCB had negotiated the appointment of a chair from the NSPCC without cost.

3.407 According to the Council's Corporate Submission, the Steering group was later known as the Executive Committee. It was accountable to both the LSCB and the CTB, which had itself evolved from the CYPP. The Inquiry understands that the Steering group made the decision to rename itself on 5 October 2005.[359] Its first act was to propose the ACPC's training post be continued and to offer the incumbent a two year fixed term.

3.408 At a meeting of the LSCB on 26 January 2006[360] the structure discussed in the Executive was confirmed: the LSCB and the CYPSP (it was still referred to as the "*Partnership"* though under the minuted heading "*Establishing the Board*") would remain separate. The LSCB Executive would report to both and the LSCB would now be independently chaired. In what appears to have been a process query, it was asked to which body complaint should be made if an agency was not addressing child protection issues, and the answer was not the LSCB or the CYPSP but the Corporate Director of Children and Young People. This seems a curious answer if the LSCB was, as intended, independent.

3.409 Notably, at this stage, there was no representative of Sexual Health Services on the LSCB. The Inquiry heard:

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358 [redacted]
359 [redacted]
360 [redacted]

"… *health was the area that... was the most difficult agency in terms of how information would get shared and the protocols that surround that*."[361]

3.410 The LSCB Executive did not discuss exploitation at its next four meetings (the ones after 9 February 2006) but at the fourth it did consider structure, concluding that there was a "*problem fitting all agencies in with only meeting quarterly but thought that whole board should play scrutiny role and not have subgroups to do it*"[362] (my emphasis). Having considered the entire lifespan of the LSCB, I consider it would have been a significantly more effective body had this plea made by the LSCB Executive been heeded.

3.411 An LSCB Executive meeting on 14 September 2006,[363] shows funding to be a difficulty. It was noted that the LSCB could not function without two administrators and a full time trainer but that Social Care were unhappy about having to fund a multi-agency trainer. Probation and Connexions were only able to commit to the current position for a further 12 months. Joint training with Shropshire had been tried but was "*not practical*".[364] This shows, in my view, and notwithstanding the funding of the training post, a lack of complete commitment to the LSCB Project.

3.412 A briefing note was prepared for the LSCB called '*Resourcing the Board'*,[365] recommending that the LSCB present to the CYPSP a request:

3.412.1 That existing funding partners undertake to continue funding existing posts in the short term;

3.412.2 That all members undertake to draw the need for funding to their respective organisations; and

3.412.3 That the local authority members and LSCB partners seek funding for a part time training post, a part time clerk and an administrator from April 2007.

3.413 At an LSCB Executive meeting on 8 January 2009[366] the group considered its own proper function in the light of the Haringey JAR. It was noted that the original intention had been for the Executive to be an operational arm of the LSCB, made up of funding partners and the leads of subgroups. The LSCB itself had grown; the Executive was to consider alternative structures for the LSCB.

3.414 Interestingly, the group questioned whether the LSCB was challenging enough and if the right people were attending – whether attendees had the right level of authority in order to make the decisions needed. There was a perception that when a member is unable to attend they are represented by a junior colleague. It was decided that the LSCB chair would be invited to attend the next Executive meeting. It is difficult not to see the Executive as the senior partner in this arrangement.

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361 [redacted] pg 15
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364 [redacted] pg 6
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3.415 On 30 July 2009, at an LSCB Executive meeting,[367] structures were once again considered. The newly appointed independent chair of the LSCB and a qualified social worker, asked – not unreasonably – why the holder of his role did not merit a seat on the Executive. It was suggested that this first, compromised independence and second, would not be able to be accommodated within the Chair's allowance of days. Neither of those seem to me to have been sensible arguments and indeed the Chair prevailed, though he would not be allowed to chair the Executive.

3.416 In an indication of the ability of the Executive group to shift structures, independent of the LSCB, it was agreed at this meeting that all subgroups would now report to the Executive rather than the LSCB. This illustrates the important role that the Executive assumed.

3.417 The LSCB Executive adopted the following Terms of Reference in January 2010:[368]

3.417.1 To carry out day to day business on behalf of the LSCB including undertaking specific pieces of work as agreed;

3.417.2 To make recommendations to the LSCB on matters of business such as budget setting and resource allocation;

3.417.3 To make recommendations to the LSCB on matters of policy and procedure;

3.417.4 To monitor performance on behalf of the LSCB; and

3.417.5 To oversee the implementation of the business plan of the LSCB.

3.418 The Terms of Reference also specified that the head of the Executive would be the head of Safeguarding and Corporate Parenting. The Executive was accountable to the LSCB and would contribute to the board's annual report. While the statement of accountability was plainly to give the impression that the Executive was now subordinate to the LSCB, the detail of the Terms of Reference shows that the reality was quite different.

3.419 At the LSCB Executive on 25 February 2010, the LSCB chair expressed the view that the subgroup memberships were very large and this can often have a "*negative effect on the amount of work that can be done*".[369]

3.420 Attendance at both the LSCB and the LSCB Executive was noted to be poor. To be fair, a witness who went on to hold senior positions in other local authorities, said of poor attendance:

"*I'm not surprised to hear that, and I'm sure it was because I recognise that in any LSCB I've ever sat in.*"[370]

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3.421 The next LSCB Executive meeting, on 3 March 2011, noted that while attendance was poor with too many deputies taking the places of named members, the Chief Executive should not attend at all save by invitation.[371]

3.422 The Inquiry heard evidence that the overall impression of non-Council members was that the LSCB Executive was run by the Council and although other agencies were present, the Council seemed to be making the decisions.[372] The Inquiry heard the Council's view was that LSCB saw the Council as having "*lead responsibility*".[373]

Children's Trust Board ("CTB")

3.423 The Children Act 2004 placed a duty on local authorities in England to make arrangements to promote cooperation to improve wellbeing for children. The "*Children's Trust*" was a term first coined in 2003 to describe the sum total of cooperation arrangements and partnerships between organisations with a role in improving outcomes for children.[374] The *statutory* requirement to create a CTB did not arise until the Apprenticeship, Skills, Children and Learning Act 2009.

3.424 Notwithstanding that there was no statutory duty so to do, the Council, like many local authorities, created a CTB in 2004, comprising representatives from the Council, WMP and local health authority, in a rebrand of the CYPSP.

3.425 The Council says that:

"*the Children's Trust Board focussed on driving a series of outcomes for children and young people that were identified in the Every Child Matters outcomes, including of course 'Staying Safe'.*"[375]

3.426 While guidance had required a Children and Young People's Plan from April 2006,[376] this became a statutory requirement from April 2010 and was the responsibility of the CTB.[377] I have seen plans for 2005-2010 and for 2008-2010. The former[378] noted that:

"*… child protection reviews within timescale have improved from 84.2%-97.2% 2002-2005…*

Multi-agency protocol developed in response to Bichard Enquiry which informs staff on procedures to follow in respect of concerns regarding under age sexual activity. Sexual exploitation protocol also developed…

Protocol re: sexual exploitation and under 18s sexual activity incorporated into working practices across the Borough."

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371 [redacted]
372 [redacted] pg 12, pg 13; [redacted] pg 42
373 [redacted]
374 https://lx.iriss.org.uk/sites/default/files/resources/Children's%20Trusts.pdf
375 [redacted] pg 48
376 [redacted] pg 4
377 Apprenticeships, Skills, Children and Learning Act 2009 section 194
378 [redacted]

3.427 The later document asserts:[379]

"*Designated Connexions4Youth staff are working with young people aged 13-19 who are experiencing, or are at risk of, sexual exploitation. These staff also provide advice and training for other professionals as part of the SCB training programme.*"

3.428 Minutes of the LSCB Executive in June 2009 suggest[380] that:

"*… the Children's Trust Board is currently reviewing value for money and wants safeguarding to be included in this. The intention is to map resources against the current level of need.*"

3.429 This is notable in that it indicates concern about the costs of Safeguarding at the existing level - which did not include a CSE response.

3.430 The CTB met on 30 September 2009. The attendees included a corporate director, a number of Council heads of service and the chair of the LSCB. It did not discuss CSE or CATE.[381]

3.431 On 19 November 2009 the CTB heard a presentation on Children Abused Through Exploitation[382] and that a meeting was taking place imminently to identify how the Care Pathway group and CATE would be resourced. The meeting on 28 January 2010 did not discuss either.[383]

3.432 In 2010 the CTB published its priority plan which included reference to reduction of exploitation through CATE but noted that full implementation of the CATE Project could not be delivered within existing resources.[384]

3.433 From 31 October 2010 the Department for Education withdrew statutory guidance on Children's Trusts and the requirement to produce a Children and Young People's Plan.[385]

3.434 In June 2011, a meeting of the LSCB noted that the CTB was "*being reformed*".[386] Minutes a month later indicate that the CTB was being re-established with the first meeting imminent.[387] On 11 November 2011 the CTB agreed to be renamed the Children and Families Board.[388]

Sexual Exploitation subgroup (later to become the CATE subgroup)

3.435 The first minutes I have seen for the Sexual Exploitation subgroup are dated 9 May 2003.[389] I have also seen minutes for a Sexual Exploitation meeting on 18 October 2005.[390] The

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385 https://www.nfer.ac.uk/publications/LGCH01/LGCH01.pdf
386 pg 2
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2005 meeting appears to have been much more strategic in character than the previous meeting some two and a half years earlier, which was essentially a case discussion, dealing with sexual health training being given in schools and also noting:

"*This group is part of the Local Safeguarding Children's Board Staying safe group but its function is still unclear. The Group needs to be both strategic and able to undertake planning and to move on local initiatives.*"

3.436 It is discouraging for any group to begin not knowing its purpose.

3.437 At the Sexual Exploitation meeting on 21 November 2005,[391] it was reported that the assigned worker only had four hours per week to devote to this work. The minutes record:

"*The meeting agreed that there were issues for staff members about the future of the Group and this could be furthered though an executive summary of the existing Protocol.*"

3.438 According to the Council's Corporate Submission, the Sexual Exploitation subgroup was renamed the CATE subgroup in 2006 (hereinafter on occasion referred to as the CATE Team or the CATE group), as a result of information gained from the initial project and reflecting the growing concern about the extent of the CSE issue locally, with a slightly wider membership. The purpose of the CATE subgroup was to be a planning and support group for agencies providing services to children who are, or may be, at risk of CSE. The objectives of the group were as follows:[392]

3.438.1 To identify, develop and share relevant information and national guidance;

3.438.2 To provide and disseminate advice and information to the LSCB;

3.438.3 To deliver multi-agency training;

3.438.4 To encourage effective delivery of interventions;

3.438.5 To encourage agencies to provide culturally appropriate services;

3.438.6 To translate central government policy and procedures into the local context and advise the LSCB on practice and implementation issues;

3.438.7 To develop exit strategies for children 'involved in prostitution', in line with the protocol adopted by the LSCB;

3.438.8 To receive feedback from the NWG; and

3.438.9 To monitor the protocol adopted by the LSCB and build on good practice by other agencies and authorities.

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3.439 On 26 January 2006 there was the first meeting of the CATE group.[393] It included representation from Children's Services, the YMCA, Connexions, the NSPCC, the LSCB, the Youth Service, and the PCT. The group would report to the LSCB (and also later to the Safe & Stronger Communities Board) and members of the group needed to be "*in a sufficient position to influence their organisation*". A witness recalled:

"*At that point I was very much trying to make it a partnership approach, so it was very much looking at the other parts of the authority or the stakeholders who had a role to play and being clear about the role each would take within the confines of their organisation... it was probably trying to make it broader than the Youth Service team and pushing it more to being a standalone team than part of the Youth Service.*"[394]

3.440 On 9 June 2006, a CATE publicity meeting was held.[395] The attendees included those who attended the usual CATE meetings. This dealt with production of artwork for a publicity card[396] (which was produced, although it is not clear when and no copy was available to the Inquiry, presumably given the passage of time). This is the only set of CATE publicity meeting minutes that the Inquiry has seen, but it is clear from this meeting that the Council was aware of the risk of CSE and the need to raise awareness.

3.441 The next CATE meeting was held on 4 July 2006[397] and considered prevention work in schools, suggesting that there needed to be funding for a "*more substantial post*". A meeting on 3 October 2006[398] heard a report from a delegate on a five-day sexual exploitation course they had attended in London including recommendations:

"*… there are no figures of how many children are abused through prostitution within the Borough... With this in mind it is very difficult to understand the extent of the problem... The lead officer for social services now holds responsibility for recording and monitoring trends…*

Telford may benefit from targeting the most vulnerable children at risk of sexual exploitation as resources are limited…

In reviewing the aims of the project in Telford [these factors] *needs to be considered: where to place the project, how it's managed, time that is put into outreach work and how beneficial advocacy work would be in enabling young people to engage with other services.*"[399]

3.442 The meeting considered a job description created by Walsall for a sexual exploitation prevention worker, an indication that the problem was being recognised across the country.

3.443 The CATE group was involved in a review of the exploitation protocol in May 2007.[400] Minutes of the meeting record that the LSCB had considered the proposal for a local support

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393 [redacted] pg 2
394 [redacted] pg 41
395 [redacted]
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worker but had felt the scope of the proposed post would be too large for a single worker; it had delegated responsibility for looking at how this might be addressed to Connexions4Youth. A senior social worker reported their view that there was a general lack of awareness of the issue of CSE or the extent of the problem. The meeting also heard reports from a youth worker who was engaging with a child subject to CSE – a youth worker who was later to become part of the CATE Team. Plainly, support work was already being done without formal structures in place.

3.444 On 2 October 2007 the CATE group heard that two Connexions4Youth workers had been allocated time to address sexual exploitation issues. This was the beginning of a formal intervention response by the Council.[401]

3.445 The meeting further noted concerns with regard to CSE in Wellington. This appears to be the first CATE group meeting at which there was a WMP officer attending.

3.446 In November 2007[402] the CATE group heard that WMP had identified an officer to collate local intelligence information. The WMP representative told the meeting that they had more power when a person was reported missing and stressed the importance of making missing person (sometimes referred to as "misper") reports.

3.447 One of those first CATE practitioners, who had background and experience in CSE in another part of the country, remembers being asked to do work with a particular child.[403] A youth worker told the Inquiry:

"*The work didn't always fit into safeguarding procedures, it was very youth work orientated – more about building trusted relationships.*"[404]

3.448 It is difficult to establish how effective the aims and objectives were as there was no plan for how objectives were to be reviewed or a system to consider progress. There was a list of what the group hoped to achieve, but without a complete sense of whether this was achieved. The meeting minutes do not track these activities and indeed often do not mention them again. This may be in part due to missing records but was also hampered by the lack of a consistent review of actions and progress in an organised way.

3.449 There remained a lack of focus on establishing or evaluating what the CSE work hoped to achieve or whether these were the right outcomes and, most importantly, what difference they made.

3.450 By way of example, there is no recorded discussion of the Sexual Offences Act 2003 (implemented in 2004) being discussed within the context of the CATE group; yet it represented a major overhaul and review of the Sexual Offences Act 1956. It made clear the range of sexual offences by an adult (anyone aged 18) against a child (aged 16). Similarly, there is no evidence of discussion of the Bichard Inquiry report in 2014, which focused on underage sexual activity by adult men with children.

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401 [redacted]
402 [redacted]
403 [redacted] pg 13
404 [redacted] pg 10

3.451 The group was not held to account for delivering on what it wanted to achieve. This may have been due to a lack of resources, and this becomes a theme over the next few years. A more organised approach to delivery of goals might have really surfaced the mismatch between ambition, commitments and the reality of what could be delivered with the resources available.

Senior Officers' Coordination group

3.452 According to the Council's Corporate Submission, the Senior Officers' Coordination group was established in 2007 and began its involvement in CSE matters. As part of this initiative, the CSE Pathway subgroup was also established, accountable to the Senior Officers' Coordination group. Meetings about sexual exploitation began to be convened by the Senior Officers' Coordination group, with the CATE subgroup also now reporting in to it, as well as to the LSCB, although with more direct access to the LSCB when CSE was formally adopted as a development priority of the LSCB in 2009.

3.453 The first Senior Officers' Coordination group meeting took place in October 2007.[405] I understand that the group was established in response to the growing evidence of organised, coordinated sexual exploitation of children in the borough. It included representatives from the Council, WMP and health organisations, and the meetings were convened as and when they were required on the issue of sexual exploitation. The CATE subgroup would request additional funding from this group as a first and main point of contact.

3.454 At the first meeting on 3 October 2007,[406] the situation in Wellington was outlined by the representative from WMP, who said that there was a group of between 10—11 children and men involved; but stressed "*information from the girls is a necessity to take matters further*" and that the only way to proceed may be by using covert methods "*which would need authority from much higher in the organisation*". WMP's view that this had been "*going on for years*" was supported by a comment from the Safeguarding Advisory Service that it was "*generational*". It was suggested that previous victims/survivors could be approached for information; WMP responded that the men were now a different group. First, on the evidence I have seen, this was not the case; second, it assumes no commonality of methods between different groups. WMP asserted that there was not a link with taxis, although one of the children involved had spoken of a link with a taxi driver. I deal further with the links between CSE and taxi drivers elsewhere in this Report.

3.455 There was discussion about how to help keep the children safe and it was suggested that there should be liaison with other local authorities "*further advanced than Telford and Wrekin*"; Walsall and Bradford were named.

3.456 As to what had been done, it was said that a package of support had been offered to schools over the preceding 12 months – some took up the offer, others did not. It was suggested that a named teacher in a local school be spoken to as they had a "*wealth of knowledge*". I deal with the evidence relevant to schools in the 'Education' section later in this chapter.

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3.457 A suggestion that the Clusters share information with WMP was met by WMP with a lukewarm response amid caution expressed over confidentiality.

3.458 The meeting decided that community school nurses should be made aware of the problem of CSE and that a WMP analyst should create a matrix of information shared between WMP and Children's Services to examine links between perpetrators and victims/survivors.

3.459 The Senior Officers' Coordination group met again on 14 November 2007.[407] The meeting minutes detail a mix of case-specific operational concerns as well as discussions around a strategic approach. The combination of operational and strategic discussions at this meeting is of concern, as it is not clear if the necessary operational decisions for each of the individuals took place.

3.460 The group heard reports on two sexual exploitation cases which had been the subject of a WMP investigation, but which were to fail to achieve convictions. The analysis previously contemplated, in terms of development of a matrix of information held by Safeguarding was ongoing. There was debate about the model to be developed and whether the needs of individual children who were being sexually exploited should be addressed through existing safeguarding processes; it was noted that the Sheffield project considered that this should only be the case in specific circumstances.

3.461 School nurses had been spoken to and were "*up to date with information*". No visits had taken place to projects in other towns because it had not been possible to agree mutually convenient dates. There were difficulties meeting school heads and a feeling that heads would not attend meetings if they felt the subject did not relate to their own school. A witness told the Inquiry: "*we did have engagement with head teachers but it was variable".*[408]

3.462 There is no evidence of the 2007 Trafficking Guidance, issued to supplement Working Together 2006, being discussed as part of CSE/CATE work.

3.463 There is no indication in the documents disclosed to the Inquiry of when the Senior Officers' Coordination group ceased to exist or have involvement in CSE matters.

CSE/CATE Pathway Groups

3.464 It is at this stage that groups and names begin to overlap significantly. While I have attempted to bring clarity to a confused picture, it has been very difficult, if not impossible. I accept that this may be because structures were put in place as response to a newly perceived need; and in such circumstances the structures may adapt and change in a way that is more organic than logical, as knowledge of the need grows. Further, I have taken some comfort from the fact that the Council's Corporate Submission qualified its responses to the Inquiry's direct questions on the point with "*to the best of our knowledge*"[409]; which tends to suggest that a definitive explanation may simply not be possible at this distance. What I have done, therefore, is simply to set out the information about these groups as it

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408 pg 17
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appears from the evidence, which does not reflect logical coherence but does accurately summarise the framework within which the work had to be done at the time.

3.465 The Council's Corporate Submission indicated that, in 2007, the CATE Pathway group was established.[410] Other material tends to suggest that this group may have been known as the CSE Pathway group[411]; a strategic group chaired by the Head of Service for Safeguarding and reporting to the Strategic Management group. The CSE Pathway group's purpose was said to be to "*develop and oversee the implementation of an agreed model of protection and support for young people identified as being at risk of CSE*". Confusingly, and as noted in paragraph 3.382.6 above, the same name was later used for a different, strategic, group.

3.466 The CSE Pathway group transitioned to become the 'CATE Care Pathway' group in 2009, merging with the CATE subgroup of the LSCB (although the operational side of the CATE subgroup continued as a separate team). I have seen documents which show that the CATE Care Pathway subgroup was still known as the CSE Pathway on occasion – an example of the confusion I have referenced above – as well as the CATE Pathway (the use of the word 'Care' seemingly dropped on occasion). For the avoidance of doubt, henceforth I will regard 'CATE Care Pathway' and 'CATE Pathway' (as taken from the evidence) as one and the same.

3.467 On 13 November 2009 there was a meeting of the CATE Pathway subgroup.[412] The meeting considered draft terms of reference. The CATE Care Pathway subgroup still reported to the CATE Strategic Management group with the risk assessment panel reporting to it, and it was noted that "*accountability to the LSCB and Safer & Stronger Communities Board needs to be established*".[413]

3.468 The stated aim of the CATE Pathway group was to develop and oversee the implementation of an agreed model of protection and support for children identified through the CATE Project.[414] Documents show the continuation of something called the CATE subgroup from 2009 until at least 2011,[415] with terms of reference as follows:

"Purpose: To ensure improvement in identification, investigation and support for those subject to sexual exploitation and reduce the numbers of those at risk.

The group aims to do this through;

- *Refining the model of service delivery to promote the safety and wellbeing of our young people, in line with best practice, and ensuring efficient and effective use of local and other resources*

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411 pg 4
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- *Overseeing the continuing implementation and review of the care pathway and policy and procedures to meet local need*

- *Identifying how sustainable funding can be sourced to meet gaps in provision, particularly post exploitation support for parents and young people*

- *Ensuring appropriate communication and awareness raising activity for young people parents and the wider community is delivered as part of the LSCB communication strategy*

- *Developing and ensuring the implementation of a specific project plan for CATE as part of the LSCB Business planning process*

- *Ensuring effective links are made with related agendas, in particular trafficking, e-safety and missing children, violence against women and girls strategy."*

3.469 In the terms of reference of the CATE Care Pathways subgroup itself, updated in 2010 and 2011, it was noted that the group reported to the LSCB and the Safer & Stronger Communities Board, with no mention of the CATE Strategic Management group, as had been the case in 2009.

3.470 It is useful to note at this stage that the CATE subgroup also continued to meet. Therefore there were now what appeared to be three different groups with responsibility for CSE (the CATE subgroup – itself a subgroup of the LSCB Staying Safe subgroup; the CATE Pathway group and the Senior Officers' Coordination group), and there remained some lack of clarity about which were entirely operational, and which were completely strategic. There was a mix, as time went on, of discussing specific young people or young people generally, and discussion on strategic development across the three groups.

The Change for Children Partnership Board, an operational group of the Mini Local Strategic Partnership

3.471 In January 2007, the Council produced a working document for the South Telford Pilot of Local Area and Neighbourhood arrangements[416] designed to:

"… *work in partnership, to build a cohesive borough with neighbourhoods that are safe, healthy and vibrant, where residents are well informed, satisfied and enabled to both shape and access high quality services.*"

3.472 This unexceptionable goal was to be achieved, the document proposed, in ways which were to be:

"… *unbureaucratic and avoid*[ing] *establishment of complicated management/governance structures.*"

3.473 Notwithstanding that laudable ambition, the document continues to set out this was to be implemented by a new body, the Mini Local Strategic Partnership ("MLSP"), overseeing two

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operational groups: the Change for Children Partnership Board, which had responsibility for, amongst (many) other things, staying safe from exploitation, and the Liveability Agenda Operational Group. Each of those subgroups would be "*tasked to MLSP to deliver on top down and bottom up priorities*", sat above Neighbourhood Action teams and (where they existed) Parish Councils in the information hierarchy. The teams and Parish Councils were to receive information via a "*continual two-way communication process through consultation and feedback with local residents (including PACT* [Partners and Communities Together] *initiative)*"[417] and to feed not only to the operational groups but direct to the South Telford Intelligence Atlas which would promulgate direct to the MLSP.

3.474 Notwithstanding the effort that must have gone into creating this complicated structure, the Inquiry has seen no further mention of the MLSP throughout the papers.

Information Sharing

3.475 As previously noted, Working Together 2006 sought to emphasise the importance and process of inter-agency working to safeguarding children. However, there appeared to be confusion nationally about the use of Working Together 2006, with Laming's report highlighting continuing problems with inter-agency working and information sharing.

3.476 The Inquiry has heard evidence about poor information sharing practices, particularly between Social Care and the other agencies:

"[A]*round about that time, that 2004, that some of my staff were coming to me with concerns that they were working with young people who were going missing. They were talking about young people who were using drugs and alcohol and they were concerned about if they were inhibited as to what was happening to them while that was happening. At this time, I mean if we knew what we knew now I think things were very different, we had that concern and certainly systems are much, much better now in terms of how we respond to people going missing.*

So, that was when we were starting to wonder what was happening because I had one senior practitioner who had a worker who would ring her up and she'd say that a young person she was working with was on a roundabout outside the hospital at Telford could she come and pick her up and take her home and she'd be thinking what on earth, it's like half nine, ten o'clock at night and what's going on... So, sometimes they were already known to other services but I would say that the synergy just wasn't there… We were, I mean there was a famous phrase that was used in Telford & Wrekin in the mid-2000s that was 'everybody's working in silos'."[418]

3.477 This strict adherence to structure was reinforced by evidence: the Inquiry received evidence from an individual who held a senior position in the local education sector that it was a time of "*structuralist, rule-based, evidence-based*" working.[419]

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417 [redacted] pg 9
418 [redacted] pg 5
419 [redacted] pg 26

3.478 This apparent silo culture extended to the operation of the recently formed CATE Team:

"… *we knew there was a CATE team but it was a bit cloak and dagger, it was all very confidential and it wasn't really, we didn't know who they working with and it was quite a select kind of team if you like. Agencies outside of the CATE team weren't fully aware of their role. I don't remember there being any information shared regarding their purpose or referral routes.*"[420]

3.479 An Education Welfare Officer described their experience of sharing information with WMP:[421]

"… *there were individual officers that were great. There was some individual officers that really wanted to protect children, and wanted to be proactive and that weren't worried about whatever backlash, maybe some of the senior police officers were worried about. I think there were senior police officers that were worried that they would be seen as racist if they pursued particular individuals.*"

3.480 It is plain from the evidence I have seen that WMP was sharing exploitation information with the CATE group in 2006/2007 and requesting information on missing children.

Clusters

3.481 Locality teams were mandated by Every Child Matters, which defined them as "*groups of agencies and services that work together and support children and young people*". The Council created locality teams known as "*Clusters*".

3.482 There were five cluster areas in Telford. The Clusters housed multi-agency teams which involved family support workers, Youth Inclusion and Support Panel ("YISP") workers (early intervention youth offending), an EWO, a Senior Mental Health Practitioner from CAMHS (Children and Adolescent Mental Health Services) and teachers specialising in behaviour support. In addition, Police Community Support Officers ("PCSOs") and, eventually, a social worker were aligned to the teams.

3.483 An ISM describes the function of the Cluster as being designed to continue the IRT process, embedding the CAF and TAC processes.

3.484 Schools and services were brought together in this way; some services were attached to a Cluster, but social workers, while technically attached to Clusters, did not work within them[422] until May 2010.[423] This, in my view, hampered the sharing of information between the Clusters, where I have heard that intelligence about CSE was being picked up, and Social Care.

3.485 The Clusters inevitably arrived with a supposedly supportive layer of bureaucracy. Each Cluster had a Change for Children local board as before, which would determine the current

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[420] [redacted] pg 16
[421] [redacted] pg 18
[422] [redacted] pg 28
[423] [redacted] pg 31

needs of the Cluster. Despite requests, the Inquiry has seen no material indicating that these boards contributed anything with regard to CSE.[424]

3.486 After the appointment of a DCS in 2005, there was allocation of family support workers to the Clusters, but Clusters were not intended to deal with a child seriously at risk or in need of Safeguarding intervention;[425] however, it being recognised that Children's Social Care was an overburdened service,[426] "*effective earlier intervention*" was necessary "*so we could reduce the number of children being referred for acute services*".[427] Whilst Clusters may not have been *intended* to deal with a child seriously at risk, the evidence the Inquiry has seen shows that they were plainly doing so.[428]

3.487 Evidence to the Inquiry suggests that the Council's focus on early intervention work came at the expense of the budget for children in care; and that this was essentially a political decision, as councillors were the ultimate budget holders.[429]

3.488 The FAST team was officially subsumed within the cluster model in September 2006[430] (although the evidence of one witness dated this change as occurring almost one year earlier).[431] The ISMs had overall oversight of the work of each team, as a multi-disciplinary support service team. Witnesses stressed to the Inquiry that the Clusters were not part of Safeguarding.[432]

3.489 Indeed although the intention was always that Clusters dealt with lower risk cases, the Inquiry has seen views that Safeguarding was regarded as the secondary service[433] to early intervention and that there was some resentment about differing levels of pay in favour of the early intervention teams.[434] Although the cluster initiative was plainly important and had potential to be valuable, it is concerning that the focus appears to have been taken away from the essential safeguarding process.

3.490 Certainly the two methods of intervention remained distinctly separate. The Inquiry heard that Clusters would undertake a common assessment with a common language and where it was decided that there needed to be support, a team of professionals would be brought into existence around the child under a lead professional.[435] Where a referral was made for social work intervention, the social worker would become the key worker as part of social work systems and processes. The ambition to have the social worker part of the TAC under a lead professional from another agency never materialised,[436] nor did the hope that the non-social care TAC would remain in the background and resume its work after the social

424 pg 29, pg 18
425 pg 36
426 pg 16
427 pg 37
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430 pg 12
431 pg 4
432 pg 6
433 pg 10
434 pg 26
435 pg 8
436 pg 12

care intervention.[437] In short, once a case was moved to Safeguarding, it stayed with Safeguarding.

3.491 The Inquiry has heard the counterpoint view that that child protection services should be centralised:[438]

"*What we do know about child protection services is that if you dislocate them or try to disperse them, they will fail badly… They are a very fixed legalistic model of process approach to cases...*

So the sense amongst agencies is that people in child protection think they're holier than thou, but the people inside child protection know that [to] *do it well, they've got to hold on to their processes and procedural stuff."*[439]

3.492 This was echoed by another witness:

"*… the more specialist teams couldn't be part of* [multi-agency teams] *and that did apply to quite a lot of the Social Service teams because they were dealing with a lot of cases at the more serious end… there'd been a need... to preserve the integrity of social services to make sure there was the quality and the quantity there because there might be a danger of disseminating things too much."*[440]

3.493 The Inquiry heard from a witness in the Education department about the operation of the Cluster system:

"*I don't think the systems then were very sophisticated… everything that surrounded the clusters was undeveloped in many ways… there wasn't performance teams, there wasn't regular data collection… there wasn't electronic systems that enabled, pulled that information together… those systems and processes just did not exist, they existed around social work but none of those systems and processes existed around clusters, there wouldn't have been, at that time there wasn't independent audits of practise* [sic], *the ISMs and managers had their own audit processes. There wasn't a sort of embedded set of audits or other kind of practise* [sic] *review processes and so on… There would have been a reliance on the ISMs to keep data…*

… But it was very unsophisticated at the time and there wasn't electronic systems and processes around data collection and performance information other than, what we implemented ourselves through spreadsheets and so on at that point in time. So it was very underdeveloped."[441]

3.494 That point was echoed by a senior officer of the Council as follows:

"The thing that shocked me, from my perspective, was Telford & Wrekin had talked and had established a massive national reputation for itself around integrated area

[437] [redacted] pg 13
[438] [redacted] pg 101
[439] [redacted] pg 102
[440] [redacted] pg 7
[441] [redacted] pg 41

management, around how they got these things called clusters, that were integrated ways of teams working together, co-ordinating. And we were dining, well not we, the organisation some of the key people who were running it, were dining out on conferences and we were pioneers. I was probably quite shocked at the reality that each cluster was operating on a separate spreadsheet. And this narrative that we were it seemed to me we were fooling ourselves with as well as fooling other people which is the worst thing you can ever do."[442]

3.495 On this "*spreadsheet*" point, the Inquiry heard how the Cluster workers were recording their interactions with the children on their own individual systems and there was no "*one place*" where all the information in relation to that child was being collated.[443]

3.496 The LSCB Executive considered risks on 9 February 2006 and identified this as one:[444] "*The development of school clusters increases the identification of children involved in maltreatment, neglect, violence and sexual exploitation*".

3.497 The *"risk"* was of course reference to the fact that an increase in children involved in maltreatment, neglect, violence and sexual exploitation could lead to a potential increase in demand on the service. However, in my view, to characterise the possibility of uncovering sexual exploitation as a *"risk"* is, at best, unfortunate.

3.498 In summary, the Clusters offered a service well placed to provide an early intervention approach to older children. It is unclear to me why the Clusters were discouraged from providing a CATE-style service. The result seems to be that at one stage there were three different possible ways in which services could be provided to sexually exploited children: firstly, where significant harm was found or contemplated, therefore triggering the usual child protection procedures; secondly, through the Clusters; and thirdly, through the CATE Team, which I deal with below. This shows at least a failure of joined up thinking and strategic planning.

Growing Awareness of Local CSE

3.499 On 4 July 2006 a CATE meeting heard that a member had attended a five-day national course of sexual exploitation and reported that the Council had made "*significant progress in comparison to some areas*".[445] Work needed to be focused on school excludes, runaways and looked after children. A later meeting in October 2006,[446] which discussed the same course (and the resulting recommendations) underlined that "*runaways*" were a "*hidden issue, associated with sexual exploitation*".[447] The meeting considered whether the Clusters' youth inclusion panel workers could play a role in sexual exploitation work.

3.500 After the evolution into Connexions4Youth, the Inquiry heard this account of a conversation with a manager:

442 [redacted] pg 14
443 [redacted] pg 9
444 [redacted]
445 [redacted]
446 [redacted]
447 [redacted]

"[They] *said to me 'tell me, what do you know about exploitation in Telford?' and I said – I can remember I think I swore, actually - 'nobody's listening to us'. My team were making referrals to the Helpdesk at social care about concerns that they had, again, not using that word 'exploitation' because we didn't have that language. They were concerned about something that they couldn't put their finger on in the community that was attracting young people and making them behave in a risky way… We never felt as though we particularly got anywhere… it seemed that the information that we were sharing, we were worried about, didn't necessarily go anywhere.*"[448]

3.501 At a CATE group meeting in May 2007,[449] a senior social worker expressed the view that there was a general lack of awareness within the team with regard to the issue of sexual exploitation and the extent of the problem locally. They were trying to map awareness of current cases within the team; in particular it was to be determined whether the Helpdesk recorded potential exploitation cases. As to the Helpdesk, one witness told the Inquiry:

"[It] *was always under a huge amount of pressure.*"[450]

3.502 A Youth Inclusion Support Officer with responsibility for the Wellington area reported working with children from Years 9 and 10 in a local school. There were links between these children, a group of Asian men and a house in Wellington. She also spoke of children being approached on the streets in Wellington and there being the need for "*detached work*". The attendees expressed concern about the lack of WMP engagement.

3.503 A senior officer within Safeguarding told the Inquiry that they had voiced concern about children having babies not being referred to the Initial Assessment Team "*owing to safeguarding issues*".[451] It is not immediately apparent what that means. In any event they note that the failure to acknowledge potential safeguarding issues meant that:

"*Children's Services were not able to ascertain any useful information in relation to whether there were any patterns, for example areas identified as hotspots or girls being identified as vulnerable.*"[452]

3.504 They said further that they raised concerns about this issue not being treated as a safeguarding matter but was told that the children were not in need of any further support and were being adequately treated by midwives and health visitors; the issue was one of sexual health, not safeguarding. Patient confidentiality was cited.[453]

3.505 Recommendations from a '*Serious Case Review Action Plan'* dated 1 July 2007[454] dealt with pregnant teenagers. So far as GP practices were concerned, a newsletter was to invite GPs to consider whether all pregnant teenagers should be "*flagged up*" on records, or only those where there was an issue of vulnerability. So far as wider information sharing, the Serious Case Review Panel considered the suggestion that all pregnant teenagers should have a

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448 [redacted] pg 10
449 [redacted]
450 [redacted] pg 41
451 [redacted] pg 15
452 [redacted] pg 15
453 [redacted] pg 15
454 [redacted]

formal assessment and a concern marker placed on the Information Sharing and Assessment, or ISA, index, but deemed this "*inappropriate*". The reasoning for that conclusion is not set out.

3.506 There had been significant concern about exploitation in the Wellington Cluster for some time, with an informal record being made - the Clusters not having read and write access to Safeguarding records[455] of all children about who the team had exploitation concerns.[456] The other Cluster ISMs were reluctant to enter into a conversation about exploitation, regarding it as a Safeguarding issue and not in the Cluster area of responsibility of early intervention/preventative services.[457] At this point the Wellington Cluster was pioneering active CSE monitoring.

3.507 I heard that it was "*easier not to lift the stone up*"[458] as there was an assumption within the Council that the children were "*acting out*" or making "*lifestyle choices*";[459] when the question of exploitation was raised with Safeguarding, the response came that "*child prostitution*" had "*always happened in Wellington*".[460]

3.508 The ISM reported that they were told repeatedly that exploitation cases were not child protection cases,[461] though it seemed that there was more likely to be Safeguarding involvement if the children came from "*good homes*".[462]

3.509 The Clusters were ultimately told by a senior figure in Safeguarding to stop sending detailed accounts of exploitation by email,[463] because the allegations could "*start a race riot*".[464]

3.510 I understand from the evidence that there was never an approach to the Cluster to work with victims/survivors of exploitation; indeed, they were told to "*step away*".[465] When Connexions was given the responsibility for dealing with CSE, its manager expressed some concern, asking "*what do I know about this?*".[466] The Cluster team took their information and mapped it out for the Connexions group; it was copied to Safeguarding.[467]

3.511 Of course we now know that children from "*good homes*"[468] or who had supportive parents were being subjected to CSE during this time period. The Inquiry heard that it was around this time that the perception of CSE being a "*lifestyle choice*"[469] made by "*vulnerable*

455 [redacted] pgs 46, 84
456 [redacted] pg 10
457 [redacted] pg 11
458 [redacted] pg 12
459 [redacted] pg 11
460 [redacted] pg 9
461 [redacted] pg 15
462 [redacted] pg 13
463 [redacted] pg 15
464 [redacted] pg 9
465 [redacted] pg 18
466 [redacted] pg 19
467 [redacted] pg 20
468 [redacted] pg 13
469 [redacted] pg 12

girls"[470] was challenged, in part thanks to the case of one particular victim/survivor. As one WMP witness explained:

"… *'these are kids from the rough end of town. They're not nice kids from nice areas, they're not our kids'… there was a bit of that... 'these kids have no relations with their dad, her mum's an alcoholic'… and that's how it was. A lot of these kids they felt fit this narrative and I think it changed with the* [Name] *case."*[471]

3.512 In terms of this particular case, it is clear to me from a review of the files of all agencies involved that this child was from a secure and loving home, a view shared by many of the agency personnel involved, who spoke to the Inquiry about it:

"[Name]*'s dad was very proactive in trying to assist and support."*[472]

"… *half the time the victims don't see themselves as victims because it's the whole lifestyles… the parents are definitely the victims. You know they're, I can't imagine the hell that* [Parent Name] *went through. You know, I've seen it but I still can't imagine it."*[473]

The Establishment of the CATE Project

3.513 In July 2006 the Council carried out a review of available resources.[474] It noted that, notwithstanding previous discussions about mapping:

"… *there are no figures of how many children are abused through prostitution within the Borough of Telford and Wrekin. With this in mind, it is very difficult to understand the extent of the problem. An attempt has been made to monitor and evaluate numbers of children involved in or at risk of sexual exploitation, in the first instance, through the Youth Development service, who allocated four hours per week to a sexual exploitation project, with little success."*[475]

3.514 I have dealt with the Sexual Exploitation Project referred in this review above. The funding of four hours per week from the ACPC continued, however the comment on lack of success may have been ungenerous, if accurate; because in those four hours a week the Sexual Exploitation Project (which was a single individual) was expected to:[476]

3.514.1 Raise awareness;

3.514.2 Provide training and consultancy to staff across agencies;

3.514.3 Coordinate and facilitate a multi-agency approach;

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470 [redacted] pg 12
471 [redacted] pg 85
472 [redacted] pg 7
473 [redacted] pg 48
474 [redacted] pg 2, [redacted] pg 2
475 [redacted] pg 1
476 [redacted] pg 2

3.514.4 Collect data to map the extent of the problem to enable development of strategies;

3.514.5 Participate at strategy/multi-agency meetings; and

3.514.6 Represent the Project at PCT meetings.

3.515 A source close to the internal review noted:

"*What we wanted was an operational project where sexual health was engaged, maybe the substance misuse team, and we were able to be available for young people in the areas that we knew they needed us."*[477]

3.516 The CSE project worker was a middle aged man; some expressed the view to the Inquiry that this was *"a barrier for some young people, and that would be quite challenging and quite difficult."*[478]

3.517 The review noted that the funding for the Sexual Exploitation Project was in any event coming to an end and that *the "lead officer for social services now holds responsibility for recording and monitoring trends."*[479]

3.518 The review also dealt with the specific work undertaken to raise awareness:

"From this project a workshop has been developed with the Education welfare service which aims to raise awareness of young people. This has been piloted in a selection of secondary school in the area with success. Evaluations from school have always been positive. However there is no resource to enable this workshop to be delivered Borough wide. The pilot is coming to an end and consideration needs to be given to how Telford will continue to develop preventative strategies and raise awareness for young people."[480]

3.519 It went on to consider known best practice and possible future strategies:

"*Projects have been developed in many areas of the country which have aimed to provide services to young people at risk of or experiencing sexual exploitation and lessons can be gained from them. Telford may benefit from targeting the most vulnerable children at risk of sexual exploitation as resources are limited. An action plan with clear objectives would give measurable outcomes with which to evaluate the impact of such work. 'Reducing the Risk' (2006) were able to recognise underlying factors and immediate risk factors for the most vulnerable children at risk of becoming involved in sexual exploitation.*

Abuse, neglect, domestic violence and parental difficulties being underlying factors.

Going missing, placement breakdown, disengagement from education, drugs and alcohol, homelessness, peer influence, and association with "risky adults" being immediate risk factors. These immediate risk factors could be used as a tool to identify children who could

[477] [redacted] pg 21
[478] [redacted] pg 13
[479] [redacted] pg 1
[480] [redacted] pg 2

be targeted for specific work... A review of the aims of the sexual exploitation project for the Youth development service could incorporate this."[481]

3.520 The underlining is mine. This passage shows that the instinct was to repurpose the Youth Development Project towards active prevention.

3.521 The review concluded that the Council should develop a clearer understanding of the local issues and map them to direct work successfully; develop strategies to combat exploitation and exit strategies, to continue to raise awareness through training and outreach and, most significantly, to "*provide a specialised service professionals can access for support, advice and carry out one to one work with young people at risk of or experiencing sexual exploitation*". It recommended that a professional, experienced person be appointed to lead the Project full time and to develop the Project by recruitment of a further officer to work directly with young people and of an administrator.[482]

3.522 As to the response to this report, the Inquiry heard that "*it didn't land well*". There was not a proactive response to the concerns raised within the report; nor did it prompt an injection of resources. One witness told the Inquiry that:

"… *there was still an attitude around young people are making choices, they're putting themselves at risk, if they didn't do that then we wouldn't need to fund such a project."*[483]

3.523 The review was expanded into a formal proposal[484] which made clear that although "*this important area of safeguarding children was started for us by the Youth Development Service*", the new resource should be based within the Safeguarding Advisory Service. An officer in the Youth Service recalls:

"[In] *a meeting I shared some of the work we'd done, and some of the information we'd found out, and I recall at the time there was quite an uneasy fidgeting in chairs. I can remember quite vividly saying something like "we've lifted the stone now, we can't put it back" meaning that we were finding information out and actually it was probably where this working group began to look at, look in deeper – as a local authority we need to do more about this, not just as a Youth Development Service."*[485]

CATE Submission to LSCB Executive

3.524 In November 2006, the CATE group drafted a submission to the LSCB Executive group.[486] It set out:

"The issue of sexual exploitation amongst young people in Telford & Wrekin has been acknowledged by many agencies over a number of years. Telford & Wrekin Youth

481 [redacted] pgs 3-4
482 [redacted] pgs 3-4
483 [redacted] pg 22
484 [redacted]
485 [redacted] pg 23
486 [redacted]

Development Service have led the way locally in taking action to raise awareness and work towards addressing this problem…

It is evident through the discussions of [CATE] *that exploitation is a very real and ongoing issue for young people in Telford & Wrekin."*

3.525 The report made recommendation of a senior practitioner-level post based within the Safeguarding team at a cost of £36,000 per annum, to be funded by the Children & Young Persons Strategic Partnership Board.

3.526 A member of the CATE group noted that the hours then allocated to the Project did not amount to a single worker for a single day, and that those who were working on the scheme were effectively gifting their time whilst working full time on other jobs.[487] Without funding:

"… *the CATE project wasn't really a project, although it may have been called that, that wasn't what it was."*[488]

3.527 Minutes of a 'Safe from Maltreatment etc group' meeting dated 31 October 2006[489] show that the group was making representations to the LSCB for more staffing and finance to address the CSE issue fully, "*rather than through the limited cash funding the Youth Development Service has been able to contribute*".[490] At the LSCB Executive meeting in December 2006,[491] the CATE proposal was presented. The current Project lead continued to offer four hours a week to the CATE Project but was about to leave. This meant that the only work being undertaken regarding CSE was awareness raising training being delivered by the LSCB training officer. It is unclear what senior management oversight there was of this gap.

3.528 There was discussion as to whether the single post was strategic or operational, and concern raised that a single person would be unable to fulfil both aspects of the role. Plainly the early submissions had contemplated more than a single post and a member of the Youth Service, expressed their view clearly: if the post was to be successful then two people were needed unless there were other ways of meeting some of the tasks envisioned. There remained a lack of clarity regarding demand or the scale of the concerns.

3.529 It was conceded by the CATE group that they had deliberately reduced the ambition of their submission anticipating difficulty in funding.[492]

3.530 As to funding solutions, voluntary agency funding was discussed, and the point made that children might find it easier to approach voluntary agencies rather than Safeguarding – nationally, voluntary agencies did this work more often than in-house practitioners. However that was rejected as the Council did not have strong links with partner agencies; a comment was made that partnership working of this sort "*needs to move up the Council's*

487 [redacted] pg 31
488 [redacted] pg 31
489 [redacted]
490 [redacted] pg 2
491 [redacted] pg 4
492 [redacted] pg 4

agenda".[493] This was not the first time that third party engagement had been suggested and nor would it be the last. On every occasion the Council seems to have been reluctant to devolve a function to third parties, even a function it was having difficulty performing itself.

3.531 Consideration was given to the LSCB funding the post itself, but this was rejected as it could only be an interim solution – presumably because of uncertainty of funding for the LSCB itself – which would pose a problem for continuity of service and referrals.

3.532 The Inquiry heard that funding by the Clusters was considered but regarded as impractical because the service would then be Cluster-based rather than reaching across all of Telford; additionally, the idea foundered on money and experience as, in the Clusters:

"… *we wouldn't have had any clue about how we would have accessed funding for clusters, and neither really was it our responsibility to go and seek that funding, you know to state the obvious, how did it become the responsibility of a school nurse, a youth worker, an EWO and an NSPCC worker when we were raising that to our strategic leaders… it's very backward."*[494]

3.533 Other solutions were considered and rejected – a lottery funding bid, because of the length and complexity of the process; the LSCB itself funding third party agencies to prepare bids. The idea that gained traction was the suggestion that the managers of the Youth Service and Connexions would explore options and see if some time could be freed up from existing staff time within their departments.

3.534 It is clear that the Action Plan for LSCB 2007/2008 had not reflected this suggestion.[495] It indicated that it had been a priority that "*service* [be] *developed to respond to the needs of children abused through exploitation - and those at risk*" and suggested – though without consideration of funding - that this be done through:

3.534.1 Links with teenage pregnancy service;

3.534.2 Stronger communications through agencies to be arranged through CATE group;

3.534.3 Pilot group work around the issues surrounding sexual exploitation with young people in a variety of settings, to be "*programmed as part of creating leaflet for YP*"; and

3.534.4 Continuation of staff training regarding sexual exploitation courses ongoing.

3.535 At an LSCB Executive meeting which took place on 8 February 2007,[496] it was noted that the presentation had been given and the Youth Service representative was tasked with keeping the group updated on the work with Connexions.

493 [redacted] pg 4
494 [redacted] pg 37
495 [redacted]
496 [redacted]

3.536 I heard from individuals involved who expressed frustration that the matter had been discussed for almost two years with no result; that in the meantime frontline practitioners were continuing to see children experiencing exploitation because although there was a protocol, there was no response. One witness told the Inquiry that they felt there was no proactive response by senior managers to the problem being described and that it felt as if there was still a view that exploitation was the fault of the children themselves.[497]

3.537 There was no mention of the CATE proposal at the LSCB Executive in April 2007[498] but at the full LSCB on 24 April 2007, it was noted that the Sexual Exploitation Project worker had retired but Connexions4Youth, as Connexions had become, was looking as to whether the post (singular) of Exploitation Project Officer could sit within their service area. A possible rationale for the adoption for Connexions as a home for the scheme has been offered to me:

"*It was placed with Connexions and they had some workers that were supporting some of the young people that were embroiled in it. But then that wasn't child protection, again it was being seen as something that could be changed under a behavioural modification type working relationship.*"[499]

3.538 On 17 July 2007, the LSCB was told that Connexions4Youth were still exploring staffing time for CATE work.[500] The Council's Corporate Submission notes that:[501]

"*The CATE project was subsequently established in 2007 and included 3 roles*:

Connexions personal advisor 2.5 days per work

Cluster Family Support worker 1 day per week

Managed by a Connexions 4 Youth Manager."

The beginning of the CATE Team

3.539 Even while these discussions were being had, practical work in responding to CSE was happening:

3.539.1 In August 2007, there was a strategy meeting in respect of a child to "*discuss continued concerns of* [the child] *being subjected to sexual exploitation by men, who* [are] *predominately from the Asian community*".[502] The meeting was told of information that other children known to Safeguarding were in the same position.

3.539.2 There had been an offer by Safeguarding to accommodate the child, but her parents did not want this to happen. Care proceedings were thought

497 [redacted] pg 22
498 [redacted]
499 [redacted] pgs 14, 49
500 [redacted]
501 [redacted] pg 13
502 [redacted]

inappropriate as she was part of a loving family and not being put at risk by, or with the neglect of, a family member.

3.539.3 The response was that a YISP worker was allocated, a family support worker was to be allocated and a TAC meeting to be reconvened.

3.540 In many ways this strategy meeting showed that what would become CATE tactics were being adopted through necessity before any sort of operational CATE Team existed. What were to be perennial complaints of the CATE Team were apparent two months before its inception, though: the meeting was told that the role of working with exploited children was difficult and those who did it did not feel they were receiving enough support – "*they are constantly passing on information and concerns but feel that this in* [sic] *not acted upon by agencies".*[503] The information was separated across teams and there should be a system whereby it could all be centrally collated.

3.541 The CATE meeting on 2 October 2007[504] (which I have referred to above) recorded the effective beginning of the CATE Team with the appointment of Connexions4Youth officers; there were to be further meetings to determine how the work was to be delivered. The meeting considered the Sheffield model, a multi-agency project in place since 1997, in which safeguarding procedures were used to identify children at risk of exploitation, referrals would be made to a specific child protection officer for child exploitation, with a social worker completing the initial assessment and a strategy meeting convened in accordance with section 47. The CATE model copied the Sheffield scheme, adopting the language of safeguarding, though without the involvement of Safeguarding.

3.542 The Inquiry heard evidence about the use of Connexions4Youth and its rationale and was told:

"*Connexions4Youth staff don't cost as much as social workers. So, it almost felt a little bit like we were back to being resource-led and if we're being resource-led the option to do this as cheaply as possible seemed to be the better option at the time.*"[505]

3.543 There was little discussion at this time recorded about the changes outlined in 2006 to the Government-reissued Working Together 2006 guidance within the CATE subgroup or the LSCB. This guidance highlighted the importance of addressing the safeguarding needs of children abused through 'prostitution' with reference to the Sexual Offences Act 2003. There was also a focus on the prosecution of those who abused, exploited children through 'prostitution' and those who incited, arranged and caused child 'prostitution'. The guidance made clear that where children were identified as being either 'involved in prostitution' or were at risk of being drawn into 'prostitution' this should <u>always</u> trigger the agreed local safeguarding procedures, with the dual aim of keeping children/young people safe from harm and to ensure adults who harmed were brought to justice.

3.544 The gap between what was proposed in terms of staffing levels does not appear to have had any high-level scrutiny. There remained a mismatch between what the group thought

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503 [redacted] pgs 32-40
504 [redacted]
505 [redacted] pg 40

was needed versus what could be provided; and there remained lack of clarity about what was needed based on the number of children at risk of harm.

CATE under Connexions

3.545 In 2007, the Youth Development Service, as it was now called, merged with the Connexions service (a private limited company with funding from the Department for Education, as described earlier in this section[506]) and the Play & Activities team.[507] The Connexions work was now delivered through the local authority and it became known as Connexions4Youth, as previously noted. Some separate advisers in the team were tasked with dealing with more intensive work with children, for example substance misuse or teenage pregnancy, and were named Targeted Youth Support ("TYS"). The youth workers dealing with CSE issues, later known as the CATE practitioners, fell into this category.[508]

3.546 On 14 November 2007 there was discussion,[509] initiated by the Head of Safeguarding, as to whether the exploitation response was best sited as part of Safeguarding. The Safeguarding Advisory Service noted that there was "*still a debate as to whether individual cases should be dealt with within Child Protection Services*" but that the Sheffield protocol suggested that Safeguarding should only be involved in specific circumstances.

3.547 It was further suggested by Safeguarding that the LSCB should devise a sexual exploitation response in the Clusters; an odd proposal as, by this time, the Connexions4Youth team was already in place. This tends to suggest a lack of awareness of the part of Safeguarding of a very significant response to a pressing problem.

3.548 At a CATE meeting on 27 November 2007[510] a group was to be convened to adapt the Sheffield manual for local use, this work replacing the review of the existing policy. The target was to produce a draft by the end of January 2008.

3.549 The Sheffield analysis, which was later adopted, dealt with the role of the various agencies. The model included WMP, Social Services, Connexions4Youth and substance misuse agencies, with roles defined as follows:

"Police action: When young person identified through strategy group meeting he/she is entered onto the police intelligence system, alerting officers to fact that they are vulnerable. Links between young person and offenders are identified. Linked addresses are also collated and can be checked if a young person goes missing again. If a young person is not willing to make a formal complaint consideration should be given to using the Child Abduction Act 1984 section 2.

Social Services action: The social worker in conjunction with other agencies involved with the young person complete a core assessment, following the strategy meeting the case will be dealt with by either convening a Child in Need Planning Meeting or a Child Protection

506 [redacted] pg 19
507 [redacted] pg 8, [redacted] pg 6
508 [redacted] pgs 6-7
509 [redacted]
510 [redacted]

case conference (the latter only when parents are actively encouraging the exploitation or knowingly failing to prevent it)."[511]

3.550 The analysis continued "*involvement of parents is key to information gathering"* and then sought to draw together common themes of all the projects it had considered, which were:[512]

- *"Identified social work lead for Sexual exploitation*
- *Links with voluntary sector to secure funding for support and prevention via bids working alongside connexions/youth services*
- *Multiagency partnership*
- *Clear action for those under 19 identified as at risk through safeguarding procedures*
- *Gathering of 'intelligence' via Police".*

3.551 The result of the model is clear: that the primary response is not a Safeguarding response. This was not wholly welcomed; one witness told the Inquiry that Connexions4Youth taking responsibility for exploitation was "*one of the worst things that happened*".[513] They expressed the view that it should have been Safeguarding. This links back to the criticisms made more generally of the Connexions4Youth service which included the lack of adequate resource to meet the needs of both universal and targeted youth provision. Connexions4Youth was responsible for getting people into education or employment, they did not have the skills or the network to deal with these cases; though the witness conceded that it might have been easier for victims/survivors of exploitation to speak to youth workers rather than social workers or the police, not least because of fear:

"… *the girls had heard about victims of CSE being involved in fires and they thought the same would happen to them."*[514]

3.552 An officer in the Youth Service developed the point about youth workers' freedom of approach:

"… *social work is there to fix a problem, whereas youth work is more about young people becoming a bit more aware about themselves... A lot of the early work we did with young people wouldn't have been around or necessarily about the kind of things they were involved in. It would have been more about them as a young person… and them making the conversation rather than us... Whereas on the social work side, it would have been the social worker saying "this is a problem, I'm going to question you on this"."*[515]

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511 [redacted]
512 [redacted]
513 [redacted] pg 20
514 [redacted] pg 20
515 [redacted] pg 31

3.553 The Inquiry has heard evidence from a witness who served in both Telford and Shropshire who confirmed that the Shropshire CSE response demanded a social work assessment.[516] In Telford:

"… *they were just Connexions4Youth, not social workers, so it would have been separate databases and separate information, even though they sat in the same building – which is a little bit bonkers, I think.*"

The CATE process

3.554 On 19 February 2008 there was a sexual exploitation support service planning meeting which set out the basis of the CATE Team process.[517] It was agreed that:

- The CATE referral process was open to male as well as female children;
- Referrals would be taken through the CAF and TAC process;
- Until the "contact point" began, sensitive information would need to be committed to a Word document which would be kept secure; and
- Connexions4Youth would not have resources to undertake preventative group work in schools.

3.555 It is of immediate concern that the new team was not provided with secure recording systems given the sensitivity of the cases with which they were dealing. This raises issues not only of security of recording but ability to share data.

3.556 Further, some of the planning meeting may have been wishful thinking, or a desire to fit the new team within existing structures which were not apt for it. A Youth Service witness recalls that referrals would come directly to CATE rather than through the CAF and TAC process; and that initial assessments were conducted informally by the CATE practitioner.[518] A practitioner told the Inquiry that at the outset they had no terms of reference or referral system. Safeguarding in particular was insistent that its referral system was used which caused difficulties because of delay in allocation of a social worker.[519] The Inquiry heard:

"*Social services we found very difficult, but I don't know whether that's because this was sort of new to them as well. We didn't have any Terms of Reference, you know, or referral type system, so what they wanted was us to use their, so if anybody was ringing in with an issue or a concern about a young person, you'd have to do your referral form and what your concerns were, so they wanted us to take that route, which we were finding very hard to do because of the time in between before something got allocated.*"[520]

3.557 The same witness nevertheless had some understanding of Safeguarding's position:

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516 [redacted] pg 40
517 [redacted]
518 [redacted] pg 61
519 [redacted] pg 10
520 [redacted] pg 10

"I think it was because they were so depleted even at that time and snowed under with things and they still wanted us to go down their referral… I don't think that any of them had worked on sexual exploitation."

3.558 A witness told the Inquiry that there was a general feeling from Safeguarding that the Youth Service was overstating the nature of the exploitation problem.[521] Furthermore there were practical difficulties in dealing with Safeguarding and consistency of response:

"[In] *other services there was nobody who had* [a] *role around CSE-type work. It was whichever social worker happened to be around, and quite often if something came up,... we'd go through the duty officer. It didn't feel very co-ordinated to us, it felt that actually the response you got was based on the person you spoke to, rather than actually having a process whereby there was a clear understanding of, if we found out some information, what would happen to it, which other services it would go to, what action would they take."*

Funding for the CATE Team

3.559 A CATE meeting on 11 March 2008[522] discussed feedback from a Senior Officers' Coordination group meeting and it was resolved that the group would explore funding of future work though the voluntary sector "*in line with the approach taken elsewhere*". This had of course been raised before, including at the LSCB Executive meeting in December 2006.

3.560 On 6 April 2008 the CATE meeting[523] began with an overview, in summary:

3.560.1 That Safeguarding had a long term concern about sexual exploitation which has grown with time;

3.560.2 That the Helpdesk has not known how to respond to exploitation reports; and

3.560.3 That the issue had grown over the last 3 months.

3.561 The overview made reference to the "*statutory commitment*" and the "*precarious nature of the* [CATE] *project*" which I understand to mean that the Council was not obliged to fund an exploitation service, other than Safeguarding, and that CATE was insufficiently funded. One of the meeting's actions was "*funding*" and was marked as "*exploration ongoing*". The Inquiry heard:

"[The case was made] *numerous times to increase the staffing for the CATE team but without actually it being new money, we were stopping something to put money into CATE and by that time I think we'd cut things so drastically there probably wasn't a lot else to cut."*[524]

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521 [redacted] pg 26
522 [redacted]
523 [redacted]
524 [redacted] pg 52

3.562 The 2008-2009 Children and Young Persons Action Plan[525] noted as a goal to develop by July 2008 the existing multi-agency work into a more coordinated response based on the Sheffield model, and to incorporate links to services for associated behaviours such as substance misuse. This Project, funded to March 2009, was to monitor uptake and seek feedback from those using the service, with a report to be produced in October 2008.

3.563 At a meeting of the LSCB Executive on 1 May 2008,[526] the designated GP told the group that Staffordshire had a system which flagged to hospital Accident & Emergency staff any child attending who had a Child Protection Plan in place; he was keen to examine the system, presumably with a view to its adoption.[527] It is not clear what transpired in this regard.

3.564 CATE funding was at 0.6 full time equivalent and designed for two workers supporting a maximum of ten children.[528] There was talk of funding sources for "*toolkits and day to day resources such as meals etc*" and varied suggestions included Parish Councils, safeguarding, WMP, and the 'Safer Communities' fund. Needless to say, as with every suggestion of alternative funding, none of these bore fruit. [529]

3.565 The first consideration of performance indicators came with a query as to how the project would be regarded as successful. Although no link was specifically made with the success of the support being given by the team, it is a fact that at the same meeting it was reported that WMP had begun Chalice.

The CATE Team – Age Threshold

3.566 A multi-agency meeting on the 19 July 2008[530] recognised the CATE Project as having been formed to work with children ("*preferably*" 13-18) being groomed for sexual exploitation and specifically to look at exit strategies, collation of information around children at risk, providing encouragement and support and to engage them in an intensive support programme. It was noted that CATE had specific referral procedures and actively welcomed referrals from any agencies or services working with or supporting children. Discussion of ongoing cases recognised links with use of taxis and fast food outlets.

3.567 Despite the above reference to the project working with children "*preferably*" between 13 and 18 years of age, I was told by the Council that only children aged 14 and over are referred to the CATE Team, unless statutory safeguarding services are also involved.[531] When I queried this with the Council, I was told that this does not prevent or cause a delay in referring to CATE. The emphasis is that those under 14 years of age will also be subject to the statutory pathway and a referral to CATE will not be a standalone activity.[532] I question whether this has always been the case, as I have seen one email dated 2016 which suggests that a child's referral to CATE was not accepted as the child was only 13 years

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531 pg 15
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old.[533] Further, I have seen reference in some documents to the threshold for referral to CATE being over the age of 13.

3.568 The Inquiry heard that the derivation of children aged 13 and under not being referred to CATE was unclear (and indeed, there is confusion within some of the documents), though thought perhaps to have derived from the fact that funding for the Youth Service was intended to be directed at those between 13 and 19 years old,[534] though the witness conceded that Safeguarding concerns were more likely to be inferred in the case of a 12 year old CATE victim/survivor.

3.569 Another reason for the age threshold could have been the 2007 Trafficking Guidance which stipulated that "*cases involving under 13s should always be discussed with a nominated child protection lead in the organisation*".[535] That said, none of the witnesses who have provided evidence to the Inquiry have referred to this guidance, which leads me to believe that it did not influence the threshold for a referral to the CATE Team.

3.570 In its response to the Maxwellisation process, the Council offered an alternative explanation and informed the Inquiry that the basis for this age threshold in the CATE Pathway is that it is reflective of, and mirror, the offences set out in sections 5, 6, 7 and 8 of the Sexual Offences Act 2003. I note, however, that these offences relate to rape and other offences against children under 13 as opposed to 13 and under which is the age threshold for the CATE Pathway.

3.571 As to the relationship between the CATE Team and statutory safeguarding services, the practitioner perception was that information sharing by Safeguarding was also poor. The Inquiry heard:

"… *with Children's social services I do feel it was very much them asking for information from us but not being prepared to share much in the other direction*."[536]

3.572 When the same witness was asked if they felt whether there was a perception in Safeguarding that CATE practitioners were not adequately trained or qualified, they replied:

"*I do think that there was a feeling by other statutory services that staff weren't as qualified or understood confidentiality or legislation to the degree that people like qualified social workers might. So it did feel, and it probably still does now to a degree,... that actually the standing of the Youth Service generally isn't regarded as being almost a professional service.*"[537]

The CATE Reports (2008) – Process and Resources

3.573 On the 10 September 2008, a CATE report[538] details the fact that, due to staff leavers and withdrawal of support, the CATE Team was not adequately staffed by CATE practitioners.

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534 pg 60
535 , pg 79
536 pg 53
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The report confirms that a manager was covering for absences and providing CATE services to children (despite having no CSE experience). Evidence provided to the Inquiry indicates that members of the CATE Team later left due to the increasing demand and lack of support.[539] Demand for the service was growing – 12 children were being supported - and in the CATE report it was suggested that "*work is capped, as numbers are growing a waiting list will need to be drawn up*." The Inquiry has seen no evidence that this cap was implemented.

3.574 A CATE report dated October 2008[540] gave a 'state of the nation' overview. This paper was presented to the LSCB Executive and to the full LSCB.

"The CATE project Workers are funded through Connexion 4 Youth for the two part-time staff. The CATE Manager's role was not specifically funded/allocated a budget or administration supports, the duties as CATE Manager are an addition to the Area Manager's existing role for Connexions 4 Youth.

Staff member 1, was dedicating one day per week from overall weekly youth work duties to work with young people at risk of and involved in Sexual Exploitation. Staff member 1 withdrew from the project in the early stages. The post was then taken up by a Family Support Worker where the funding for this was secured through C4Y. The Family Support worker was previously supporting and coordinating the development and distribution of information around Sexual Exploitation, current duties expand on this area of work. The expansion of duties includes one to one intensive support to young people.

Staff member 2 was allocated another 2.5 days to her current role as a Personal Advisor for C4Y (2.5 days) to work on the CATE project, working with young people at risk of and involved in Sexual Exploitation through one to one intensive support, advocacy, protection and lowering risk through intervention. (Other contemporaneous material notes that although this post was half time the workload was such it was infringing on the officer's other duties.)[541]

Staff member 3 is currently the Area Manager for the South Cluster C4Y. The CATE project is managed by staff member 3 and currently is an addition to her existing role and spans over a 5 day week. The Area Manager also works with Young People that are involved with CATE where one to one interaction is required with the young people. The Area manager is responsible for managing the budget for service delivery, seeking and securing further funding for service delivery including staff to the end of the pilot project March 2009, administration directly relating to the CATE project, monitoring and evaluation directly related to the CATE project."

3.575 The CATE Project had received 23 referrals since July 2008, were working intensively with eight and awaiting information on a further seven.

3.576 As to process:

539 [redacted] pg 15
540 [redacted]
541 [redacted]

"It was initially thought that referrals would come to the project through the CAF and TAC process but this is already impossible as young people are identifying siblings and friends who are also being subject to abuse or individuals that are self-referring. The CATE Project will not ignore any concerns regarding young people involved or at risk of Sexual Exploitation and will always investigate.

All referrals made to the CATE project follow a protocol where CATE staff liaise with the Children's Social Care Safeguarding Team's Helpdesk at the Mount. This enables the CATE project staff to gain information on whether the young person referred is known to Social Care and establish the extent of child protection concerns for the young person.

Where the safeguarding team consider there to be significant concerns for the young person, the protocol determines that a Strategy Meeting is called by Helpdesk. All referrals of alleged Sexual Exploitation received through Children's Social Care should then be referred to the CATE project. The Team Managers, Helpdesk and CATE Manager then agree immediate action."

3.577 A witness noted:

"[the] *numbers grew relatively quickly because of the relationship that a young person may have built with* [a named worker]*, for example. They felt comfortable and safe talking to* [the named worker]*, they would then talk about young women they'd met, or who they knew were involved in the same activity and they then introduced them* to [the named worker] *as well, as they felt it was a safe thing to do, whereas within the social work team that never happened."*[542]

3.578 At the time of this CATE report in October 2008, not a single strategy meeting had been convened. The report's recommendations plainly, and rightly in my view, regarded that as an omission, suggesting that there be strategy meetings for all children subjected to sexual exploitation and at high risk within a week of referral.

3.579 The further recommendation that the Helpdesk have a dedicated CATE officer was obviously linked, although it is not clear how the already stretched CATE service was to accommodate this extra work.

3.580 The CATE report made another plea for funding to run the project on a full time basis including evenings and weekends and that administrative support was built into any funding initiatives. Additionally, information/data recording systems needed to be considered as part of the Liquid Logic system development as a longer term vision. A spreadsheet needed to be developed and funded, as an interim project, for the input of the information gathered from the monitoring forms.

3.581 The reference to the 'Liquid Logic' system (also on occasion referred to as 'Protocol') and to the spreadsheet underlines the continuing problems of secure recording and data sharing, to which I have already referred. A case management system that enabled the recording and sharing of information would not be open to CATE for almost a decade.

542 [redacted] pg 32

3.582 There was a CATE meeting on 6 October 2008.[543] The purpose of the meeting was to agree the referral process: there was to be immediate consultation between the Helpdesk and CATE on all referrals; if the matter satisfied section 47, the enquiries were to be pursued and there should be a CATE meeting within seven days, and if the matter was not taken up by Safeguarding there was to be an agreed CATE response within ten days.

3.583 A referral form had been developed and was shared with the meeting. This would be circulated to schools and other agencies; it was thought this would increase referrals "*perceptibly*".[544]

3.584 As to personnel, the comment was made that the sole remaining CATE practitioner was now working half time on CATE as opposed to their original duties, but was under significant pressure because of workload. This is worthy of note, considering that two workers had already left due to the impact of their workload and having to work evenings and weekends when contracted for weekday office hours only.

3.585 Workload increased as Chalice progressed:

"*… the police have identified Operation Chalice and are becoming increasingly involved through* [an officer in] *the Reactive CID section.* [An officer] *and a colleague are already working with young people and have conducted several Achieving Best Evidence interviews. This has enabled action against alleged abusers and they have used the Child Abduction Act as part of their strategy with these offenders.*"[545]

3.586 At a CATE meeting on 15 October 2008,[546] it was noted that another CATE practitioner had joined the team for one day per week. The next step was for the team to provide evidence to support the need for permanent staffing to the LSCB and Senior Officers' Coordination group. Funding would only last until March 2009.

3.587 The team was involved in training but the minutes record that officers spent "*a lot of time training staff and <u>challenging attitudes of people and professionals</u>*".[547] The emphasis is mine. The pressure on staff time was such that it was not certain that a specific information sharing group in Wellington – comprising WMP, PCSOs, NACRO (a social justice charity) and CATE – could be accommodated. It was noted that meetings were taking up time which could be used more intensively with children.[548]

3.588 At an LSCB Executive meeting on 6 November 2008[549] sources of funding were again discussed. It was noted that equivalent services in Birmingham, Derby and Sheffield were funded by "*partner agencies*", rather than having to find the money themselves, and that central government funding was available for a Sexual Assault Referral Centre ("SARC") which was intended to provide help and guidance through the prosecution process.[550]

543 [redacted]
544 [redacted] pg 2
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Connexions4Youth was to formulate a business case for a future Senior Officers' Coordination group meeting.

3.589 On 26 November 2008, a CATE meeting was told that the project was "*at bursting point*".[551] A request for there to be an Accident & Emergency representative on the CATE group was approved, it having been noted that there had been three Accident & Emergency CATE training sessions.[552]

3.590 On 14 January 2009 a CATE meeting reported the delivery of workshops at a local school,[553] which would serve as a model for work in other schools, but there were only the resources to work in one school at a time. It was noted that there were still issues in two named local schools. CATE was now supporting over 20 children. Staff were working over hours to support the project, including out of hours and weekends. The hope was expressed that long term funding would be provided for CATE as part of Safeguarding and it was agreed that these additional hours needed to be logged to evidence the need for future funding. There is no evidence that this happened.

3.591 The meeting minutes noted that while "*Police, C4Y* [Connexions4Youth] *and help desk have met on several occasions to agree common processes and ways of working*" there was less engagement from Social Care: "*a S*[ocial] *W*[orker] *to be allocated to the project to discuss Safeguarding issues has been discussed – to be confirmed – there was reluctance.*"

3.592 On 22 January 2009, this internal Council communication[554] was sent:

"*I have just had a conversation with* [Name of Connexions4Youth manager]*… and* [they have] *told me that following a conversation with* [Name of the Director of Children's Services], [they have] *managed to secure a budget to fund the CATE project for another year. The funding will be as it stands now so I am really pleased to let you both know you are in it for another year…*

During this period we will obviously have to work hard to secure future funding, however that's for the future."

3.593 CATE was to continue – but on the same uncertain basis as before. The Inquiry was told:

"*I don't think the Youth Service as a whole had enough resources to deliver what we were expected to deliver, so CATE, as a very small part of that, definitely wasn't*[555]*… If we had more resource we could do more, but I think in terms of CATE, because of the rate that young women were coming forward and the severity of some of the cases we were hearing, I think the authority could have put more resources in earlier than they did."*[556]

551 [redacted]
552 [redacted]
553 [redacted]
554 [redacted]
555 [redacted] pg 40
556 [redacted] pg 43

The CATE Report 2009

3.594 On 15 July 2009 a report[557] was prepared on the future of services in respect of sexual exploitation. The purpose of the report was to provide an update to the CTB and to the LSCB about the work undertaken by the CATE Project and to propose that the service "*becomes a mainstream jointly funded service within the Borough*".

3.595 Even in 2009, the author of the report wrote:

"*It has been difficult to quantify this problem or to develop strategies to address this issue as the young people have not sought to acknowledge or make referrals in respect of their exploitation. Thus it has not been identified as significant by Children's Social Care or the police because of the lack of formal reported incidents. However workers with individuals have become aware of such incidents but if formally referred the young people have chosen, for a number of reasons including embarrassment and often fear of the consequences, not to report this to the Police.*"

3.596 The Inquiry's social work expert has suggested that the characterisation of the situation as a failure by children to acknowledge their own exploitation displays a (probably unwitting) victim-blaming attitude; the Council has replied that this is a simple statement of a central difficulty in dealing with CSE cases and that the difficulty was addressed by awareness raising efforts in schools. This difference in interpretation really does illustrate the distinction between treating risk as external and requiring children to be protected – the essential safeguarding approach - and treating risk as coming to some extent from a child's behaviour, and reducible by behaviour modification. I have not seen evidence that these philosophical questions were grasped at an early stage of the Council's CSE response.

3.597 The CATE Project was referred to as the "*temporary project*"[558] and it was acknowledged that it had insufficient resources to provide support to the number of children involved. Again it was suggested that CATE needed a full time worker; there was agreement for a family support worker for one day per week, a Connexions4Youth worker for two and a half days per week and management oversight from Connexions4Youth. The project was to be based in the Youth Development Service or Connexions4Youth because children were said to be reluctant to engage with teachers, social workers and police officers. Whilst I can understand why children may have been reluctant to engage with teachers, social workers and police officers, I do not understand the logic that youth workers were in a different position; they too would have been under a duty to report or act upon any disclosure of abuse. To suggest otherwise to children would have been misleading.

3.598 A temporary measure was proposed and the project, and its sole worker, would be moved into the WMP-funded accommodation at West Road. The report noted that it had also been agreed that the project worker would be supervised by an assistant team manager from Safeguarding.

3.599 The CTB and the LSCB were asked to endorse continued planning to identify the scale of sexual exploitation in Telford and to provide resources to effectively address it. They were

557 [redacted]
558 [redacted] pg 2

asked to approve funding for a properly funded and structured sexual exploitation project in Telford. The actual cost of the project could not be provided until the scoping work had been carried out. The report acknowledged that this was:

"[a] *potentially dangerous and taxing area of work and full diligence will be required to ensure that supervision is available to workers*".[559]

3.600 The Inquiry heard from someone involved in the early days that they did not consider that there were ever sufficient resources to perform the task required, and questioned the use of funds to raise awareness around professionals and parents, rather than using those funds to support children.[560] The witness said it "*seems the wrong way around, really*".

3.601 Another witness told me:

"*It was very challenging…we just needed more structure, we needed more resources and we needed to really get a grip of what was happening.*"[561]

3.602 There was a complete lack of follow through from many of the meetings or tasks agreed.

Sexual Exploitation – Becoming an LSCB Priority

3.603 At an LSCB Executive meeting on 11 June 2009 it had been decided that sexual exploitation would become a priority of the LSCB. As a result there would be a CATE subgroup to the LSCB (distinct from the CATE group which was standalone) which would lead on sexual exploitation and report directly to the LSCB.[562]

3.604 The explanation for why sexual exploitation became a priority may lie in the 2009 Sexual Exploitation Guidance,[563] which, as discussed earlier in this chapter, made clear the key role that LSCBs should play; they were required to ensure that it was regarded as a priority by the Children's Trust.

3.605 At the LSCB[564] itself, in a meeting dated 15 July 2009, a commissioning exercise on "*mainstreaming*" the project was noted because although the "*CATE group is a well-established group that has already achieved a lot but a sustainable way forward is urgently needed*".

3.606 A CATE practitioner told the LSCB that there needed to be preventative work in schools but that they could not even consider it presently, as they were spending so much time on high risk cases. To be sustainable the CATE Project required two project workers, one full time and the other three to five days per week; one part time parent support worker; a part time administration officer; an operational base; a named person in each organisation with

[559] [redacted] pg 3
[560] [redacted] pg 31
[561] [redacted] pg 15
[562] [redacted]
[563] Department for Children, Schools and Families (2009) '*Safeguarding Children and Young People from Sexual Exploitation'.* HMSO: London.
[564] [redacted]

responsibility for CATE issues; and resource for preventative initiatives.[565] This was in reality little more than had been proposed in 2006.

3.607 The DCS was to consider CATE resources as an "*urgent priority*"[566] and to indicate to schools that CATE training should be mainstreamed within PSHE.

3.608 The advice from the Safeguarding Advisory Service was that each of the cases being dealt with under Chalice was extremely serious and may lead to a SCR. I regard this as a sensible assessment and a reasonable forecast; though in fact there was not to be an SCR, for reasons I discuss later in this chapter.

3.609 There was a report to the LSCB and CTB repeating the CATE practitioner's requests and underlining the need for staff working in the field to have appropriate support and supervision. It was recommended that a lead officer be nominated as project manager to build upon the commissioning work that had begun and a need for "*mainstream support and funding*".[567]

3.610 A stated priority of the LSCB for 2009/2010 was the work of the CATE group, with one of the aims being was to "*commission a sustainable service based on the successful pilot and the experience of good practice elsewhere*".[568] The Action Plan for 2009/2010[569] tasked the Senior Officers' Coordination group with "*develop*[ing a] *Project on permanent basis with identified staff; Secure multi agency funding*". These aims were laudable but no practical solutions were offered.

3.611 Further, the LSCB said there needed to be work on children's support and developing links to any local work to address "*runaways*".

Response to Growing Exploitation and Evolution of the CATE Team

3.612 The LSCB Executive noted in early 2009[570] that approximately 40 children were known to be being sexually exploited locally. WMP was working with the PCT on a SARC, but some felt it unlikely that Telford would have sufficient cases to warrant a standalone SARC. The particular difficulty that an out of area SARC would pose for children using the service was raised as a concern.

3.613 The Senior Officers' Coordination group was to be reconvened "*to see how the Partnership Group can be sustained*" because the number of children being sexually exploited was increasing at an "*alarming rate*".[571] It was agreed that the project was unsustainable as work is unmanageable as it was increasing "*as a result of increased awareness*".[572]

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3.614 CATE was actively working with 12 children, although the documents provided to the Inquiry do not evidence what this work looked like. A CATE practitioner was concerned about management structure and support – there was no system for dealing with when urgent decisions had to be made. There needed to be a safeguarding CATE procedure and allocated social workers should have CATE training. Further, frustration was expressed about not being consulted with respect to Senior Officers' Coordination meetings despite working "*on the ground*" and understanding the issues.[573] This has echoes of early Sexual Exploitation meetings, which largely featured decision makers rather than practitioners.

3.615 There were proposals for creating a permanent specialist service but mainstreamed through multi-agency funding arrangements being developed through the Joint Commissioning Team. In the meantime, an extra CATE practitioner was required.[574] It was recognised that the temporary project – which involved the Connexions4Youth worker being allocated full time to the project,[575] supervised by an assistant team manager from Safeguarding and with clinical support available from the Psychology service – provided insufficient resources to provide support to the number of children involved.

3.616 In short, CATE was overwhelmed.

3.617 So far as CATE management is concerned, some documents are missing. I have however seen a note of action points arising from a Senior Officers' Coordination meeting dated 26 May 2009,[576] in which it is suggested that a senior officer and social worker in Safeguarding explore taking a management lead role for CATE, and a CATE meeting agenda for 10 June 2009[577] with the line "*Management for* [CATE practitioner] – *line manager*". By 1 July 2009 the CATE practitioner was described as "*line managed by senior social worker*"[578] and was working full-time on CATE.[579] At this point, CATE was co-located with the WMP Chalice team.

3.618 Although there was now a full-time CATE practitioner, it appears that there was only one, who was often alone[580] and negotiations were underway to find resources for a further project worker.[581]

3.619 In September 2009, it was reported to the LSCB Executive that the team now comprised a full-time project worker and two WMP Detective Constables, working full time on the CATE Project. It was noted that resources would be discussed at a Senior Officers' Coordination meeting in October 2009.

3.620 At the LSCB in October it was noted that CATE was "*more than just a resource issue*"[582] with no further explanation of what more was to be considered.

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575 [redacted] pg 16
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581 [redacted]
582 [redacted] pg 3

3.621 The Inquiry heard the following evidence in respect of the CATE Team:

"[T]*here was no structure.* [The team] *needed structure and resources.* [Individual] *was asking for support. From August 2009 until the end of the year* [individual] *had a high number of young people and no line manager.* [Individual had] *asked for a line manager and additional resources.* [Individual] *needed to be part of a structure and to have a manager.* [Individual] *was dealing with referrals coming in, trying to see multiple young people on a daily basis,* [Individual] *was multi agency working, feeding information to the police, raising safeguarding concerns… it was unsustainable.*"[583]

3.622 On 16 October 2009 a CATE Heads of Service meeting[584] was convened to "*reach some agreement about how to progress the CATE project*". It appears to have done so by recommending there should be a "*Gold Group*" convened though one positive recommendation was made, namely that there needed to be provision for a family support worker to help parents understand and support their children.

3.623 On 29 October 2009 the LSCB Executive noted that there had been discussions about increasing staff for the CATE Project, with a previous CATE practitioner scheduled to return.[585]

3.624 The meeting considered research which had taken place with regard to the Helpdesk, which tended to indicate that too much was being referred through the Helpdesk, with relatively few of the referred cases meeting the threshold level for Safeguarding intervention. Agencies needed to be clear what should and what should not be referred to the Helpdesk. The Inquiry understands that CATE practitioners had difficulties with the Helpdesk's approach, which was based on social work intervention criteria:

"[We] *would refer to the Helpdesk and they would see it as 3rd party or hearsay information and be asking us for evidence – we had a barrier hitting their threshold.*"[586]

3.625 This was confirmed by a senior officer, who explained:

"*We in Safeguarding did not understand or recognise the indicators as we had always worked with evidence. CATE tried to talk to us in the Helpdesk but we still weren't with it in terms of the indicators… It was drummed into us as social workers that you don't interfere in someone's life unless there is evidence to do so – it's an infringement of their human rights.*"[587]

3.626 I heard further that there was a lack of understanding on the part of professionals given that "*social workers are trained on evidence…building evidence around safeguarding and having to make huge decisions based on the evidence*".[588]

583 [redacted] pg 45
584 [redacted]
585 [redacted]
586 [redacted] pg 41
587 [redacted] pgs 22-23
588 [redacted] pg 21

3.627 The above demonstrates that rigid insistence on evidence undermines the real test, which should be whether there is (so far as the presence of or risk of serious harm to a child) reasonable cause to suspect. I have seen minutes of a CATE Team meeting on 8 January 2009, which show[589] that there was WMP involvement in a case, arising from a series of reports in a local school, where Safeguarding had declined to act. The minutes do not reveal the reason why Safeguarding declined to act, given that a child had disclosed a sexual relationship with a male and was ready to speak with the police, but it tends to underline the point that CSE was seen as outside the sphere of Safeguarding responsibility and that if any response was mandated, it was to be a CATE response.

3.628 A former member of the CATE Team told the Inquiry that they were seen as the "*poor relation*" to Safeguarding:[590]

"*I used to sit and think, God have we been set up to fail here…have we just been used…like some sort of puppet to pilot this?*

I still think fundamentally that people did not want to admit that this was going on and how bad and how we were a small project, small funding, but this was big, this was big, and even I didn't know… it [was] *an historic sort of situation that we're in that I wasn't made aware of even when we started by social services or anybody.*"

CATE Team and Safeguarding

3.629 On 29 July 2009 the CATE group met.[591] It noted that although the CATE practitioner was full-time, the manager had left the project. CATE was still under the overall management of Connexions4Youth, which was looking for funding for additional hours. There were proposals to link the CATE Project with a specified officer in the Safeguarding team. The project was dealing with 15 active cases, 14 of which required intensive support. Frustration was expressed at health professionals' lack of awareness of exploitation.

3.630 An action plan had been drafted, which was discussed at this meeting, covering:

3.630.1 The development of the CATE project plan and funding/staffing profile;

3.630.2 The delivery of training to be planned and incorporated into child protection awareness; and

3.630.3 The need to revise the protocol and referral pathway, as well as review the child and young person leaflet.

3.631 These plans were not then reviewed or tracked, as far as the Inquiry is aware. Meetings which followed make no mention in any detail of these tasks and therefore it is impossible to ascertain from the information provided if or how anything was actioned. The issue of

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590 [redacted] pg 47
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staffing is not addressed however, as in early 2010 there are concerns about low capacity and there would not be confirmation of any changes to capacity until 2012.

3.632 The Council told the Inquiry that the DCS took the view that the CATE Team needed strong links to Safeguarding and appointed the Service Delivery Manager of Safeguarding to manage the CATE Team in place of Connexions4Youth.[592] This solution was designed to:

"… *ensure that the right decisions were being taken and that the correct support was in place for both the young people and Council staff.*"[593]

3.633 On 29 October 2009, a CATE risk assessment panel met for the first time.[594] The purpose of the meeting was to use the Lancashire Child Exploitation Threshold Assessment Form to assess the risk faced by 43 individuals known to the CATE Project. Due to a lack of resources, only 23 could be assessed, of whom 15 were placed at significant (eight) or moderate/significant (seven) risk. The meeting concluded that:

3.633.1 The CATE subgroup of the LSCB *"to lead on embedding the statutory guidance which addresses the need for developing local prevention strategies, identifying those at risk, taking action against perpetrators, developing local procedures, undertaking serious case reviews and supporting local communities etc*";

3.633.2 In the meeting it was also noted that:

3.633.2.1 Strategic and operational leads should be identified with roles clearly delineated. It was noted that in Derby the Principal Officer for Child Protection took ownership of the meeting and chaired the Child Exploitation strategy meetings;

3.633.2.2 There should be immediate consideration of financial resourcing; it was noted that Derby's model was underpinned by intensive partnership working which included the Crown Prosecution Service and police and a pooled budget; and

3.633.2.3 Establishment of policies and guidance will not change practice or attitude; this therefore must be facilitated and encouraged at multi-agency strategic level as well as owned by all the agencies involved with children and young people.

3.634 One attendee at this meeting, with a background in safeguarding, explained how they started the meeting unsure of whether they could take any action in respect of the individuals because there was no 'evidence'. However, by the end of the meeting she finally understood and described the meeting as the moment they "*got it*", saying "*It's almost like these blinkers went and I so got it*".[595]

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592 [redacted] pg 8
593 [redacted] pg 9
594 [redacted] pgs 3-4
595 [redacted] pg 23

3.635 A former member of the CATE Team reflected on the team's adoption of its own procedures and assessments:

"[CSE] *didn't really fit into social work structures until we got the CATE pathway up and running and new structures in place and the risk panel meetings – I think social workers felt helpless because it really didn't fit into the safeguarding structure. It wasn't about parents failing to protect, it was about perpetrators*".[596]

3.636 It was not that they could not act; it was that they would have had to act differently. However the procedures were still largely informal: "*a lot of it was in my head*". [597]

3.637 On 9 November 2009 a senior social worker joined the team,[598] though on a part-time basis shared with the community social work team.[599] It was noted in a CATE Team meeting[600] that there needed to be full discussion about recording and storing of CATE information which, at that stage, was still entirely informal.

3.638 On 21 December 2009 it was noted in a report to the LSCB Executive that the CATE Pathway group had identified a strategic lead and an operational lead, both from Safeguarding, for CATE.[601] This was the first time that the CATE Team had formally sat within the Safeguarding team. Evidence to the Inquiry was that CATE should always have sat within Safeguarding, "*because it's safeguarding and high risk business*".[602]

3.639 A CATE update in January 2010 revealed:[603]

3.639.1 A "*vast*" increase in referrals (since 2008 the team had undertaken 40 investigations of young people, it was intensively supporting six young people and had completed work with a further 16);

3.639.2 Very little take up of CATE referral procedures by partner agencies;

3.639.3 Difficulty with using the CAF/TAC process because of the sensitive nature of the information received and because workers had no time to complete the forms;

3.639.4 That there was "*still a lot to do*", particularly around communication with Safeguarding/the Helpdesk; and

3.639.5 That demands of the role had led to the resignation of a CATE practitioner (at this stage staff were taking calls in the evening and at weekends from distressed children and attempting to fulfil the CATE role alongside their other work commitments).

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597 pg 32
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3.640 The recommendations of the outgoing manager were that the project needed to be funded to the extent of two full-time project workers; a part-time support worker to help families; a manager, and an administrator. The manager noted that the project had:

"… *now reached a stage where it is desperate for more resources/funding. We cannot ignore the importance of this Project and the work that has so far been done. It would be a tragedy if the Project were to fold and we would be doing a great disservice to the young people we are trying to protect from Sexual Exploitation."*[604]

3.641 It has been highlighted in the Council's Corporate Submission that clinical psychology services provided support to the CATE Team alongside the Council's Occupational Health Service. However, based on the documents the Inquiry has seen, I question whether members of the CATE Team saw the benefit of this, as it is clear to me that the team was so overwhelmed by the work that this led to ill-health within the team, linked to the demands of the job. There were no agreed changes to the capacity of the team until 2012 and the Council's Corporate Submission makes no comment about how this change came about. No subsequent minutes from meetings or reports give any idea of how this change occurred.

3.642 On 14 January 2010 it was reported to the LSCB Executive that the CATE Care Pathways group was on the verge of completing a "*care pathway model*".[605] This would later become known as the CATE Pathway. It was thought that the section 47 route did not fit with children experiencing exploitation, though section 47 would not be excluded in apt cases. There was some concern at this and it was questioned whether legal advice had been sought as to non-compliance with section 47; the view was expressed "*most people would be saying it* [(exploitation)] *was a child protection issue"*. It was remarked that there was a need to raise awareness of the CATE service amongst professionals.

3.643 The Inquiry heard:

"*Before Chalice, children would be referred for the child protection route, but that then was very scathing of parents, and it was labelling parents as irresponsible or neglectful or whatever which they weren't. If anything, the parents were screaming out for us to do something or for somebody to do something, for some help... then the policy came in to have the pathway, the CATE pathway where the child exploitation was seen in a different way."*[606]

3.644 At the LSCB on 27 January 2010[607] it was acknowledged that there was a great deal of further work to do with regards to CATE "*which will be very demanding and will require a lot of resources*". Further there was to be a subgroup to focus on missing children.

3.645 On 3 February 2010 it became clear that the NSPCC was unable to offer a therapeutic service to CATE children; there was discussion within CATE about appropriate alternatives, in particular Relateen (a branch of the Relate service designed specifically for children) and

604 [redacted]
605 [redacted] pg 7
606 [redacted] pg 12
607 [redacted]

Axis Counselling, a support service for survivors of sexual abuse.[608] This gap in service appeared unresolved, having first been raised in 2006.

3.646 At a CATE Care Pathways meeting on 5 March 2010,[609] it was decided to adopt the "*Derbyshire scheme*" with specific modules on CSE, into PSHE through initial training then implementation for 11 schools. There would be targeted work in a particular local school with key children. A decision was taken not to commission counselling support from the Axis service; there needed to be consideration of services available to under 16s and over 16s including CAMHS and Relateen. The Coalition for the Removal of Pimping ("CROP") would be commissioned for parental support work. Additionally, SARC commissioning was under way and was estimated to be in place by 2011; and Independent Sexual Violence Advisor ("ISVA") support was to be commissioned through Worcestershire Rape Crisis, for up to 21 hours per week for women (around 43 of them) involved in Chalice.[610]

3.647 An operational update[611] showed that there had been four allocations to CATE over the preceding month with a total of eight cases awaiting assessment; 20 cases requiring intervention; and a total workload of 32 cases.

3.648 The CATE subgroup's terms of reference were updated on 5 May 2010,[612] defining its aim thus:

"Identifying how sustainable funding can be sourced to meet gaps in provision, particularly post exploitation support for parents and young people."

3.649 It is notable that, although CATE's workload was high, it was suggested that in the event of high demand on the Helpdesk, CATE practitioners would provide cover. It is not clear if the implications for the CATE Team were considered or whether they were trained or qualified to carry out this work, however.

3.650 A Council structure chart published on 10 May 2010[613] listed the CATE Team as a Safeguarding service.

3.651 On 20 May 2010, the LSCB Executive[614] received an update on changes following research into the Helpdesk. Senior social workers were to sit in the Helpdesk taking calls, and its name would change when a new name had been agreed.

3.652 A CATE operational update prepared for a CATE Care Pathway meeting on 17 June 2010[615] recorded that there had been within the month of May seven new referrals, two of whom were male; there were a further six open cases in assessment and 19 cases where assessment was complete and children receiving intervention – a total of 32 children. There

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had been communication with the 'RISQ' sexual health service about providing support; the group was to monitor staff time spent on supporting sexual health needs.

3.653 The Children and Young People 'Priority Plan' was published in final form on 14 June 2010.[616] One of the top five priorities requiring most urgent action was to "*improve support to those subject to sexual exploitation and reduce the number of those at risk (CATE)*".

3.654 On 1 July 2010, the Executive considered the rise of children in care numbers, which was "*putting added pressure on all services/agencies*".[617] It was determined that:

"… *work will be carried out with the clusters with regards to preventing children coming in to care and to assist them in going home quickly due to figures showing that children are in care for a longer period of time than in previous years*". A minute "*we need to ensure the work is not politically based on financial reasons and is about the needs of the children*" does not reassure me that there was not an active policy to divert children away from the section 47 process on the basis of costs grounds.

3.655 By mid-September, the Helpdesk changes had not been implemented. This was because of staffing shortages.[618] It was intended that when operational, all concerns reported to the Helpdesk would be tracked on Protocol. Of course it is important to remember that the CATE Team were still denied access to the Protocol system at this stage.

3.656 A CATE Pathways meeting on 7 September 2010[619] considered a by-Cluster breakdown of CSE referrals:

North	21
Central	8
South	4
Wellington	14
Newport	0

3.657 In a CATE service update, prepared for a CATE Pathways meeting on 12 October 2010,[620] it was noted that in the seven months to September there had been 36 referrals, of whom 32 were female children.[621] There had been seven new referrals in September, including two cases from Shropshire postcodes. The total open caseload was then 37. The senior social worker who had been manager was to have a period of absence. An interim replacement had been appointed to allow the CATE Team access to Protocol, which they did not have on their own account. Further, there were to be monthly supervision sessions

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for CATE practitioners from the Safeguarding team leader. There had been interest from private providers in purchasing CATE training. The meeting was joined by substance misuse practitioners and a representative of RISQ.

3.658 As detailed in the National Landscape section for this time period, Working Together guidance was reissued in 2010 (now, "Working Together 2010"). Within this, there was a brief section on CSE and a reminder of the responsibilities contained in the 2009 Sexual Exploitation Guidance and the fact that children and young people who are sexually exploited are the victims/survivors of child sexual abuse, whose needs require careful assessment.

3.659 The model being used by the CATE Project at this time meant that children were risk assessed, but an assessment of their needs in the context of the family was not always completed, unless there were co-existing child in need/child protection plans. The risk assessment process looked at CSE concerns only.

3.660 It is hard to know whether this gap had an impact because it was never discussed in the meetings. It may have been the right decision not to undertake a full assessment for some children. The case studies I have analysed in Chapter 8: Case Studies provide a very mixed picture regarding this, where there is a sense of delay and drift in decision making regarding safeguarding. Further, the 2010 guidance is not mentioned in CATE-focused meetings.

3.661 A CATE Gold meeting on 14 March 2011[622] noted that the Care Pathway group had not met recently and the question was posed "*are we finding new victims? Is the crime carrying on*" and although the meeting underlined that if exploitation was continuing it should ensure a rapid response, it seems naïve or wishful thinking to suggest that it might have been extinguished.

3.662 The LSCB Business plan for 2011/2012[623] spoke of developing a "*service plan Phase 2 to include proposals for mainstreaming the CATE project approach*".

3.663 It noted that detailed plans would be launched in September 2011. It further spoke of a plan to use Barnardo's, though no detail was given; this proposal for third party funding was never heard of again.

3.664 There was a CATE Pathways meeting on the 5 April 2011[624]. An increase in teenage pregnancy was reported and it was suggested that it would be sensible to formalise Health Service input into the CATE process – this to be raised at the LSCB Executive. The meeting did not address the new victims/survivors point, and it was raised again at CATE Gold's next meeting,[625] which suggested:

"*… it is felt that there is this type of activity outside of the group identified but on a much lower scale; so not to the extent we have had it previously*".

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3.665 The minutes do not record who felt this, or on what basis. On 16 May, CATE Gold said again there was a need to get the prevention message into schools and tasked the "*Silver Group*" (CATE Pathways[626]) to look at it.[627]

3.666 A CATE Service update on the 6 June 2011[628] reported that in the first six months of the year CATE had received 20 referrals, all but two of them female, with an average age of 15. There were in total 30 children open to the service and ten supported as part of Chalice. There had been an increase in teenage pregnancies and it was reported that the "*issue on emergency contraception not being available on the spot is being resolved*" - though the issue was not described.[629]

3.667 At a CATE Pathways meeting on 7 June 2011[630] it was noted that an (unspecified) information sharing agreement was now in place. The development of a tool for identifying "*Chalice-type situations*" was in the hands of a WMP Superintendent, who was content with progress. CATE practitioners were to offer training to the Victim Support service. It was suggested that Axis Counselling be invited to future meetings. Notes suggest that CATE referrals were being classified by sexual exploitation type and by perpetrator status, though I have not seen that analysis. There was concern about "*GUM* [genito-urinary medicine] *data not being robust*".

3.668 The CATE Team now had a second full-time officer, but the team complained they no longer had access to Profile, the Connexions4Youth information system.[631] Nor did they have access to Protocol.

3.669 The Inquiry received the account:

"[By 2011, our relationship] *was improved … we'd started having better working relationships … with Helpdesk and with social workers."*[632]

3.670 In August 2011 it was noted at a CATE Pathways meeting that there had been a large increase in CATE referrals, an average of five per month, which was "*due to awareness*".[633] Referrals came mainly from schools but also from WMP, Safeguarding, a GP and one from a TAC meeting.

LSCB Missing Persons Subgroup

3.671 I explained at the outset of this section (covering the period 2004-2012) that one of the many Council sub-groups included one relating to missing persons – which was a LSCB sub-group.

626 [redacted]
627 [redacted]
628 [redacted]
629 [redacted], pg 2
630 [redacted]
631 [redacted]
632 [redacted] pg 78
633 [redacted]

3.672 On 16 April 2010, the LSCB Missing Persons group met, and noted that a previous Missing Persons group had been formed but had withered due to "*minimal attendance*".[634] It was impotent, having formed an action plan but seemingly had no power to implement it. Six people attended this 16 April inaugural meeting whilst ten sent apologies. It was further said to be essential that there be attendance from both Safeguarding and from an ISM in the Clusters; previously there had been neither. My sense from the 2010 meeting notes is that those present lamented the failure of the earlier group.

3.673 It was noted that, since 2009, the UK Government had classified 'Young People who go Missing' as a National Performance Indicator, identified as NI71.[635] It was noted in the meeting that this had brought focus upon the issue, there being a requirement for a quarterly response to the Government. WMP indicated that it sent daily notice of children reported missing to Safeguarding, which forwarded the notifications to social workers, the CATE Team and other services indicated on the Safeguarding records.

3.674 At the next meeting dated 10 June 2010,[636] it was suggested that an administrative officer was required to ensure that the right agencies received the information and noted that 'found' notifications were rarely forwarded by WMP. Although there were protocols, they were sparingly observed in Safeguarding; the system was *"very ad hoc"* and dependent heavily on the experience and knowledge of a single officer.[637]

3.675 There was a West Mercia group to monitor work and share best practice and a young runaways regional forum.[638]

3.676 At the LSCB Missing Persons group on 9 July 2010,[639] while administrative support was put in place from the Safeguarding Advisory Service, there was concern raised that the level of data coming in would require a dedicated administrator to deal with properly. This was to be raised at the LSCB but following the next LSCB meeting there was no advance; the minutes record that "*MISPERS are being recorded but they are not recorded as found when they return. This is an admin issue. Resource is needed for data collection and analysis*".[640]

3.677 Further, when it was questioned whether the budget was sufficient to ensure that every missing person received a Return Home Interview ("RHI"), the CATE senior social worker expressed the view that there was no requirement to interview every returner. The Inquiry was told:

"*We didn't have a formal return home interview; there wasn't a formal notification to police or process, If we became aware a child had been missing, if it was reported to us through whatever route, there'd be an expectation that you went out and you visited that child and found out whether they were reporting any concerns but that was about as far as it went*

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and it wasn't probing, as it is now. I don't think there was even the data collected or missing, either."[641]

3.678 So far as missing persons was concerned, an action plan updated in a meeting in September 2010[642] noted:

"Pan West Mercia meeting *to be convened in September by* [a Detective Inspector] *with Children's Society to consider setting up a Return Interview scheme across the four Local authorities."*

3.679 At the meeting on 9 July 2010,[643] the terms of reference were drawn up and shared around the group. The aim of the group was to help children feel safe in their community. It was agreed that the group would meet bi-monthly and that data would be fed back to the LSCB every six months.

3.680 On 15 November 2010 at the LSCB Missing Persons Group[644] a system was agreed whereby WMP would furnish the Council with information on missing children on a monthly basis – the information to include the name of the child's social worker and whether the child is in care. The members were to be circulated information relating to the children who were missing most often for discussion at future meetings – it was acknowledged that a significant number were known to Youth Offending Services and Safeguarding. There needed to be guidance on whether a CATE child going missing should be reported to WMP. Furthermore, it was not recorded on Protocol whether a child was being supported by CATE, so others – for example, emergency duty team officers – were unable to know and respond accordingly.[645]

3.681 The meeting heard that the NI71 performance indicator had been withdrawn upon a change of national government.

3.682 The NSPCC was reported to be undertaking RHIs for Shropshire; whilst Worcester was looking at involving the Children's Society with RHIs. Notwithstanding these examples, the minutes record that the Council was not going to have additional funding for RHIs and it was therefore necessary to "*look at those existing services that are involved with the client*". It was acknowledged that an independent service could carry out the RHI if the Council was blamed by the missing child for a missing episode.

3.683 Progress was slow, it seems; at the next meeting a review showed "*local procedures to support effective prevention* [of children going missing]" marked "*red*" and "*creating a comprehensive system for Return Interviews*" marked "*orange*" with the note "*cost implications*". After that there was a suggestion that the Clusters or Connexions4Youth perform RHIs.[646]

641 [redacted] pg 35
642 [redacted] pg 3
643 [redacted]
644 [redacted]
645 [redacted]
646 [redacted]

Chalice – a CSE Investigation

3.684 Chalice was WMP's most high-profile investigation into CSE in Telford. It ran for four years and culminated in the conviction of eight men in 2012. I deal in detail with this police investigation in Chapter 5: The Policing of CSE in Telford. This part of this chapter is intended to look at the role of the Council in this police operation and the impact Chalice had on the Council's response to CSE.

3.685 The significance of Chalice on public awareness of CSE cannot be overstated. A number of current and former Council employees, including social workers and senior officers within Safeguarding, have told the Inquiry that until they learnt of Chalice, they had no knowledge of CSE.[647] Other Council witnesses have told the Inquiry that it was not until Chalice that children who had been subjected to CSE were seen as victims, rather than as "*runaways*" or "*promiscuous*" children.[648] Despite this, and for reasons that I explain below, sadly I am not sure that Chalice and subsequent prosecutions and convictions had anything more than a transient impact on the Council's response to CSE.

Acknowledging the problem

3.686 On 30 August 2007, a strategy meeting was held in respect of a child, to "*discuss continued concerns of* [the child] *being subjected to sexual exploitation by men, who a*[re] *predominately from the Asian community*".[649] This child was ultimately one of the victims/survivors forming a key part of the Chalice investigation. The meeting was told of information that other children known to Safeguarding were in the same position, and four of those children were named.

3.687 It was explained to those present at the strategy meeting that the children would become a man's "*girlfriend*" and would then be "*passed around*" to have sexual intercourse with his friends. Additionally, concerns were reported that taxi drivers were offering free rides for sexual "*favours*". The meeting was told of the steps that had been taken to disrupt the exploitation by moving the children out of the area, though it was known that the men then turned their attention to other children and that the exploitation of those moved just continued in the new locations.

3.688 A WMP officer who was in attendance reported that he had:

"… *conversed with his colleagues within the Police regarding this exploitation of women and established that this has been happening for almost a decade, as these girls never make a complaint to the Police*."

3.689 The minutes report that the child remained "*unprepared to make any complaints regarding young men in Telford or Birmingham*." A referral was to be made to WMP's Public Protection Unit if the child agreed to make a formal statement.

[647] [redacted] pg 38, [redacted] pg 5, [redacted] pg 13, [redacted] pg 2, [redacted] pg15, [redacted] pg 7, [redacted] pg 13, [redacted] pg 11, [redacted] pg 42, [redacted] pg 7, [redacted], pg 6
[648] [redacted] pg 13
[649] [redacted]

3.690 A YISP worker was allocated; a family support worker was to be allocated, and a TAC meeting to be reconvened.

3.691 A Council employee present at this strategy meeting reported that:

"[The] *Safeguarding Children's Board received a report from CATE requesting funding for a role for someone to work with these young people. The Safeguarding Children's Board asked Connexions 4 Youth if there would be a role available within their services*."

3.692 An internal Council communication referenced this strategy meeting and noted that they:

"… *went on to consider a number of girls who have been associating with a group of Asian men and* [that] *it appears to be a clear example of sexual exploitation. You will remember that papers were presented to the Safeguarding Children Board by the CATE Group that highlighted this situation. There have been numerous Strategy Meetings in the past to consider various young women. One meeting was held in Birmingham because the problem had transferred there with several YPs who had been placed by us*.

The Strategy Meeting was of the opinion that this was a problem that had been increasing in the Borough over the last ten years or so. We had reacted in the past by taking legal proceedings on a number of young people and seeking placements a distance from Telford in order to break the cycle. The men then move on to target a different group of young women and the problem persists.

It was therefore proposed that the Serious Case Review Panel [("SCRP")] *be asked to convene a meeting to look at this problem at a strategic level with senior officers from a range of agencies to consider how best to react to the problem. There are concerns that all of these young women are at risk of serious harm but none are prepared to make formal statements to the Police — or indeed social Care - of what had happened and to identify the people involved. Some do not recognise the risk and to others it is exciting and brings them rewards in the term of money, telephones etc."*[650]

3.693 It is clear that there was a desire for this to be presented to and considered by the SCRP.

3.694 Replies to the email included:[651]

"[A senior Council employee] *has been trying to get this matter higher up the agenda for some time*";

3.695 On the substantive question of whether the case should go to SCRP:

"I'm not sure that the SCRP is the right forum, as that is meant to review death/serious injury and where things have possibly gone wrong with inter-agency working and where lessons need to be learnt for the future… the Senior Officers' Group could be much more practical in actually getting things done/drawing up appropriate protocols etc."

650 [redacted]
651 [redacted]

3.696 The question around the SCRP was not responded to until January 2008. This meant that the issue was not put before the SCRP in October 2007, as it should have been. In my view, this delay was unacceptable given the circumstances, and the decision not to refer it should have been challenged.

3.697 It is the Council's position that Senior Officers' Coordination group meetings were established in 2007 in response to the growing evidence of organised, coordinated sexual exploitation of children in the borough. The Council will say that the group supported the development of Chalice.[652] I have only seen limited records of these meetings.

3.698 At the first meeting of the Senior Officers' Coordination meeting held on 3 October 2007,[653] the situation in Wellington was discussed, noting that "*information from the girls is a necessity to take matters further*" and that the only way to proceed may be by using covert methods "*which would need authority from much higher in the organisation*". Reference was made to the longstanding nature of the crime locally and a suggestion made that previous victims/survivors could be approached for help as to what the agencies and professionals could do to assist the current targets. This was met with the WMP reply that previous victims/survivors had been spoken to, but that the men were now a different group, a statement upon which I have previously given my view.

3.699 In January 2009, a member of the Council's legal team whose advice was sought regarding whether the SCR criteria was met for children who were being sexually exploited, now gave the view that this did not meet the criteria set out in Working Together 2006[654], where the basis of undertaking a SCR was when a child had died or had been seriously harmed, and where there were concerns about inter-agency working. The legal team member recognised that harm had been caused to the children but questioned whether there was any evidence of poor inter-agency working. They suggested that it would be more appropriate for the issues to be discussed by the Senior Officers' Coordination group.

3.700 It is accurate to say that, at this time, the threshold of significant harm was interpreted very narrowly across LSCBs, but the assertion that there were no issues with inter-agency working had not been tested and was not known. This surely presented an ideal opportunity to explore and address this; many of the case studies reviewed by the Inquiry suggest there were concerns about inter-agency working and debates about who provided services.

Information Sharing with the Police

3.701 In Chapter 5: The Policing of CSE in Telford, I deal with the systems that were in place to share information between WMP and Safeguarding. Briefly, WMP told the Inquiry that detectives in WMP's Family Protection Unit ("FPU") would review incident logs allocated to them and in appropriate cases send a referral to Children's Social Care Referral and Assessment team. There would be a strategy discussion – usually a telephone call – or in more serious cases a strategy meeting between WMP and Safeguarding managers.

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[652] [redacted] pg 13
[653] [redacted]
[654] at Chapter Eight, paragraphs 8.5 to 8.9.

3.702 Whilst I have seen nothing from the Council to support the fact that there was a formal working arrangement in place between WMP and Safeguarding during Chalice, what is clear from the evidence is that a small number of Council employees played a significant role in feeding intelligence and information to WMP and in supporting the children, which ultimately helped lead to the successful prosecution and conviction of the Chalice defendants. I heard how the work carried out by the Council employees in feeding information to the police "*snowballed*" into identifying a group of children that were victims/survivors of the investigation which became Chalice.[655]

3.703 There was no formal sign-off or agreement from the managers as to this process.[656] A WMP officer told the Inquiry:

"[We] *started to interact with the CATE team, which…obviously they were doing it from the Council point of view. So we started to work together on that side of things. There was no formal agreements, there was no bosses' agreements, there was nothing.*"[657]

3.704 A difficulty that WMP faced, which is reflected in the strategy meeting referred to above and which is not uncommon in investigations of this nature, was to secure children's cooperation. The Inquiry has heard evidence about WMP's frustration that they did not have sufficient evidence to take the prosecutions forward sooner.[658] The children might occasionally provide information to professionals which would suggest that they were being exploited. However, as soon as this was reported to WMP or Safeguarding, the allegation would be denied. It is clear from evidence provided to the Inquiry that what WMP wanted was disclosure or hard evidence to support a prosecution, and that this was difficult to obtain; that children often do not provide evidence, they provide intelligence and describe indicators.[659]

3.705 The difficulties caused by the scarcity of disclosure from children who were being exploited was recognised by the Council in a learning review published in 2014:

"… frequently child protection enquiries were not initiated as there were no specific allegations on which to base the enquiry. On the occasions where information did enable child protection enquiries to take place either jointly with the Police or as a single agency, typically the young person did not disclose any information."[660]

3.706 The Inquiry has heard evidence that, given the sensitivity of the WMP operation, there was a degree of nervousness within the Council about sharing information about Chalice.[661] Information relevant to the WMP investigation was kept under close guard by the Council.

3.707 The Inquiry has seen emails from 2007 which record a request from WMP to view Council material relating to children potentially subject to CSE, and the Council response, which was positive.[662] Later, an information sharing request dated 19 January 2012 confirmed

655 [redacted] pg 14
656 [redacted] pg 17
657 [redacted] pg 17
658 [redacted] pg 44
659 [redacted] pg 36
660 [redacted] pg 3
661 [redacted] pg 48
662 [redacted] pg 20

that a WMP officer viewed the Protocol case records of eight individuals as part of the Chalice investigation.[663]

The Chalice arrests

3.708 The first Chalice arrests were arranged for 8 December 2009. By now, the CATE Team was co-located with WMP and I accept played a pivotal role in the ongoing investigation.[664]

3.709 The day of the arrests was referred to as a 'strike day'. WMP were arresting two principal suspects. Careful arrangements were put in place which demonstrates to me how closely WMP and the CATE Team were working together. A list of the children involved with those suspects was prepared and two interview rooms were set up in a Council office in the hope that the children would provide statements, giving the investigation the necessary evidence to pursue the perpetrators.

3.710 Social workers and health workers were brought in to support the children. After the arrests were made, WMP officers would visit the children, accompanied by a social worker, and ask them to provide an interview. Two CATE practitioners oversaw the process and were described as "*trouble shooters*".[665] The Inquiry heard about the relief felt by one Council employee by the number of children that did agree to provide statements to WMP following the arrests. She attributes this partly to the effectiveness of the arrangements for the strike day.[666]

3.711 In recognition that these events raised child protection concerns, strategy meetings for the children involved were scheduled for the following week.[667]

Gold Group

3.712 The Inquiry was told by the Council, in its Corporate Submission, that a Gold, or CATE Gold, subgroup was established in 2009, as a direct response to Chalice. It was convened by the then Chief Executive of the Council and led by WMP, involving senior managers from the Council with the CATE subgroup (still in existence it seems) sometimes being referred to as the 'Silver' group. It is a feature of policing nationally that a senior officer can convene a Gold group if a particular investigation merits senior oversight from a police perspective. WMP may invite senior members of staff from all agencies, so that information can be shared, and strategy agreed.

3.713 A CSE timeline document created by the Council[668] records that the Gold meeting was first convened in December 2009.

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664 pg 61
665 pg 1
666 pg 62
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3.714 The purpose of the Gold meeting, as reported by the Council,[669] was to develop strategy, rescue victims, disrupt prepetrators, prevent further activity and consider impact on the community, rather than to direct investigations.

3.715 The first minutes that I have seen are from a meeting that took place on 14 April 2010.[670] It was led by WMP and involved senior managers from the Council. I note that the Chair of the LSCB was not a member of the Gold group. The Inquiry has seen one Executive report dated January 2010[671] which referred to the "*joint WMP and Council press release issued in December 2009 confirming that five men had appeared in Telford Magistrates Court charged with a number of sexual offences*", and set out the Council's governance structure for dealing with CSE. Despite this, I have seen evidence, which I accept, that there was an informal policy to keep LSCB chairs "*in the dark*" as to important developments. I consider this to be significant given the key role the LSCB should have played in partnership working, and remarkable given the seriousness of Chalice.

3.716 Strategy was discussed and updates were provided from WMP. The group initially met on a monthly basis but later convened at key stages of the criminal process. I have heard evidence that, until the first Gold meeting, a number of senior officers within Safeguarding did not know about the existence or extent of Chalice.[672]

3.717 At the meeting that took place on 14 April 2010, Safeguarding officers indicated their belief that following the second phase of Chalice arrests they did "*not believe there* [was] *any at risk young women not identified*"[673] which is, if correctly minuted, startling.

3.718 There was a CATE Gold meeting on 23 November 2010.[674] It was noted that:

"*Police analyst is continuing to work through information on possible offenders and victims. Police are visiting each girl which has brought to light other young women. They are not 'new' victims but ones that have not until recently been identified…*

A Disruption strategy is being finalised, to assist in reducing crime taking place in Wellington. Proactive raids have taken place in local eateries and the UK Border Agency will carry out more of these raids and strategies."

3.719 There was evidence of appropriate liaison between the Gold group and the CATE Pathways group, particularly sharing of information across the different services.

The impact of Chalice

3.720 I have seen conflicting evidence about the impact Chalice had on the Council's response to CSE. Some Council employees have described a sense of accomplishment with the trial and convictions, and a general feeling locally that CSE had been brought to an end.[675] Others

669 [redacted]
670 [redacted]
671 [redacted]
672 [redacted] pgs 13-14, [redacted] pgs 4-5
673 [redacted]
674 [redacted]
675 [redacted] pg 19, [redacted] pg 34

have described it as the moment they finally realised that there was a problem that needed to be addressed and that this was just the beginning of the Council's continuous learning in terms of dealing with CSE cases.[676]

3.721 A number of Council witnesses have spoken about the learning that came out of Chalice. One senior social worker spoke about the impact it had on practice and how it taught them to look out for indicators, something that they did not believe social workers did before Chalice. That would certainly accord with the victim/survivor evidence the Inquiry has heard.

3.722 However the Inquiry has also heard evidence which suggests that the investigation and prosecutions raised awareness not only of CSE but also of the existence of the CATE process and that this led to increased numbers of CATE referrals. Minutes from a CATE Pathways meeting dated 2 August 2011 notes that:

"*… due to awareness there has been a large increase in referrals. The average is 5 referrals a month and the average age is 14… mainly from schools, but there have also been referrals from the Police, Social Care Team, GP and one from a TAC.*"[677]

3.723 Whilst the investigation and prosecution undoubtedly shone a spotlight on the issue of CSE in Telford, it was not the catalyst that the CATE Team so desperately needed to secure more support, funding and appropriate governance structures. Despite the welcome decision to provide a Safeguarding overview to the CATE Team and a recognition that CATE work was safeguarding business, CATE was effectively stood down and moved away from the Safeguarding structure during the Council's 2011 restructure. The planning for the CATE stand down must have taken place before the first, ultimately aborted, Chalice trial. No sooner had the Chalice investigation concluded, the decision makers at the Council felt that CATE's role was done, when nothing could be further from the truth.

Operations Alpha and Beta

3.724 In light of the number of potential victims/survivors identified during Chalice, a decision was made to spin-off two complainants' cases into standalone investigations, Operations Alpha ("Alpha") and Beta ("Beta"). I deal with these two investigations in Chapter 5: The Policing of CSE in Telford of this Report.

3.725 Alpha arose[678] when a victim/survivor of CSE was identified during the Chalice investigation in October 2010. The woman concerned was in her 20s at the time she was interviewed. On 24 August 2011, the decision was taken to close Alpha.[679] The victim/survivor told WMP that she no longer wished to pursue her complaints.

3.726 Beta involved another victim/survivor that was identified during Chalice. It led to the arrest of 15 men,[680] but the case was closed following a CPS decision in January 2014 that that

676 [redacted] pg 38, [redacted] pg 42
677 [redacted]
678 [redacted]
679 [redacted]
680 [redacted] pg 13

there was "*no realistic chance of any prosecution* [sic]*, or of passing the CPS full code test.*"[681]

3.727 Both of the victims/survivors concerned were known to Safeguarding and the CATE Team. Child protection procedures had been taken in respect of one of the victims/survivors. Despite this, I have seen no evidence to show that the Council had any significant involvement with these operations. There is brief reference in minutes of meetings relating to Chalice about the existence of the operations, and WMP updated the Council in respect of wider concerns relating to one of the victims/survivors, but the Council played no active role in the operations, which is perhaps understandable given that the victims/survivors concerned were in their 20s at the time of the operations.

The Daphne Project

Early stages of bid

3.728 In March 2009 planning for the Daphne Project bid. The Daphne Project was a European scheme aimed to develop and share expertise in the area of CSE. A "Call for Proposals for Action Grants" document, dated 2009/2010,[682] shows that the Safer and Stronger Communities Partnership ("SSCP"), coordinated the Daphne Project bid on behalf of the Council. The SSCP was made up of a wide range of public, private and voluntary agencies, with the list of partners including the Council, WMP and health services. It is noted in this document that the Daphne grant would provide up to €600,000 for the two year project, with the EU funding 75% of the total project costs. The LSCB was supportive of the proposal, which had the potential to address the shortfall in capacity in CATE work.

3.729 Minutes from an early SSCP Daphne Project stakeholder meeting dated 4 March 2010[683] show that this stakeholder group had been formed to support the development of a joint project between the Council and WMP, in response to emerging evidence that organised internal trafficking of children was evident in the local area. This group was separate from the CATE Pathways group, but with some crossover. Later that month, in another stakeholder meeting about the Daphne Project,[684] it was noted that Daphne derived from the CATE workstream and that the Safe & Sound Partnership in Derbyshire and a European MP had already expressed support for the project.

3.730 The key features of the Daphne Project were that new approaches on the exploitation of women and children at a transnational level would be developed, with partners in Italy and the Netherlands already having been identified. The overall goal of the project was to raise awareness of internal trafficking and identify the measures that could be taken to address it.

3.731 Barnardo's had previously completed similar projects, for example, a 2007 report, '*Mapping the scale of internal trafficking in the UK based on a survey of Barnardo's anti-sexual*

681 [redacted] pg 14
682 [redacted]
683 [redacted] pg 1
684 [redacted] pgs 1-2

exploitation and missing services' and a 2009 '*Whose Child Now'* report.[685] The Daphne Project aimed to take forward the lessons learned from this work, in order to build a larger mainstreaming model.[686]

3.732 A report to the Children's Trust Executive group and the CTB dated 25 March 2010[687] gave further information about the purpose of the project, summarising the benefits as follows:

"*This project supports the current workstream on CATE (Children Abused Through Exploitation). There is substantial evidence of this activity locally, and growing evidence nationally, with a number of police forces taking assertive actions against those responsible. The project beneficiaries are children and young people who are being abused in intimate partner relationships, through a process known as 'internal trafficking'. There is a significant body of knowledge and activity that can be exchanged by working on a transnational basis with partners in Europe which would have mutual benefit to partners. This will help identify resources to address these issues, and improve our response to victims by developing the pathways of support, and share learning across all partner organisations. This will help to embed best practice and support change.*"

Goals of the project

3.733 At a SSCP Daphne Project stakeholder meeting on 1 April 2010,[688] attendees were reminded that the deadline for the project was the end of the month. It was pointed out that the project could only go ahead with two partners, the Council being the lead body, with further discussion had around other possible partners such as Barnardo's and the NSPCC. The minutes show that the group was struggling to find partners and that a public authority needed to be on board. Meeting attendees were informed that endorsement of the Daphne Project and the merging with the CATE subgroup was to be requested at the Safeguarding Executive meeting later that day.

3.734 An annex to the Daphne Project grant application[689] and Daphne Project summary[690] note the goals of the project as being as follows:

3.734.1 To build on the learning from previous work in this area and apply that learning to statutory agency processes and structures, so that it can be widely applied;

3.734.2 To develop and test screening tools and training which will increase the capacity of front line workers to recognise and respond to signs of internal trafficking (either from working with victims/survivors or perpetrators);

3.734.3 To identify and publicise a range of good practice actions that can be used to safeguard children who are, or who are at risk of becoming, victims;

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686 pgs 1-2
687 pg 1
688 pgs 1-3
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3.734.4 To identify the essential components of a specialist service accommodation to enable effective reintegration of victims/survivors;

3.734.5 To develop and test a model for joint working which will enable agencies to mainstream a specialist service in an effective and sustainable way; and

3.734.6 To use national and international networks to raise awareness of internal trafficking and measures that can be taken to address it.

3.735 Beneficiaries and target groups were listed as being:

3.735.1 Beneficiaries:

- Victims of internal trafficking;
- Young people at risk of becoming victims; and
- Families and peers of victims.

3.735.2 Target groups:

- Front line workers: e.g. teachers, social workers, police officers, care home workers, youth workers, probation officers and school nurses;
- Senior officers: e.g. police officers, child protection officers, managers of care homes, head teachers; and
- Lead officers: e.g. chairs of safeguarding boards, policymakers.

3.736 A sign off document, titled '*Turning the Stone – A Transnational Proposal (Daphne Fund)*'[691] further details the goals, which appear to be closely aligned with the Council's CSE targets.

3.737 Children's Trust members were asked to endorse the outline proposals in this document, which noted that 20% match funding had already been agreed.

Funding of the Project

3.738 Details of funding are recorded in a briefing note about the Daphne Project, which is dated 2010.[692] In brief, Daphne was a source of funding made available by the EU to support projects which aim to combat violence against women and children. In order for a bid to be successful and the funding to be offered, projects had to meet certain criteria.

3.739 In summary, the Council was planning to use the Daphne funding to:

3.739.1 Research and identify best practice within the UK and in Europe;

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691 [redacted] pg 3
692 [redacted]

3.739.2 Adapt best practice to local needs;

3.739.3 Ensure that resources are deployed in the most cost effective way; and

3.739.4 Influence national debate and policy on this issue, highlighting the need for additional support.

3.740 Potential partners in the UK were noted as being Barnardo's, the UK Human Trafficking Commission, and Safe and Sound (a Derby based charity).

3.741 A 2010 draft Council report by the Head of Community Protection to Cabinet/Council members[693] details specifically what the Daphne funding would be spent on. It notes that the CATE Project had been established from within existing resources and, as such, was likely to be difficult to sustain over an extended period,[694] therefore the Daphne funding was needed. If the bid was successful, the funding would help sustain and support objectives of the CATE Project, providing additional resource in the form of a Training Coordinator and covering related administration costs. The bid would also cover new costs arising from the project (for example child engagement, developing training resources and developing Victim Support resources) plus some provision for monitoring the project.

3.742 At a CATE Gold meeting on 14 April 2010[695] it was minuted that the team had received a very positive response on raising the profile of the project and that this work would build on the Care Pathway and learning from good practice elsewhere. Also that:

"*Barnardo's have identified scope within their organisation to work as a partner and there are also strong links to the Derbyshire Project, through the work developing the Care Pathway model. A trans-national partner has been identified in Italy and there is potential to work with the Dutch police on this project.*"

3.743 It was confirmed that a formally subscribed bid on the Daphne Project would be submitted by the end of April and that the Council would be the nominated designated lead partner.

3.744 The following day, at a SSCP Daphne Project stakeholder meeting,[696] it was agreed that the project would be known as "*Stopping Internal Trafficking through Multi-Agency Partnership (SITMAP)*", with workstreams and costings discussed. It was reported that the Chief Executive had signed off the bid proposal the previous day.

3.745 A CATE Pathways meeting, held on 5 May 2010,[697] noted that the Daphne bid was of a good standard and that Barnardo's was now a full partner. With this funding it was confirmed that the project would deliver specialist training for staff whose core business was in the area.

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694 pg 2
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3.746 The bid proposal was successful. The Council was invited to work with several European cities, being awarded a significant grant on the condition of some match funding from the Council.

Withdrawal as lead partner

3.747 Ultimately the Council's involvement in Daphne did not go ahead. The Council withdrew, citing budget cuts caused by a change in government and the onset of austerity measures as the reason it would not be able to match funding after all.

3.748 At a CATE Gold meeting on 20 July 2010,[698] it was announced that Daphne would cease "*due to funding issues*", but that partners would move ahead with the key principles of the project.

3.749 These principles were listed as being:

3.749.1 An intervention model being developed where police and partner organisations share information;

3.749.2 Continuation of multi-agency working;

3.749.3 Continuation of care for the victims work;

3.749.4 Work on prevention (to be led by the Safeguarding team); and

3.749.5 Learning to be shared amongst the teams, partners and across other authorities.

3.750 There is no apparent consideration of how these principles would be pursued in the absence of Daphne funding.

3.751 Minutes of the CATE Gold meeting on 8 September 2010[699] report that the work was to be taken forward by way of small working parties for each action point, with each working party tasked with producing a briefing note to update on progress.

3.752 On 13 August 2010,[700] the Head of Community Protection advised local partners about the Daphne bid being withdrawn, indicating that there had been significant changes in the intervening period from inception of the bid through to "*the very challenging financial outlook facing public, private and third sector agencies*". It suggested that, whilst the Daphne bid required a proportionately low level of match funding from partners, the largest single contribution required was nevertheless from the Council, which would no longer support it.

3.753 A witness to the Inquiry[701] recalled that the report had been taken to cabinet just prior to the "*credit crunch*", the result of which was that Daphne "*hit the buffers with finance*". They recalled that, as a group, they were very keen that what resources they had were better

698 [redacted]
699 [redacted]
700 [redacted]
701 [redacted]

spent in-house, in maintaining the CATE Team and working locally. The witness said further that, as the resources were quite limited by that point, it was felt that the Council needed to concentrate on the problems which existed locally, rather than being part of a larger project.

3.754 The Inquiry heard other explanations for the withdrawal from the bid, with one witness[702] attributing it to a senior Council officer; another stated that it was Italy's withdrawal that stymied the process.[703]

3.755 The Inquiry also understands from a source close to the Daphne Project that:[704]

"[Several people in the Council] *were so shocked that the bid was approved by, so it was a successful bid, and then you move to a new stage. But at that point they obviously needed to take everybody in the Council with them and, because, put bluntly, when people thought about this could be very bad for Telford, because it's, what was said was because it's bringing the wrong kind of attention to Telford.* [A number of individuals] *did* [their] *best to positively reframe what* [the project was] *trying to do which is, actually, this is big and it's much, much bigger than Telford, and if you stick with it you will see that Telford might lead the way. It would be able to pilot, you could do a proof of concept."*[705]

3.756 The Inquiry heard that a conversation took place with one of the decision makers at the Council, who in essence said, "*It's because the leadership won't agree with it.*"[706]

3.757 The Inquiry further understands that a local Councillor was approached by someone close to the project in an effort to persuade the Councillor to reconsider. However, the individual felt that they were simply not heard and was of the view that the Councillor felt that Telford would be singled out for all the wrong reasons.[707]

3.758 As to the argument the Council could not afford the Daphne bid, evidence suggests that no actual money needed to be spent by the Council. Hours spent by existing staff attending Daphne-funded training could count to the Council's contribution.[708] In this way the Daphne scheme:

"[would] *not have cost Telford & Wrekin Council a bean, a penny…* [an individual felt that the Council] *did not want attention, negative attention, brought. Which was ironic, because… a year later when… Operation Chalice… really got going and people were appearing before the crown courts… that was front page news for all the wrong reasons.*"[709]

3.759 The Inquiry heard that:

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702 [redacted] pg 53
703 [redacted] pg 32
704 [redacted]
705 [redacted] pg 11
706 [redacted] pg 12
707 [redacted] pg 13
708 [redacted] pg 14
709 [redacted] pg 15

"… *on both accounts, the racism and the money, both of which in my view, were easily put to bed… the bottom line was… that they did not want attention, negative attention, brought*."[710]

3.760 The Inquiry heard a different perspective again from a Council officer at the time, that the Conservative administration at the time of this bid was intensely sensitive about European projects. This may not have been entirely ideological, but perhaps also based on perceptions of the previous administration and a desire to draw a distinction:

"*One of the things that Labour did a lot* [pre-Conservative administration] *was get involved in European projects which sometimes involved… how can I put this subtly? Trips for officers and Councillors to go to other parts of Europe. All good worthy projects, but they weren't in Telford at certain times, shall we say. And there were perceptions from the Conservative administration coming in that actually people were having jollies. I remember one of the groups, one project I do remember because it made me smile at the time,... was called Med-Urbs and it was about urban authorities in Europe who were, it won't surprise you to know, by the Mediterranean. Didn't immediately see the synergies and linkages and opportunities for Telford in that…*

When the Conservatives came in, the previous labour leader had been flying the European Union flag which was seen as hugely controversial, so the Conservatives came in and took that down, to fly the Union, more Union Jacks. European projects actually, never mind what they're about, we're not doing more European projects."[711]

Continuation of the bid

3.761 Some months later, a further CATE Gold meeting was held, on 14 March 2011,[712] and Daphne was again discussed. The group was informed that, having withdrawn as the lead partner, the Council had resurrected this work and was working with the rest of the partnership to find an alternative lead. In the meantime the budget had been revised, with all activities relating to being lead partner stripped out. This left a grant of approximately €65,000, with the project start date hoped to be in April 2011.

3.762 Partners, including WMP and Barnardo's, were emailed on 7 June 2011 with an invite to a 'kick off' meeting for the project.[713] It was noted in the email that the final word on the Grant Agreement was still being awaited, but that all that remained to be done was just "*'formality' and not substantial*". The formal starting date was scheduled to be either 1 or 10 June 2011.

3.763 It was shared in a CATE Gold meeting on 20 June 2011[714] that 'SITEMAP' (an acronym for Stopping Internal Trafficking and Exploitation through Multi-Agency Partnership), previously titled SITMAP, would be launched internally on 22 July 2011.

710 [redacted] pg 15
711 [redacted] pg 40
712 [redacted]
713 [redacted]
714 [redacted]

3.764 However, the LSCB Business Plan 2011-12 Quarter 1 monitoring report (April – June 2011) notes there is uncertainty about whether the Daphne Project is going ahead,[715] and the LSCB Business Plan 2011-12 Quarter 2 monitoring report (July – September 2011) notes that all action points relating to the Daphne Project are now on hold.[716]

3.765 In June 2011, however, it was confirmed that the CATE Pathways group would be the subgroup for the Daphne Project,[717] and in a CATE Pathways meeting on 2 August 2011,[718] a further update was given about the Daphne Project, as follows:

"*Daphne was due to start in Italy with partners presenting their project with stakeholders. However, Commission have done a U-turn on the decision. After consultation with SMT we are not in a position capacity wise to carry on with this project and will look at re-visiting the objectives with key partners.*"

3.766 A report dated 15 September 2011[719] updated the Senior Management Team on the current situation with the Daphne/SITEMAP Project and the EU Commission's request that the Council retain the lead. The report sought approval from the Senior Management Team as to whether more resources should be committed to rework the project with the EU Commission, and thereby enable the Council to reclaim its original planned status as lead partner. The report stated that the project was due to be delivered by a number of UK and EU partners over two years and that the total budgeted expenditure for the life of the project was anticipated to be €455,283; 80% or €364,097 of this anticipated expenditure would be funded from the EU bid, with the balance of €91,816 coming from the existing resources of the partners.

3.767 It was noted that:

"… *due to the nature of the bid the EU Commission is insisting that the lead partner must be Telford and Wrekin Council. This therefore means that we will continue to be responsible for the ongoing monitoring and the total bid, regardless of which partner is due to deliver. Given resource constraints and funding cuts it was previously decided that this would tie up resources far in excess of our element of the award and we therefore tried to reallocate these responsibilities to another party* [–] *this has proved unsuccessful.*"

3.768 The resulting recommendation was that the resource constraints remained the same as they were when the original decision to withdraw from being the lead partner was made. The request from the EU Commission was not deemed to be feasible, due to the existing resources that were available.

3.769 Amongst the reasons given, it stated:

[715] [redacted] pg 7
[716] [redacted] pgs 4-6
[717] [redacted]
[718] [redacted]
[719] [redacted]

"… the risks relating to delivering the project far outweigh the benefits and opportunities it will bring. The majority of the project activities are currently being delivered through the work of the CATE group, however the transnational learning is the only identifiable gap."

3.770 At a CATE Pathways meeting on 12 October 2011,[720] the group was informed that it had been formally agreed that the Council was no longer going ahead with Daphne and that the EU Commission had been advised of the Council's decision to withdraw as the lead partner. The actions which were to be part of Daphne were scheduled be picked up as an agenda item at the next meeting.

3.771 Two days later, the LSCB meeting was held[721] and attendees discussed the fact that funding from Daphne was no longer available, as the Council was no longer willing to be the lead. Minutes note that the group considered how to achieve some of the objectives without the funding.

3.772 On 9 December 2011, at a CATE Pathways meeting,[722] delivery of the services which would have been delivered in Daphne were further discussed. It was noted that local partnership organisations had been asked what part of the project they could still deliver but that no one had yet come back on this. An action/continuation plan was to be circulated to the group, to be populated and returned, with the expectation that this stated action plan would be used to develop this work.

3.773 The action was surely that no one involved in the action/continuation plan had any real belief that there would be any further action or that the project would continue. For the Council – though not for the other partners that had been involved, who presumably reaped the anticipated benefits – Project Daphne was over.

3.774 As I have set out, the Inquiry heard a number of explanations as to why the Daphne bid was discontinued. While I am not able to come to a settled conclusion as to which of those accounts is correct, I do nevertheless accept the detailed evidence the Inquiry has heard as to the actual costs to the Council. As a result I am firmly of the view that this was a missed opportunity which had the potential to provide much needed funding for the CATE Team. It must have been very disappointing for all those involved who had put a great deal of work into this project and had high hopes about how this could improve the strategic response to CSE locally.

The CATE Pathway

The Development of the CATE Pathway

3.775 I have heard expert evidence, which I accept, that there has been considerable concern nationally about the extent to which the safeguarding system in place since the 1989 Act (and outlined within various iterations of *Working Together*) meets the need of children subject to significant harm from those outside their family environment.

720 [redacted]
721 [redacted]
722 [redacted] pg 3

3.776 I further heard that this has led to the development of different arrangements across the country to address this issue. In some areas the existing statutory safeguarding procedures have been used, in others a contextual safeguarding approach has been adopted and yet in others there have also been individual arrangements.

3.777 In Telford, a system of working was developed by the CATE Project (later Team) which was intended as an alternative to statutory safeguarding procedures. I understand that the approach was drawn from examples of schemes in other local authority areas. The evidence shows that it was developed as a result of the orthodox view within Safeguarding being that the traditional child protection statutory response was not regarded as an effective model for CSE.

3.778 The rationale seems to have been that, notwithstanding that CSE plainly has always had the potential (and in my view likelihood) to cause a child significant harm, it appears that the assessment of whether a child was likely to suffer serious harm, and therefore whether intervention was necessary, depended upon whether children's families were regarded as incapable of offering them appropriate support.

3.779 The view – which I regard as unnecessarily restrictive - was not universally held; one Council witness who was dealing with victims/survivors of CSE told the Inquiry about a sense of frustration and helplessness that CSE did not fit into the usual Safeguarding structure.[723] The witness could not understand the reluctance on the part of social workers to instigate section 47 enquiries and, I heard, pushed for child protection procedures to be put in place to protect some of the victims/survivors.

3.780 I heard evidence that where there was a safeguarding response, it was so focused on parents' actions and failures that the parents - who had often tried their best to protect their children - felt marginalised and even blamed.[724] Another witness described traditional child protection procedures as "*oppressive*" to the families.[725]

3.781 I have been reminded by the Inquiry's social care expert that child protection procedures do not have to be oppressive; it is the manner of implementation that determines whether they have that effect. The Inquiry has not seen evidence that there was reflection on whether formal child protection procedures could have been implemented in a less critical way. Having heard evidence of how parents often felt that they were being held solely responsible for their child's exploitation, despite the fact that they were often utterly powerless in the situation and desperately trying to protect their child,[726] I find it disturbing that a more sensitive approach was not taken to the application of the statutory process.

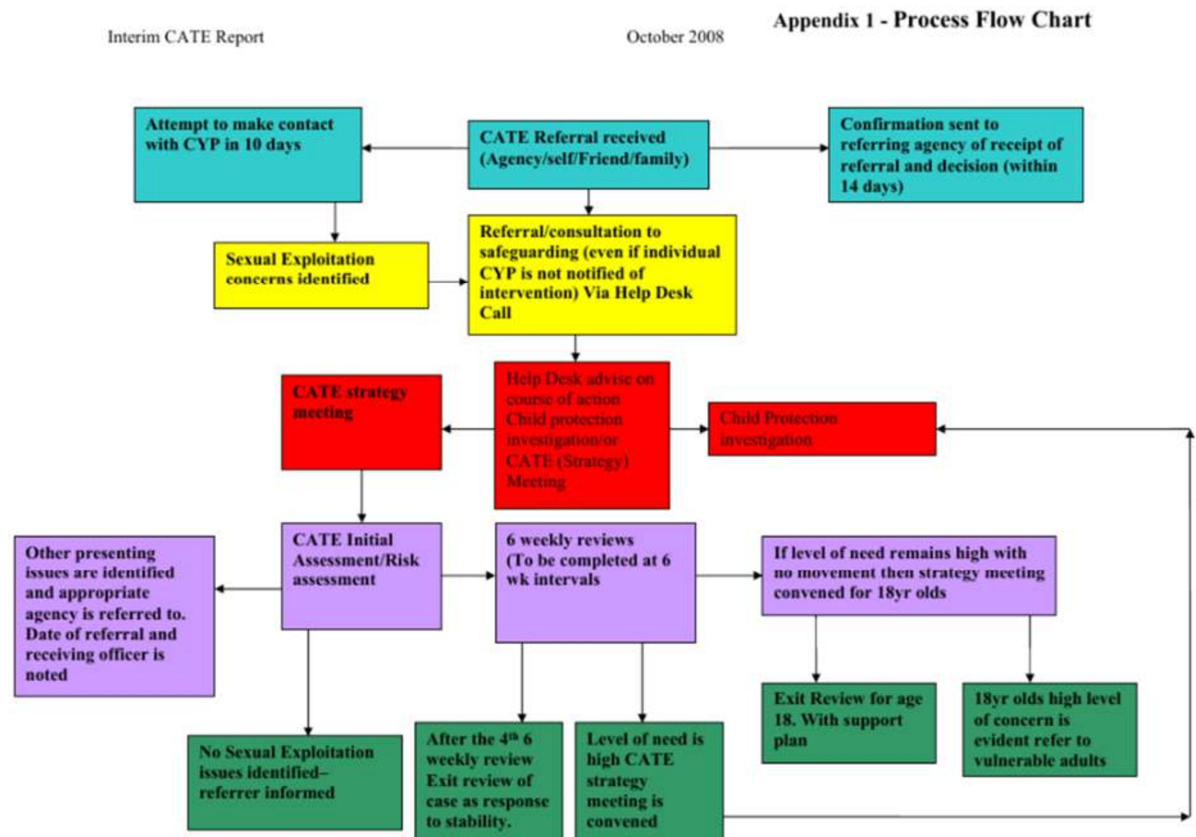
3.782 I have also heard evidence to suggest a powerful local belief that a safeguarding response was inappropriate because children were reluctant to talk to social workers, regarding them as authority figures. This, of course, overlooks that while a child may have that view, the reality is that a youth worker has the same duties of disclosure in the event of suspected risk to a child's safety as a social worker, teacher or police officer.

723 [redacted] pg 27
724 [redacted] pg 18
725 [redacted] pg 18
726 [redacted] pg 30

3.783 A senior Safeguarding officer told me that the statutory child protection procedures were also not always being followed in respect of victims/survivors of CSE because children did not see themselves as victims and would therefore disengage from social workers.[727] Of course, it is for the Council to determine whether to pursue safeguarding procedures based on its assessment of risk of serious harm: it is not dependent upon child consent or engagement.

3.784 In the event, it is plain that the statutory procedures were regarded as inapt in cases of CSE and that this led to the CATE Team developing its own measures. The genesis of the scheme through the *ad hoc* work of the CATE Team appears in a CATE report dated October 2008[728],which sets out the "*CATE Processes*" whereby the CATE practitioner would complete an initial assessment to identify the child's individual needs and risk before moving towards achieving a positive outcome for the individuals through intervention:

Figure 3A:[729]



3.785 As with references to the CATE group itself, the scheme or "*pathway*" has been referred to variously as the 'CATE Care Pathway', the 'CSE Care Pathway' and the 'CATE Pathway' – all of which refer to the process outlined above. It has also more recently been referred to as

727 [redacted] pg 10
728 [redacted]
729 [redacted] pg 10

the 'Child Exploitation Care & Support Pathway'. For the purpose of my Report, however, I will refer to the pathway as the CATE Pathway.

3.786 The CATE Pathway formalised criteria for when victims of CSE should move through the CATE Pathway and when they should be subject to child protection procedures. Those criteria were if a child was aged 13 or under, or their parents were either implicated in the CSE or had knowingly failed to prevent the harm.

3.787 The Council describes the CATE Pathway as offering a "*more supportive*" approach to parents when there are no concerns about their parenting abilities, their collusion or lack of action regarding CSE.[730]

3.788 These criteria reinforce that parental behaviour will (save for very young children) determine whether there is a safeguarding response. I pause to note again that statute (and *Working Together*) suggests that this question should be determined by a consideration of risk of serious harm, and that it will not be in every case that the statutory question is answered by the behaviour of parents. The new scheme, as formalised, deviates away from the usual child protection statutory duties under section 47 and represents an entirely separate response from the statutory one, and the evidence I have seen tends to reinforce this, particularly as the decision as to whether children were dealt with statutorily or non-statutorily was not made by trained social workers, and the CATE Team began to generate its own cohort of child service users.

3.789 As to its operation, the CATE Pathway introduced a new process for those who met its criteria. The approach was described as multi-agency and intended to disrupt and eradicate potential CSE risks.

3.790 A referral form was developed and circulated to key agencies including schools, training providers, WMP, housing, Connexions4Youth, the PCT and Safeguarding. It was apparently intended that all referrals to the CATE Project followed a protocol where CATE staff liaised with the Safeguarding Team's Helpdesk. However, the witness evidence that I have heard suggests that there was separation between the intention and actuality with a lack of structure around the referral process as referrals and new cases continuing to be picked up directly by the CATE Team.[731] Furthermore, as can be seen in the diagram above, the child protection investigation route does not link with the existing statutory pathway, but rather loops back round to CATE. The CATE strategy meeting is not distinguished from a child protection strategy meeting under *Working Together*; nor is the CATE Initial Assessment distinguished from statutory Initial Assessments. These are different processes. It is not clear to me that anyone in the Council had a clear understanding of the intended interaction between the Safeguarding and CATE Pathways.

3.791 Furthermore I have heard expert evidence, which I accept, that the intended method of operation of the CATE Pathway was to give children the tools to make themselves safe, rather than actively to safeguard them through intervention – although I have read of acts of conspicuous selflessness and even bravery on the part of early CATE practitioners in protecting children, this was not the statutory model response. No doubt this was as a

[730] [redacted] pg 12
[731] [redacted] pg 15

result of the CATE practitioners, who developed the scheme, being trained essentially in youth work rather than as social workers; and whilst helping a child to help themselves has a place in youth work, the essence of safeguarding is understanding and mitigating risks to children. This element was missing from the CATE Pathway from the beginning.

Governance of the CATE Pathway

3.792 I understand from the evidence that around the time of Chalice, a senior Safeguarding officer noticed that the statutory child protection procedures, as detailed in Working Together 2006, were not always being followed in respect of victims of CSE. As to a possible reason for this, I understand that it was often the case that children did not see themselves as victims and would therefore disengage from the formal statutory procedures, leaving them without any form of support.[732] Of course, it is for the Council to determine whether to pursue safeguarding procedures based on its assessment of risk of serious harm: it is not dependent upon child consent or engagement.

3.793 Whilst the officer understood the rationale behind this new approach for dealing with some (not all, the data collected from 2013 suggests around a 50:50 split[733]) victims/survivors of CSE, they were concerned at the time that no clear policy or procedure had been formally agreed and signed off by the LSCB.

3.794 The CATE Pathway was to be overseen by the CATE Care Pathway Group.[734]

3.795 I have seen the terms of reference for this group, apparently dated 2009.[735] Its described purpose was "*to develop and oversee the implementation of an agreed model of protection and support for young people identified through the CATE project.*" Members included employees from the Council and WMP. The Inquiry has seen no evidence, though, that the CATE practitioners were involved in the CATE Care Pathway group. This is a further example of strategic groups being separated from ground level experiences and indeed from those who had developed the scheme and could rationalise and explain their choices.

3.796 The documents that I have seen suggest that the group reported to the Gold Strategic Management group.[736]

3.797 The Council has not confirmed when the CATE Care Pathway group was established, but based on the evidence the Inquiry has seen, it is unlikely to have been before October 2009.[737] The Inquiry understands that this group was convened prior to the Chalice "*Strike day*", which was in December 2009.[738] An agenda for a meeting dated 13 November 2009[739] refers to there being "*draft terms of reference*" suggesting that this could have been the first meeting.

732 pg 10
733 pg 54
734 pg 10
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736
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738 pg 57
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3.798 To add to the confusion, the Council claims in its Corporate Submission that in 2009 the CATE Pathway group merged with the CATE subgroup of the LSCB and formed the new CATE Care Pathway.[740] However, in the minutes from 2009 to 2014, the title CATE Pathway*s* group is used. Having considered the use of both terms on the same day in November 2009, I conclude simply that the terminology had not been finalised. For the purpose of my analysis here, I will refer to the group as the CATE Care Pathway group.

3.799 I understand from witness evidence that the CATE Care Pathway group was initially set up to ensure that there was proper supervision and support arrangements in place for CATE and that there was proper safety planning for the families and the children.[741] I question the use of the word "*Pathway*" for this group, whatever its function, given the scope for confusion with the CATE referral process.

3.800 The Inquiry has seen documents which suggest the group was regarded as having improved the governance around the CSE Care Pathway, including the use of shared language, training, reporting on performance and robust policies and procedures.[742]

3.801 The CATE Care Pathway group later became a subgroup for the LSCB as proposed in a report to the Executive of the LSCB dated 21 December 2009.[743] The report proposed that "*the current CATE Care Pathway group becomes the sub group of the Board, replacing the existing group.*"

3.802 In 2012 the CATE Pathway was said to involve representatives from TYS, the Public Protection Unit of WMP, and Safeguarding. There were operational leads from each agency providing direct support, a manager overseeing the Pathway from each agency and a strategic lead from each agency; however it is simply not clear to me how these different layers of direct work, managerial oversight and strategic planning came together to plan or how the Pathway representatives had expanded so significantly.

Ofsted Inspection - 2010

3.803 Between 18 and 19 May 2010 inspections were conducted as part of Ofsted's annual unannounced inspection of contact referral and assessment arrangements within Safeguarding.[744] The inspection sampled the quality and effectiveness of contact, referral and assessment arrangements and their impact on minimising any child abuse and neglect. Inspectors considered a range of evidence, including: electronic case records; supervision files and notes; observation of social workers and senior practitioners undertaking referral and assessment duties; and other information provided by staff and managers. Inspectors also spoke to a range of staff including managers, social workers, other practitioners and administrative staff. The strengths identified included:

3.803.1 Effective working relationships were also in evidence with schools in the TAC processes;

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740 [redacted] pg 16
741 [redacted] pg 58
742 [redacted] pg 12
743 [redacted]
744 [redacted]

3.803.2 The use of the CAF was well established and evidenced by high quality CAF assessments and plans;

3.803.3 The LSCB promoted effective partnership working across the borough to address the safeguarding needs of local children. For example, a multi-agency initiative had been developed to provide a comprehensive service to support children who had become victims of sexual exploitation and those at risk of becoming victims; and

3.803.4 Senior managers had a good understanding of the performance of the Safeguarding team and were committed to improving practice.

3.804 Areas for development included:

3.804.1 Screening systems for contacts and referrals were not sufficiently robust. In some Children In Need cases, decision making was not made within set timescales and previous history or wider contextual issues were not always taken into account. This potentially placed some children at risk. The Council was aware of this and plans were put in place to improve practice;

3.804.2 Social worker capacity was limited and caseloads were generally high;

3.804.3 The quality of assessments was variable. In many cases, robust analysis of factors impacting on the wellbeing of the child was limited. In child protection cases, risk assessments were generally satisfactory but in child in need cases, they were insufficiently rigorous; and

3.804.4 The majority of case recording of contacts with children and families and other professions were not up to date.

3.805 It is notable that these concerns identified were essentially the same as those raised in the damning report of 2001.

3.806 Between 23 and 24 March 2011 the next annual unannounced inspection of contact, referral and assessment arrangements within Safeguarding was conducted by Ofsted. This was an inspection of contact, referral and assessment ("CRA") arrangements for children in need and children who may be in need of protection. The Inquiry understand that these were short tariff inspections, conducted by two inspectors over only two days, the purpose of which was to assess the effectiveness of front-line practice in managing potential risks to children and young people and minimising the incidence of abuse and neglect. CRA inspections were not an audit of every case coming into the front door, or of wider activity within the local authority.[745] There were very positive comments about the Council's approach to protecting children at risk of CSE:

745 [redacted]

"*The authority operated an innovative and effective multi-agency approach to protecting children at risk of sexual exploitation which was recognised nationally as a practice leader in this area*."

3.807 Although it is important to consider these comments in the context of what was known about CSE at the time. The report also noted that the use of the CAF and TAC approach was well established and there was a good range of family support services which meant that many children and young people were appropriately supported without the need for specialist Safeguarding services. I note that the inspection made no reference or comment about the 2009 Sexual Exploitation Guidance, which saw children subject to or at risk of CSE being assessed using the Assessment Framework and decision made about child in need or child protection. Ofsted made no reference to the fact that the Council's guidance '*Pathway for Responding to Children Abused through Sexual Exploitation*' (now called the '*CSE Care & Support Pathway'*) was not compliant with this 2009 Sexual Exploitation Guidance.

3.808 Again, the use of the CAF and TAC approach was well established and there was a good range of family support services. This meant many children were appropriately supported without the need for specialist Safeguarding services.

3.809 However, areas for development included supervision of files which were seen to be of poor quality and the issue of supervision processes not being subject to consistent auditing.

3.810 This report was disappointingly brief; nevertheless there were obvious points (re)raised which had remained unaddressed for years, and supervision was clearly shown to be sub-par.

A Council restructure: 'One Council, One Team, One Vision'

3.811 In 2010, the Council commenced a restructuring programme for the whole of the organisation titled "*One Council, One Team, One Vision*".[746] As part of this programme, a review of Safeguarding was carried out. There is a paucity of documents from this period, but the Council's Corporate Submission claims that this programme was designed to improve the efficiency and effectiveness of the organisation as a whole.

The Review

3.812 The LSCB had been informed that the Chief Executive had ordered a review of Children's and Adult Services and Education, to be completed by the end of the year.

3.813 The review led to consideration of restructuring, the purpose of which was to "*fundamentally change how it* [the Council] *works and deliver £126m in savings*";[747] £18.4 million in savings were predicted by 2013/2014.[748]

[746] [redacted]
[747] [redacted] pg 25
[748] [redacted] pg 52

3.814 I have seen a document headed "*Review of Services for Adult Social Care and Children, Families & Schools*" dated 12 January 2011.[749] It was marked "*Confidential*". The Executive Summary spoke of the Council having:

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

3.815 The document went on to deal with a number of the things that, presumably, 'mattered most' (my words); it dealt, for example, with "*silo working*" including disconnect between Safeguarding and the Clusters, the overly complex CAF system, the incompatibility of information technology systems, the under-use of the voluntary sector;[750] yet there was not a single mention of the CATE Team, of CSE, or of exploitation.

3.816 Some of the views most frequently raised by Safeguarding employees were apparently:

3.816.1 Workload was too heavy and lack of capacity;

3.816.2 Poor or inconsistent communication;

3.816.3 Lack of funding or funding constraints;

3.816.4 Lack of vision/direction;

3.816.5 Lack of planning due to uncertainty over future;

3.816.6 Lack of understanding of roles (within and between teams and also for people outside of services);

3.816.7 Too many managers and too little autonomy for front-line staff;

3.816.8 Too many meetings and meetings badly-run; and

3.816.9 Lack of recognition and appreciation.

3.817 The review continued:

"*Through all of these proposals, we will make savings and reduce current levels of spending. We have no choice but to do this. However, by many of the changes that we are proposing, we will be able to achieve a significant amount of this through efficiencies and realising economies of scale. We are also confident that many of these proposed changes to service delivery will result in more effective models of service provision that will improve outcomes and life experiences for the most vulnerable young and adult members of our community.*"

3.818 The workload of social workers was of particular concern given:

749 [redacted]
750 [redacted] pg 17

"Inadequate triage *of cases across the service lead*[s] *to too many inappropriate cases being accepted and passed on from the Safeguarding Helpdesk to social workers ... social workers spend most of their time on either legal care proceedings or transferring children back to the clusters rather than offering intensive support."*

3.819 As a result there would be a new service, 'Community Cohesion', to "*bring together a range of services offering intensive support for children, young people and families with the most complex needs*". It stated that youth workers:

"… *will deliver a range of activities for all young people aged 13-19 and those up to 25 with learning difficulties and disabilities. Activities will vary from area to area but could include youth clubs or arts and sports projects. Youth workers will be focused on early intervention; identifying, assessing and helping young people who are just starting to need extra support, for example around bullying, domestic violence or general 'adolescent' concerns. This early 'screening' of need will allow those young people that have more complex or specific needs to be referred at the right time to the Targeted Youth Support Team."*

3.820 CATE was at this stage part of Safeguarding, as I have noted. The review document said of Safeguarding:

"Because of the vulnerability of the children involved and the increasing pressures on these services (see Section 2.3 'Issues & Challenges'), our priority is to maintain a safe service. Therefore, we are not proposing to make major changes to most of the organisational structure of the Children's Safeguarding service at this stage, although there will be some relocation of resources between teams to manage workloads."

3.821 A senior Council official told the Inquiry:

"*'One Council, One Team, One Vision' was about stripping out some of the infrastructure that allowed these services to operate as separate departments. So actually we all started to look at the same information in the same way, we used to have departments with HR support, finance support, their own planning teams, their own performance teams, they were able to operate as separate organisations and obviously that took a huge amount of cost away from the frontline delivery… I said to* [a senior official in Safeguarding] *it appeared to me that someone had passed them the screaming baby that was Children's safeguarding and then everyone had run in the opposite direction."*[751]

3.822 The "*screaming baby*" characterisation was elaborated:

"*Children's safeguarding was the poor relation in that department... It was never going to have kudos was it? But it never had the vision and aspiration. It was kind of off to one side, was my perception."*

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[751] [redacted] pg 14

Implementation

3.823 The LSCB Executive noted on 4 November 2010 that the reorganisation was proceeding, by Heads of Service being appointed. Social worker recruitment and retention was on the agenda, with one contributor musing that:

3.824 "*… an analysis is needed of why Telford & Wrekin do not retain Social Workers and why a lot of people with a Social Worker qualification do not want to work in here, as otherwise we will not know how to retain them.*"[752]

3.825 As to social worker recruitment and retention, it was recorded in minutes dated December 2010 "*some of the incentives that were being done to address this are no longer current*".[753] Presumably this demonstrates that when jobs are made less attractive fewer people want to do them.

3.826 At the LSCB Executive on the 16 December 2010[754], the Chair of the LSCB indicated that he had expressed his concerns to the Chief Executive about structural proposals.[755] His letter says:

"*The proposed structure… appears to show services for children and families in four different service delivery units. This in my opinion will lead to a fragmented service for children and families and could lead to increased risks for children who are vulnerable and at risk of significant harm.*"

3.827 The response[756] came:

"*You express concern that my proposals will lead to a fragmented service for children and families and could lead to increased risks. I categorically refute this. You express concern that my proposals show services for* children *and families in four different service areas. Services for children and families in the current structure are already delivered through at least four different service areas so I do not see my proposals as increasing risk at all*."

3.828 It continued:

"I have to say that there appears an unwritten implication in your letter that the arrangements of the present, or should I say the recent past are all working well and no need for change. Through the service review that we are undertaking, we have held workshops for all employees in those service areas and met with all Heads of Service and Service Delivery Managers. Through this we have identified many ways in which services can be improved…."

3.829 The Inquiry heard from a senior Council officer that the reality was that no one had thought to consult the LSCB on the changes being proposed:

752 [redacted]
753 [redacted]
754 [redacted]
755 [redacted]
756 [redacted] pg 4

"… *that was an error and oversight on our part, not done with any malice whatsoever. It was simply, you know we saw what we thought would be a really important thing to improve, how we could improve it and that's what we were trying to do, but I think the reflection I had was actually, the Safeguarding Board didn't seem to be anywhere. It didn't seem to have a profile… we never consulted him, we never thought about it in all honesty.*"[757]

3.830 It is worth reflecting that by this stage the LSCB had not been consulted on or briefed about initial CATE Team creation or major reorganisations. So far as the Council was concerned, it appears to have been irrelevant.

3.831 The LSCB did consider the reorganisation on 26 January 2011[758] and noted in respect of the reorganisation that while previously the Safeguarding team undertook all child protection and child in need work, henceforth a Child Protection team would purely undertake section 47 investigations on referral from the Helpdesk. In addition, a Community Social Work team was to be formed, including social workers from Safeguarding, to undertake the child in need work. The Community Social Work team's focus was to be on preventing children becoming child protection cases and also act as consultant to the Clusters.

3.832 An organogram accompanying a document headed "*Improving Safeguarding*" did not include the CATE Team[759] though I have heard evidence that CATE was at this time to be regarded as part of the Community Social Work team.[760]

3.833 On 19 May 2011 the LSCB Executive confirmed 'Phase 2' of the restructuring, pending agreement by a change of political leadership in the Council.[761]

The CATE Team and Cohesion

3.834 A key outcome of the restructure was the establishment of Cohesion Services. The Council's Corporate Submission explains Cohesion in this way:[762]

"… *this new service brought together a range of services to children, young people and families including:*

- *Family Intervention Team*
- *Targeted Youth Support*
- *Family Intervention Officer (resettlement)*
- *CSE*

757 [redacted] pgs 23-25
758 [redacted]
759 [redacted]
760 [redacted] pg 23
761 [redacted]
762 [redacted]

- *MISPERS* [terminology for Missing Persons]
- *Homelessness*
- *Community Safety*
- *Youth Innovation."*

3.835 Cohesion is further described as "*built on the Targeted Youth Support model*". A report commissioned by the Department of Children Schools and Families in October 2008 describes the TYS model as follows:

"*Targeted Youth Support (TYS) is an initiative aimed at vulnerable young people and involves ensuring that agencies work together to meet young people's needs. The initiative's rationale is that a collaborative, "joined-up" approach is needed because young people may have complex and multiple needs which cannot be met by mainstream or specialist services in isolation."*[763]

3.836 It was suggested in evidence to the Inquiry that the TYS model was a cost-saving exercise:

"*One of the things to go in my days in Cohesion was the youth service in essence. I think it was probably, I'm not saying it was a quick win, I'm sure there was plenty of thought but it was a very generic, expensive service. I think what they did then was provide this Targeted Youth Service."*[764]

3.837 In advance of consultation, a proposed restructure chart was promulgated.[765] A copy of this chart appears at Appendix E to my Report. CATE was to sit under the umbrella of Family and Community services, rather than Safeguarding as before. Clusters were to be reduced from five to three.[766]

3.838 On 18 October 2011, the Phase 2 restructure proposals were publicly launched for consultation.[767] The Inquiry understands that Safeguarding was not required to make any social worker staff savings.[768] So far as CATE was concerned, on the other hand, there was a proposal:

"To mainstream the support offered by the Children Abused Though Exploitation (CATE) project staff ensuring that the right help or intervention is offered in a timely way. It is proposed that:

New referrals will be triaged through the Safeguarding Duty Team with advice from the Safeguarding Advisory Service (SAS) regarding the most complex cases

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[763] https://eppi.ioe.ac.uk/cms/Portals/0/PDF%20reviews%20and%20summaries
[764] [redacted] pg 18
[765] [redacted]
[766] [redacted] pg 5
[767] [redacted]
[768] [redacted] pg 26

The responsibility to chair strategy meetings will be split between the Safeguarding Duty Team Leader (TL) and the TL for Conferencing and Review Unit (CRU).

Support for children affected through sexual exploitation will be delivered through the Cohesion Team."[769]

3.839 I have underlined the last of these as it is the most significant change: it amounted to a dismantling of the existing team:

"*In short these amount to transferring the responsibility for leading on CATE from Family intervention to Targeted Youth."*[770]

3.840 Evidence provided to the Inquiry is that:

"[Cohesion] *was actually not really an intervention, it was between prevention and low level safeguarding and raising awareness."*[771]

3.841 It is clear from the restructure chart that the CATE Team was not envisaged in the new Council structure. The CATE practitioners were expected to apply for a family support worker role, which would essentially have been a demotion. I heard that the restructure reflected director-level thinking, rather than delivery manager thinking. They had a view that they could *"mainstream"* into existing services. I heard that this would have diluted the service offered by the CATE Team.[772]

3.842 I heard that "*mainstreaming*" meant "*… the plan was they were going to train everyone to do CSE".* [773]

3.843 A CATE officer wrote to a senior manager in late 2011:

"*How does the structure propose to retain specialist skills re: CATE, I am unable to apply for one of the cohesion family support worker jobs as it is below my scale, it does not recognise my qualifications… it would not be financially viable for me to do so. I was advised by personnel that I would not be expected to apply for a job that is below the S02 scale.*

As I am currently unable to apply for the jobs that are linked to direct work with sexually exploited children and young people then this would be detrimental to those young people that have been case worked by CATE Workers for over three years. What will happen to the young people involved in the trial, this is not due to happen until June 2012. It was suggested that for consistency social workers who move into the new team would retain their cases what about CATE young people?

If mainstreamed as a part of the cohesion family support workers role the co-ordination of the CATE care pathway and CSE Strategy meetings would be extremely difficult, would all of these workers be expected to undertake the CATE risk assessment? Would these workers

[769] [redacted] pgs 14-15
[770] [redacted]
[771] [redacted] pg 19
[772] [redacted] pg 79
[773] [redacted] pg 59

be expected to work directly with the victims of CSE and the family? Children abused through sexual exploitation are often isolated and excluded from their family unit due to the nature of the grooming process. If a worker is directly working with the child and the parents this could be detrimental in building trust with the young person. I have seen this first hand through my early days helping to develop the CATE project."[774]

3.844 This reply was suggested:

"It is accepted that the CATE work may focus on providing support to the victim only and that there may be occasions when joint working initiatives maybe required to further support additional needs within the family. However, the skills of the CATE worker should incorporate a holistic insight and understanding of family and community dynamics, therefore being objective so as to contribute to any assessment processes with a view of ensuring the right support is being made available at the right time. Cohesion services are aimed at breaking the cycle and raising aspirations in families and children and young people. We are developing the Co-operative Youth Offer, which is a 3-tiered approach to providing provision for young people that will help ensure that the right provision is delivered to the right young people in the right place at the right time."[775]

3.845 This response says, in many words, absolutely nothing. The central point about loss of expertise is not addressed. Furthermore, the analysis of "*breaking the cycle*" focuses again on steps that can be taken by a child, rather than on managing risk presented by addressing perpetrator behaviour, showing again the essential difference between a youth and safeguarding approach.

3.846 The point does appear to have achieved some cut-through; an internal communication to the CATE practitioner in question from the Interim Head of Safeguarding, on 22 November 2011[776], says:

"... your views have fed into some discussions which are likely to lead to some changes in the proposals. In short these amount to transferring the responsibility for leading on CATE from Family intervention to Targeted Youth. We still want to ensure the approach is mainstreamed and includes a broader team approach but recognise the need for a sharper focus on CATE as a specialism and intend to achieve this by making one of the Senior Targeted Youth Support worker posts the lead…."

3.847 The effect of this was to retain a single CATE specialist. As they pointed out at the time, this was at a very sensitive stage between the two Chalice trials.

3.848 On 11 November 2011 a report to the Children and Families Board[777] referred to the restructure, noting "*minimal*" changes in Safeguarding and "*no reduction in social workers*". The latter may well have been true; but the loss of a specialist CSE team is not easily characterised as a "*minimal*" change in my judgment, unless only financial aspects are

774 [redacted] pg 1
775 [redacted] pgs 1-2
776 [redacted]
777 [redacted]

considered because in this regard it is important to note the evidence of a senior figure in Safeguarding:

"*It wasn't until it went to Cohesion that CATE was in base budgets at all, it was merely a project.*"[778]

3.849 A side issue at the time of this discussion was about CATE access to Protocol again. An email of 4 November 2011[779] noted:

"*… when CATE was established no consideration was ever given to admin support for recording or general help. Whilst latterly admin support has been provided by the support officers in* [the Community Social Work] *team, this was out of necessity as opposed to an identified role within their capacity or remit. Activity does need to be recorded in a consistent way and does need to be on the Protocol system – sometimes as cases in their own right and sometimes as activity linking to already open cases.* [A responsible officer] *has expressed concern about the capacity coming from CSWT support officers, but because no resource has ever been identified, my concern is about how this will be picked up within the restructure, whilst ensuring that case records are retained appropriately and that there is adequate resource to minute CATE strategy meetings."*

3.850 The response came:

"[In the] *proposed structure there will be administration provided to the family intervention team and this includes staff who will be focussing on sexual exploitation. In Cohesion services there is a proposal for both senior administrators and administrators to support the service. It has been agreed that there will be links between Cohesion service and protocol and there will be further developments with this during the development of the family connect service and the data systems that are being considered. <u>There is dialogue in place between relevant personnel and cohesion around access to Protocol at this time.</u>"*[780]

3.851 The underlining is mine; the "*dialogue*" in respect of Protocol was to prove extraordinarily protracted and it appears there were arguments on both sides – it is clear from evidence provided to the Inquiry that Protocol had been developed specifically for use with legislatively driven social care pathways and could not be adapted easily to CATE use; the Inquiry heard the view that attempting to gain access to Protocol was:

"… *the bugbear of* [an individual's] *life for five years probably.* [Name] *fought for the CATE team to have access to Protocol...* [Name was told] *they had it at one stage and it was taken off them or whatever.* [Name] *thinks the initial feeling was that because they weren't social workers they couldn't have access to this sensitive information.* [Name] *thinks they were forgetting that the sensitive information that the CATE team had access to was probably a lot more sensitive than some of the information that Protocol was holding on some of the cases*".[781] This ran contrary to all the required need for information sharing and "*safeguarding being everyone's business*", as per the Children Act 2004.

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778 [redacted] pg 55
779 [redacted]
780 [redacted] pg 2
781 [redacted] pgs 23-24

3.852 The Inquiry also understands that the Protocol issue was indicative of entrenched attitudes and poor awareness of the CATE process:

"[CATE] *was very much the poor relation … I think that goes back to one group of teams being social workers and the other group being "just youth workers". They had their own qualifications but weren't social workers. We were almost, and it did feel a bit like Oliver Twist, going cap in hand to social workers and the social work team 'please sir, can I have some more information' and we wasted a lot of time and to be honest we duplicated a lot of stuff because we didn't have that information. We didn't know a particular activity the social worker was undertaking and they didn't know what activity we were undertaking.*

It was, I felt, a second class process.. when [we] *went to talk to their teams about CATE and what we could offer and what we did for them the feedback we got was 'we never knew what you did, never knew what activities, never knew what information you needed, I didn't know I could refer into CATE'. It was a surreal process…."*[782]

3.853 Meanwhile, in the CATE Team there were seven referrals received between September and November which remained unallocated as at 5 December 2011; and another four allocated to a senior social worker to gather information for allocation.[783]

3.854 At the CATE Pathways meeting in December 2011[784], it was noted that while the restructure had aimed to "*mainstream*" CATE, this had been reviewed and "*it has been agreed that there is a role around supporting victims and identifying early grooming"*. Lest there was any doubt that "*a role*" implied the singular, the minutes underlined "*from the end of January there will only be one CATE Practitioner. There is only one CATE Practitioner until April".* The reprieve may not have been widely known, as the LSCB recorded in January 2012 *"under the new structure CATE will be delivered through the Safeguarding Helpdesk…"*[785] (I pause to note that the Family Connect rebranding of the Helpdesk had not filtered through either) *"... <u>and Targeted Youth Support</u>".*[786] The emphasis is mine.

3.855 So far as training more CATE practitioners was concerned, the LSCB Executive recorded in February 2012[787] that funding was a problem, noting:

"*CATE training is crucial as entering new phase for CATE. Difficulties in facilitating the training due to NSPCC resource not being available. Therefore,* [an attendee] *advised that £1k of the £15k from Munro could be used by the Training Subgroup for CATE training."*

3.856 Despite the relatively modest sum, this was not uncontroversial; there was disquiet expressed in email correspondence from a manager in the safeguarding arena.[788] The difficulty with money was foreseeable, though, and had been foreseen in November 2011.[789] It is remarkable that at a time when a restructure of CATE-style services was

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dependent on wholesale training of new CATE practitioners, no one had thought how to pay for it.

3.857 Funding aside, there were practical problems in training new CATE practitioners. The sole remnant of the previous team was expected to train TYS colleagues while maintaining a caseload. The Inquiry heard that the CATE practitioner moved across with 30 cases and was tasked with training TYS workers to provide CATE support. There was a trial period and the allocation of CATE work to TYS workers did not always work out.[790]

3.858 The restructure also led to reconsideration of arrangements for RHIs. Once again, third sector involvement was floated, though it seems not seriously, as responsibility was settled upon TYS on a pilot basis.

3.859 The Executive noted that, again, "*support for missing children is a significant gap*".[791] Voluntary groups involvement in RHIs was recommended as "*very effective*" as providing an independent person for children to speak to, though resources had been identified in TYS for RHIs and there would be a pilot. Cultural resistance to voluntary group involvement appears to have been strong.

3.860 The CATE Pathways meeting on 16 February 2012[792] was concerned with establishing Safeguarding and Cohesion pathways to support the CATE Pathway; it was decided that a consultation would take place. So far as CATE was concerned, a barrier to its goals was said to be "*the impact the Phase 2 restructure has had on the services while it has been in the interim period*". Presumably this means that there was only one CATE practitioner.

3.861 It is at least a curiosity that the LSCB Annual Report for 2011-2012[793] made no mention whatsoever of the restructure in its body and just one in the appendix; and although CATE was a LSCB priority, there was no LSCB consideration of CATE's movement within the hierarchy.

The Chief Executive as Director of Children's Services

3.862 On 15 July 2010[794] it was noted at the LSCB that the Council's Chief Executive had taken on the DCS role, following the retirement of the previous incumbent.

3.863 A senior Council officer recalls this Chief Executive's tenure as a time of extreme stress, "*a state of chronic unease, always looking for the next problem looming on the landscape*";[795] they regarded his decision to take on the DCS role as "*not understood by anyone apart from as a cost saving measure*" and notes that subsequent national guidance was against the practice.[796]

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790 [redacted] pg 81
791 [redacted] pg 3
792 [redacted]
793 [redacted]
794 [redacted]
795 [redacted] pgs 13-14
796 [redacted] pg 15

3.864 The Inquiry has not heard from anyone who thought the combination of the DCS and Chief Executive roles was a sensible move. The Inquiry heard:

"*I know he announced it at the meeting where there were a lot of headteachers in the room and one of the headteachers from Newport basically questioned what experience he'd got to be the DCS, which was one of those awkward stony silence moments… I thought it was symbolic, I never thought it was even the medium term solution. I thought it was the stopgap way to make some of the changes that would have then created the space to… re-appoint… the DCS.*"[797]

3.865 An independent member of the LSCB told the Inquiry that they remembered that the period when the Chief Executive held the DCS role "*presented significant challenges that negatively impacted the work of the LSCB*".[798] The Inquiry heard evidence that during the joint-role period it was difficult to implement change, as the Chief Executive was resistant to change and immovable.[799]

3.866 Following a change in administration in 2011 a new Chief Executive was appointed; a full time DCS immediately followed.[800]

Family Connect

3.867 By 2011, the Helpdesk had social workers in post. This had led to an increase in the percentage of contacts leading to referrals "*which suggests that the contacts to the Helpdesk* are appropriate*".* As I have noted, under the restructure, the Helpdesk was to be replaced by Family Connect[801], which had been in design since 2009.[802] Family Connect, a key goal of the restructure, was to be a triage system offering greater scope of support than classical safeguarding services.

3.868 On 22 September 2011 the LSCB Executive met. Family Connect was discussed - some attendees said they knew nothing about it. The Chair of the LSCB revealed that he had been given a "*brief introduction*" a week before; despite it being quite plain that plans were well advanced - not only had Family Connect been discussed at previous meetings referred to above, but a Council officer with a social work background[803] was listed on these minutes as *representing* Family Connect. It seems that the January 2011 review document[804] was still regarded as confidential.

3.869 The Inquiry heard that any CATE referral to Family Connect would be screened by a social worker for safeguarding issues.[805]

797 pg 25
798 pg 25
799 pg 15
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802 pg 8, pg 49
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805 pg 34, pg 49

Chalice – consideration of a Serious Case Review

3.870 Following Chalice, consideration was given to whether SCRs should be carried out regarding the children identified in the course of the Chalice investigations. Undertaking SCRs, and advising the Council and LSCB partners on lessons to be learned, was a statutory function of the LSCB as defined in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006.

3.871 The purpose of SCRs, according to Working Together 2010, was to:

- *"Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;*
- *Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and*
- *Improve intra- and inter-agency working and better safeguard and promote the welfare of children*."[806]

3.872 Chapter Eight of Working Together 2010 sets out the processes that LSCBs should follow when undertaking a SCR. When undertaking a SCR, the guidance made clear that the prime purpose of the exercise was to learn lessons both on an individual and inter-agency/LSCB level.[807]

3.873 Paragraph 8.11 of Working Together 2010[808] stated that LSCBs should consider whether to conduct a SCR whenever a child had been seriously harmed in the following situations

- *"A child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect;* or
- *a child has been seriously harmed as a result of being subjected to sexual abuse; or*
- *a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004; or*
- *a child has been seriously harmed following a violent assault perpetrated by another child or an adult;* ***and***

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806 [redacted] pgs 19-20
807 [redacted] pg 235
808 [redacted] pgs 237-238

- *the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working."*[809]

Serious Case Review Group

3.874 The decision whether or not a SCR should be undertaken rested with the Chair of the LSCB. However, the Council had established a LSCB '*Serious Case Review Group'* ("SCRG") whose role was to make a recommendation, following discussions at multi-agency level, for the Chair of the LSCB to consider. Membership of the SCRG included a representative from the Council's legal department, a manager from the Safeguarding Advisory Service and a Principal Officer for Education as well as representatives from West Mercia probation, NSPCC, WMP, education and health. It seems to me, based on the witness evidence this Inquiry has heard, this is another example, along with the over-powerful LSCB Executive, of the Council seeking to exercise control over the nominally independent LSCB.

3.875 It would appear from the documents available to the Inquiry that the LSCB first considered whether to undertake a SCR, or SCRs, in around the Spring of 2011. The starting point was that the senior operational lead for CATE carried out a cross-check of the names of all those involved in Chalice as alleged victims/survivors or witnesses (as provided by WMP) against the Council's Safeguarding records. I understand that a detailed analysis for the children about serious harm and inter-agency working was prepared to identify any whose circumstances might potentially meet the criteria of paragraph 8.11 of Working Together 2010, listed above.[810] I have seen reference to the list of cases in minutes of meetings to which I refer below, but I have not seen the detailed analysis prepared by the senior operational lead for CATE as the Council said it could not be found.

3.876 A meeting of the SCRG was convened on 16 June 2011 to make a recommendation to the Chair of the LSCB as to the best way forward. The minutes note that "*the group needs to consider whether or not the criteria are met for a SCR and if so, whether this is the best method of learning*".[811]

3.877 Two points arise:

3.877.1 First, if a SCR was contemplated then the exercise should be carried out separately in respect of each child, unless a thematic SCR was being considered (and there is no evidence that it was, and thematic reviews were rare at the time).

3.877.2 Second, whether a SCR was the best method of learning was not the correct test to apply when considering whether to undertake a SCR. If the criteria for a SCR were met, the LSCB should consider whether to undertake a SCR regardless of whether it was thought to be the best method of learning. Paragraph 8.12 of Working Together 2010 listed further questions to help in deciding whether a

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[809] [redacted] pgs 237-238
[810] [redacted] pgs 237-238
[811] [redacted]

case should be the subject of a SCR. The list did not include consideration of whether a SCR would generate the best method of learning.

3.878 At this meeting the SCRG identified that of the list of children, concerns were raised about four of them and three required closer examination of whether the circumstances might generate useful learning across partner agencies. Again, the emphasis appears to have been on what the best method of learning might be and not on the harm they had experienced and the multi-agency response to this.

3.879 A further meeting of the SCRG was held on 29 July 2011.[812] At that meeting, the SCRG explored the details of the 23 cases with each agency sharing relevant information. Their ages were not included (an issue that has occurred across many discussions of those subject to CSE). A comment was made that:

"… *there have been recent incidents which were dealt with via the traditional Section 47 route when they should have gone via CATE. As a consequence the girls did not disclose anything.*"

3.880 The conclusion of this meeting was that all agencies had worked together and there were no concerns regarding multi-agency working in the context of CSE. There was evidence of all the children being harmed, but the CATE Team was seen as making a substantial difference.

3.881 The SCRG referred to the criteria for a SCR and it was noted that:

"*The information shared today shows that agencies have done what was needed. It has not been heard that information has not been shared. Agencies have worked under their own policies and procedures and have recorded their own involvement. A lot of work and support seems to have been put into place once a referral has been made to CATE…*

[Name of an attendee] *acknowledged that it is clear that the young women have suffered significant harm and although agencies followed their respective procedures at the time, it can now be seen that things could have been done so much better had the CATE pathway been in place at the time of involvement with some of the more historical cases….*

[Name of another attendee stated it] *could be argued that the criterion is met for a SCR for a small number of the girls*."[813]

3.882 I pause to note that although the fact that the cases were going via the wrong route was remarked upon, it appears that no action was recommended to strengthen or clarify referral pathways.

3.883 As to next steps, it was agreed that:

"… [a] *formal response* [was] *to be written to the independent chair of* [the] *LSCB that this group does not feel that a SCR is appropriate, although there are potential lessons to be*

812 [redacted]
813 [redacted]

learnt using a more systems based approach involving staff at all levels to identify how to improve current rather than historical practice."[814]

3.884 By this point, the decision appears to have been cast in stone and made on the basis of assuming what the conclusions of the SCR(s) would have been, rather than allowing the SCR process to take its course. The emphasis again is on alternative learning.

3.885 On 7 September 2011, an email was sent to the Chair of the LSCB who had asked for a recommendation from the SCRG about whether there was a need to consider holding any SCRs. He was informed that they were in the process of agreeing the wording "*but we will be recommending an alternative learning opportunity to SCR*".[815]

3.886 On 13 October 2011, the Chair of the SCRG wrote to the Chair of the LSCB[816] to confirm the SCRG's recommendation that a SCR was not appropriate for any of the children concerned. The SCRG also recommended, however, that there were potential lessons to be learned using a more systems-based approach involving staff at all levels to identify how to improve current, rather than historical, practice. This ignores the fact that the purpose of a SCR is to review current practice in the light of historical concerns and identify multi-agency learning; this demonstrates an unwillingness to admit, or at least the reluctance to consider, the possibility of error or the need for learning from practice.

3.887 On 14 October 2011, in a CATE update to the LSCB, it was noted that there had been a special meeting of the SCRG to consider whether it was appropriate to conduct SCRs for those children involved in Chalice and that:

"… *the recommendation to the Chair of the SCB was that although there is definitely some learning to be had, conducting Serious Case reviews would not be the best method of learning."*[817]

3.888 A further SCRG meeting was held on 20 October 2011.[818] On that same day, the Chair of the LSCB had written to the Chair of the SCRG to advise that they were still considering their decision.[819] In helping them to reach a decision, the Chair of the LSCB had contacted another borough which had undertaken a number of SCRs when they had a similar case of sexual exploitation, as well as the Social Care Institute for Excellence.

3.889 The Chair of the LSCB expressed the view that, given the number of victims/survivors in the case, whatever decision was reached, there would be a need for an independent element in the learning process. I take the view that this demonstrates the Chair of the LSCB clearly thought independent scrutiny was appropriate. The minutes of the meeting held on 20 October 2011 note:

"*Discussion ensued as to whether a special meeting should be arranged to discuss the comments made* by [the Chair of the LSCB]. *There is a need to ensure that learning is fed*

814 [redacted]
815 [redacted] pg 2
816 [redacted]
817 [redacted] pg 2
818 [redacted]
819 [redacted]

into the Phase 2 restructure, Although there is a desire to reinforce that the group is keen to learn in tandem with the restructure it is not felt that an SCR will help in the current climate. The criminal trial has not yet concluded. [One attendee] *felt that the focus should be on whether the current approach is working.* [Another] *agreed that preventative services have been identified and more energy should be put into that.* [Another] *stressed that Telford and Wrekin were more advanced than* [another borough] *and their rationale was different. It was agreed that* [the Chair] *should draft a letter to* [the Chair of the LSCB] *in response to his email.*"[820]

3.890 The emphasis here is mine. Reference was made to the fact that the trials had not yet concluded and to the wholesale restructure of the Council. Consideration appears to have been given to the fact that a SCR would not help in the current climate. This was not of course the test set out in Working Together 2010. Further it was, in my view, inappropriate for the decision of whether to carry out a SCR, or SCRs, to be influenced by how a SCR might impact on other factors facing the Council at the time.

3.891 On 15 December 2011, the Chair of the LSCB wrote a further letter to the Chair of the SCRG seeking further details.[821] He did not feel he had enough information to inform his decision as to whether a SCR should be held. He was keen to understand what proportion of the victims/survivors were in local authority care in Telford, as this would influence his decision; the higher the proportion, the more justified a SCR would be.[822]

3.892 I understand that on 11 January 2012 a meeting was held between the Chair of the LSCB, the Chair of the SCRG and Interim Assistant Director of Safeguarding Children to clarify the issues raised. However, a copy of these minutes could not be located by the Council.

3.893 On 1 February 2012, the Chair of the LSCB wrote to confirm his decision not to conduct any SCRs.[823] He agreed with the recommendations of the SCRG that the criteria was not met. He elaborated that:

"… *whilst it could be argued that some of the grounds are met, I consider that Partner Agencies, once they recognised the sexual exploitation of young people was taking place, worked together and set up Operation Chalice and the CATE pathway to protect and prevent further abuse*."

3.894 He agreed with the SCRG that there was a need to set up a more "*systems-based approach for learning*" from all partner agencies. I pause to point out that SCRs were, in fact, systems-based approaches.

3.895 In addition to the documents the Inquiry has seen, the witness evidence that the Inquiry has heard has led to me to believe that the decision not to undertake any SCRs was, in part, influenced by the following factors:

3.895.1 The experiences of other local authorities – the SCRs that had been conducted in other authorities had focused on the individual child's circumstances each time

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and did not take account of other children who may also have been affected, nor did they address any system failures.[824]

3.895.2 It was felt that a SCR is most useful in identifying learning from an individual case – given the number of children involved over the lengthy period of time, it was felt that what was required was a review of the whole system. It was felt necessary to look at the situation "*in the round*" and to conduct a more global review of learning and any gaps in services and processes.[825]

3.895.3 The number of children who had links with the Council - one witness told me that only three of the 23 children involved in Chalice had links with the local authority. This information further strengthened the view that a SCR was not the correct approach to take and that any future learning should involve the experiences of all the children.[826]

3.895.4 There were no known or reported concerns about the way agencies had worked together – I have been told that the second limb of the test i.e. "*the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working*" was not satisfied. This lack of evidence was not tested.

3.895.5 Costs - witnesses who have provided evidence to the Inquiry have denied that the cost of a SCR was a deciding factor in the eventual decision not to proceed with a SCR.[827] Despite this, it is clear to me from the evidence heard[828] that the significant financial outlay of a SCR was considered at the time.

3.896 Some Council employees who have provided evidence to the Inquiry have reflected on the decision not to carry out a SCR, or a number of SCRs for the individual children, and now recognise that a SCR would have been a good opportunity for the Council and its partners to learn lessons.[829]

3.897 I am not persuaded by the argument that a SCR was more appropriate for individual cases than for an Chalice-type situation; the SCR could have been thematic and could have looked at the whole system.

3.898 As to the number of people who had links with the Council, the Inquiry's analysis shows that this number was in fact far greater. I have reached this conclusion having cross-checked the names of potential victims involved in Chalice against documents disclosed to me by the Council.

3.899 As to there apparently being no concerns about the way agencies worked together, given everything the Inquiry has heard about early attitudes in CSE cases, this conclusion is

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difficult to understand and lacked evidence.

3.900 I am in no doubt that whether to undertake a SCR (be that an individual SCR or a thematic SCR) was a difficult decision for the Chair of the LSCB, and one that he grappled with for many months. He was anxious to make the right decision, and indeed actively made his own enquiries, but the evidence suggests that there was a clear preference amongst partner agencies not to hold a SCR. In my view, whilst the decision not to carry out a SCR was ultimately that of the Chair of the LSCB, he was reluctantly persuaded by the combined forces and clear preference of the partner agencies to reach this decision.[830] Whilst it is important to note that the cost of a LSCB would have been paid by the LSCB partnership's budget, rather than the Council's budget, I am persuaded by the evidence I have seen that the reluctance to undertake a SCR was no doubt partly influenced by the restructure facing the Council and the reason for it: the restructure was, of course, driven by cost.

3.901 Whilst the Chair of the LSCB concluded that the threshold for a SCR had not been met, the Council was keen that a more "*discursive*"[831] learning review take place. According to the Council, this was achieved through the NewStart Networks review and subsequent report.

3.902 There was an opportunity here for important reflection. The known difference between children at risk of/subject to CSE and the two pathways through which they received services needed more testing. Records were not being kept at this time, but from 2013 to 2020 substantial numbers of children were subject to child protection processes. There was no evidence about whether CATE involvement led to more disclosures and there remained a lack of descriptions of what exactly the CATE response looked like, beyond the process model. The assertions made by the SCRG may well have been true, but as I will demonstrate in Chapter 8: Case Studies, there is evidence of drift and delay in the safeguarding response when children were known to CATE.

3.903 Of the numerous groups who assumed responsibility for CSE, none of the groups were responsible for looking at practice. This was another reason why a SCR would have been so valuable at this stage.

The NewStart Networks Review

Background

3.904 NewStart Networks is a Community Interest Company based in Shropshire, which was formed in 2012 following the closure of the NSPCC therapeutic support offering for children in Telford & Wrekin, Shropshire and surrounding authorities.[832] It describes itself as delivering specialist services for children who have experienced trauma and promotes best practice, with the aim of safeguarding them and ensuring their wellbeing.[833]

3.905 NewStart Networks was commissioned by the LSCB to conduct a review into its response to CSE between 2008 and 2013 (the "NewStart Review"), following the decision not to

830 [redacted]
831 [redacted] pg 33
832 [redacted] pgs 4-5
833 [redacted] pg 1

conduct a SCR or SCRs. At the time it was commissioned by the Council, NewStart Networks comprised one office manager and four social workers[834] and was not directly connected to the Council, so could therefore be independent.[835]

3.906 As has been explained, the decision not to conduct a SCR, or SCRs, post Chalice was because, in the Council's view, the criteria for undertaking a SCR had not been met. The NewStart Review was instead intended to encompass a broader range of children, rather than only one or two, as well as their families and the staff involved.

3.907 It was confirmed to the Inquiry that, although the consensus was that one or more SCRs would not be an appropriate route to take post Chalice, the Council did want to crystallise the learning that had been developed in the wake of Chalice. This was deemed to be important for everyone affected by the CSE situation, as well as being able to identify what could have been done better to improve services for the future.[836]

Remit and scope of review

3.908 The remit for the NewStart Review was set by the LSCB and was as follows[837]:

3.908.1 To look back on the experiences for all stakeholders and to explore how and what the Council might do better in the future;

3.908.2 To assess the quality of the support offered to the children, families, communities and staff affected by CSE; and

3.908.3 To determine to what extent the support offered was accessible, available, timely and of the right kind.

3.909 The scope covered all children and their families who were known to the CATE Team between December 2008 and March 2013 and all Safeguarding staff who were involved with cases of CSE for the same time period.[838] Its stated aim was to build upon the (unspecified) learning from Chalice and the measures which had already been taken, such as the CATE model and Pathway and the multi-agency response work.[839]

3.910 Collection of data was carried out by liaising directly with children and their families in face to face meetings and by the setting up of a forum for staff to give feedback, alongside completion of a questionnaire.[840]

3.911 Of a potential pool of 13 children identified to fit the remit, only seven[841] took part in the review, and four parents.[842] Of these, only two of the children agreed that NewStart

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835 [redacted] pg 1
836 [redacted] pg 22
837 [redacted] pg 5
838 [redacted] pg 5
839 [redacted] pg 4
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841 [redacted] pg 8
842 [redacted] pg 8

Networks could access their case files.[843]

3.912 In the staff group, qualitative data was collected through the use of questionnaires and qualitative data via staff forums, where professionals were invited to share their views on attitudes, knowledge, role and impact.[844] It was noted in the NewStart Review itself that both the individual interviews and the agency forums lacked a multi-agency dimension, in terms of the discussion that took place.

3.913 In total, 45 professionals' names were put forward by the Council, from a range of organisations, with a further ten identified by NewStart Networks. Of these, 25 professionals engaged with the review process.[845]

3.914 Despite the ambition for the review to seek the views of all children and their families who were known to the CATE Team between December 2008 and March 2013, plus Safeguarding and multi-agency staff, it is clear that the NewStart Review did not succeed in obtaining a wide set of data and it is important to set the findings in this context. It is disappointing that the voices of the staff, children and their families were not captured in the immediate aftermath of Chalice, as this could have been a valuable learning opportunity for the Council.

Interim findings

3.915 A series of interim findings were made,[846] which largely related to there having been an understandable focus on the "*rescue*" of these children post-Chalice and that further developments were now required in relation to their long term recovery or rehabilitation.[847]

3.916 It was noted that there were issues regarding multi-agency working and communication, with a general feeling that good communications were based on personal networks, as opposed to organisational networks. It was also identified that there was a lack of resources, particularly for preventative work post-18 services; accommodation; and therapeutic input, plus a need for improved support and training. There was also an awareness and anxiety regarding the dangers of a focus on race.

3.917 From the children's perspective, the overall experience of CATE was positive, although the courtroom experience during the Chalice trials was not, and indeed some elements of the police investigation "*were experienced as abusive".*[848]

3.918 Family members who had engaged with the review at this point felt that they had been blamed for failing to protect their children from CSE and that there was a lack of support/resource for siblings or other family members.[849]

843 [redacted] pg 10
844 [redacted] pg 8
845 [redacted] pg 9
846 [redacted]
847 [redacted] pg 9
848 [redacted] pg 1
849 [redacted] pg 2

Final report

3.919 The final report of the NewStart Review was submitted to the LSCB on 31 October 2013, with key findings as follows:[850]

3.919.1 Neither children nor parents were aware that exploitation was taking place until they received information from CATE or WMP;

3.919.2 Even after agencies were involved there was a high level of anxiety and fear on the part of children about disclosing what happened to them;

3.919.3 CATE was perceived as being very helpful to the children because of its flexible "*needs led*" approach;

3.919.4 Neither children nor parents felt that the support from Safeguarding was consistent or helpful;

3.919.5 Parents felt they did not receive enough support and advice;

3.919.6 Families and peers recognised significant changes in behaviour first;

3.919.7 There were issues about the provision of therapeutic support in that it was not universally available;

3.919.8 Training, supervision and support were highlighted as being important factors by staff in order for them to be able to function effectively;

3.919.9 Staff generally felt that there had been improvement in their understanding of CSE and the resources offered during this time period; and

3.919.10 The point was made that the impact of CSE is long term, so Adult Services and Children's Services should work cooperatively over the long term.

Analysis of findings

3.920 Further analysis of the findings demonstrated that the efforts made, post-Chalice, to improve practices had not always been successful. For example, in relation to multi-agency working, "*attempts to involve multiple agencies often left young people feeling confused about the roles and responsibilities of different professionals".*[851] Also that, "*it seemed very clear that the respondent's perception of agencies was very much based on the nature of the relationship they had established with a particular worker".*[852] The experience of family members echoed this sentiment, noting that, "*it is clear from the respondents that a multi-agency approach to CSE was not evidenced".*[853]

3.921 Long term support for the children also seemed to be a particular feature, with the comment

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852 pg 13
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being made that:

"*… most of the respondents felt that their access to services became less clear and consistent once they reached the age of eighteen and some were not aware how long they could continue to receive a service from their CATE worker."*[854]

3.922 In addition, it was noted that, despite suffering ongoing consequences of their CSE experiences, "*of concern is that none of them* [the children] *reported that they were engaged in therapeutic services or receiving ongoing support, other than through the CATE service".*[855] Again, this was echoed by the parents spoken to, who "*felt disempowerment at the lack of support and information to help"*[856] and noted that "*support from agencies was not enough, or* [was] *inappropriate".*[857]

3.923 In terms of professionals, it was identified that processes and procedures still required further improvement. By way of example, "*there was a lack of appropriate processes and mapping of concerns initially and there is still a lack of processing and mapping where problems are".*[858] Furthermore:

"… *it was felt that there was a lack of understanding about the scale of the problem initially and that this is probably still the case today in that agencies suspected there was more CSE happening than they were aware of."*[859]

3.924 Generally a feeling was expressed that, "*the victims of CSE were made to 'fit' existing systems rather than developing more relevant support systems to engage and protect".*[860]

3.925 The Council restructure had led to a backwards step in some of the respondents' view, with it being stated that:

"… *it was felt that the reorganisation of services within local Social Care has affected ways of working and the way help is provided to victims of CSE. Staff feared a potential loss of local working arrangements/networking due to changes in the way services are now organised, staff redundancies and movement across teams. There was a feeling that the restructure of Children's Services has broken up good networking and not yet been able to restore these to previous good levels."*[861]

3.926 Resourcing issues were also flagged, which included a "*lack of training, use of the intranet and access to information generally."* There was also concern that "*knowledge, expertise and networks linked with various staff members had, or would be lost through the reorganisation".*[862]

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[854] [redacted] pg 14
[855] [redacted] pg 14
[856] [redacted] pg 20
[857] [redacted] pg 20
[858] [redacted] pg 27
[859] [redacted] pg 27
[860] [redacted] pgs 27-28
[861] [redacted] pg 29
[862] [redacted] pg 33

3.927 Potential areas of development were identified as including:[863]

3.927.1 Education;

3.927.2 Support to families;

3.927.3 Therapeutic services;

3.927.4 Work with communities;

3.927.5 Post-18 support; and

3.927.6 Staff training, support and networking.

Criticisms of the report

3.928 Following publication of the report, the Council released a public relations statement noting that the review had effectively done the work that an independent inquiry into historic abuse would cover.[864] However, within senior management at the Council, there was some criticism of the report:

"*I'm not sure if you should major too much on the NewStart networks piece of work ? It wasn't the greatest.*"[865]

3.929 A number of witnesses to the Inquiry have also commented on the quality of the report produced. One of them commented that:

"*… I thought it was a very good report. I thought their analysis seemed to me at the time, quite sound and it was child-centred, appropriately so. It recognised the tragedy that has unfolded and that if only we had responded earlier, or if only we had recognised what was going on under our noses at the time, things might have been different and we might have saved a lot of children from great pain, trauma and distress.*"[866]

3.930 However, another witness told the Inquiry that:

"*I think they didn't get a lot of response from the parents and the young people so in terms of who they would have talked to, a very, very small group of people…* [and]

… I think I was a bit disappointed from the point of view I didn't get an understanding of what it was that people were saying that they were being… it's quite wide, almost like high level statements if you like, without really helping us get an understanding of what it was that the families really felt about information being withheld from them. So you know there was that part to it and they also, they just were very high level recommendations. So you get a list of recommendations and then you're just left to try and, it's almost like a

[863] [redacted] pg 2, [redacted] pgs 35-38
[864] [redacted] pg 1
[865] [redacted] pg 1
[866] [redacted] pg 19

government report I suppose…."[867]

3.931 Another witness recalled that it did not have as much of an impact as they had wanted. They were hoping that it would, "*give everyone the wakeup call needed as to what could be done better*", and did not find it hard-hitting enough in this regard.[868]

3.932 Within the Council, the CATE Pathway group was responsible for overseeing implementation of the recommendations of the NewStart Review, as well as other recommendations identified by the linked CSE Overview Report prepared by the Council's Principal Child Protection Officer in Spring 2014.[869] No evidence has been provided to the Inquiry about how this work was taken forward or evidence of actions taken to address these recommendations. They do not feature in any substantial way in reports going forward.

3.933 Whilst the opportunity to hear from children themselves and family members (though just mothers in this sample) was positive, this was a qualitative feedback process, without much analysis, and no scrutiny of the case decision making; its compliance with existing policies and procedures; any scrutiny of the multi-agency processes, or reflections on the wellbeing and outcomes for the children. A detailed case analysis or a SCR would have complimented this piece of work.

3.934 As I will cover, later in this chapter, I do not agree that this was a review, but rather a feedback exercise. It did not cover the ground of SCRs – individual or thematic - and did not review practice from the child's perspective in terms of what happened, whether they were they kept safe and, if not, why not. Furthermore, in what was clearly a common pattern for the Council, recommendations of the report were not followed through either.

Conclusions

LSCB

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

3.936 Another difficulty arose which would be perennial in all its iterations: the LSCB quickly became too big to do any real work and there was inconsistency in its attendees. I do recognise that in the safeguarding arena staff regularly change jobs, are promoted or leave, requiring a change of personnel; however the evidence I have seen does not suggest that the inconsistency was wholly or substantially due to staff churn.

3.937 Moreover, when it became clear that an independent chair was required for the LSCB, the Council isolated the LSCB and ran it through the LSCB Executive group – which was in form little different from the ACPC.

3.938 The first independent chair was chosen on cost grounds, and even on his own account

867 [redacted] pg 13
868 [redacted] pg 23
869 [redacted] pg 20, [redacted]

lacked the background or skills to navigate the bureaucracy successfully. As a result, the LSCB was restricted in its access to information and effectively was only fed that which the LSCB Executive chose to pass on.

3.939 The LSCB may have been independent, but it was also so isolated that it was quite unable to provide the oversight role effectively, as envisaged by the Children Act 2004. This is clearly demonstrated to me by the fact that its Chair at the time of the inception of CATE does not remember being involved in discussions about the development of the project, or being kept abreast of the funding issues involved.

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

3.941 It seems to me that in this way the LSCB was isolated, by the LSCB Executive putting itself in control of day to day decisions and monitoring, left little role for the LSCB chair or the LSCB itself. Furthermore, the LSCB was allowed to grow to a size that made it incapable of functioning as a decision making body. In what may be a related issue (or may simply indicate the lack of esteem in which the LSCB was held), significant players often delegated their attendance to substitutes. I do accept that these features may have been an innate flaw with the LSCB model and not a local difficulty.

3.942 Ironically, as time went on the LSCB Executive itself was bedevilled by the twin problems of bloated delegate numbers and poor attendance of principals, illustrating the eternal truth that people choose not to go to meetings that they know will not achieve anything.

CSE groups

3.943 There were, even at the earliest stages, too many groups dealing with CSE. There was insufficient clarity as to their roles and purpose and confusion as to whether the groups had a strategic or operational role. As early as 2005, at a Sexual Exploitation meeting (a subgroup of the LSCB) the group was lamenting that its function was unclear. In the same year the volume of sexual exploitation work was noted to be "*incredible*"[870] and there was a need to "*collapse as many meetings as possible*"[871] to cope with workload. This early warning went unheeded; little seems to have changed over the period save for incessant reconstitution of essentially the same groups: the Sexual Exploitation meeting was rebranded the CATE group in 2006, but did not become a decision making body, still reporting to the LSCB and later to the Senior Officers' Coordination group, itself an ad hoc group that appears to have done nothing other than hear reports, and which was created quickly and fell just as quickly into oblivion.

3.944 This was at a time when decisions needed to be made. An obvious example is the early funding of the CATE project: the CATE group recommended practitioner funding to LSCB; the LSCB delegated the decision to Connexions, which scrabbled around looking for solutions while, in the meantime, CATE work (as it would become known) was being done

870 [redacted] pg 2
871 [redacted] pg 2

by youth workers in addition to their "*day jobs*".[872]

3.945 The MLSP is just one example of the fractal level bureaucratic complexity in the Council provision. There are endless committees, which give the impression of serving no purpose other than to exist. I have addressed this issue in my recommendations.

Provision for victims/survivors

3.946 With the subsuming of the FAST team within Clusters, the rigid hierarchy between Safeguarding and early intervention was formalised. In theory, the Clusters were not intended to deal with children "*seriously at risk*"[873], but the reality is they did deal with CSE victims/survivors who simply did not qualify for section 47 in Safeguarding's (or the Helpdesk's) view; which views were often heavily informed by the assessment of parental support, leading to Safeguarding not becoming involved with children whose families appeared to be supportive of them. This Clusters attempted to fill this provision gap, but the experience of ISMs was that Safeguarding was not only not interested in the CSE problem identified by youth workers and particularly seen in Wellington, but that Safeguarding actively discouraged the Cluster teams from engaging with the problem.

3.947 Whether the cause of this was cultural (based on the historically separate "*elite*"[874] service); a lack of imagination (Safeguarding being unable to see beyond the characterisation of CSE victims' experiences as "*risky behaviours*"[875]); overreliance upon an assessment of the family situation; or because of other pressures, cannot be determined.

3.948 The Inquiry has certainly heard that social workers were focused on finding "*evidence*"[876] rather than acting on indicators. While I accept that safeguarding intervention needs to be properly founded, it is over-rigid to assume that every case demanding intervention will display incontrovertible evidence.

3.949 It is certainly the case that there was political disquiet about the cost of the wider Children's Social Services bill, especially that for looked after children. The Council reminded the Inquiry that it was, of course, under a legal duty to balance its budget. At the time Safeguarding was under extreme financial pressure: the DCS post, although new, was empty for a year; and social workers were choosing not to work in Telford, leading to large use of agency staff with commensurate extra costs. The LSCB Executive was urging Clusters to reduce the number of children coming into care because of the high costs involved. By the time a new DCS was in post, and looking to integrate social workers into the Clusters, the large funds uplift intended to that end was largely used to pay agency staff bills.

3.950 It is regrettable that, as the CATE Team developed, it was not better known. So far as the Clusters were concerned, there was little knowledge of the existence of, let alone the work of, the CATE Team, despite the Clusters' historical role in identifying and raising concerns about CSE. For a time, there were three potential services for victims/survivors of CSE – Safeguarding, the Clusters, and CATE – without common referral or working practices. This

[872] [redacted] pg 85
[873] [redacted] pg 36
[874] [redacted] pg 2
[875] [redacted] pg 2
[876] [redacted] pg 53

speaks of a lack of strategic thinking on the part of the Council. Moreover there was not, as *Working Together* contemplated, a single entry-point.

3.951 It would plainly have been desirable that there was close working between the CATE Team and Safeguarding; as I have indicated, CATE should not have been seen as a substitute for Safeguarding response. The evidence I have seen shows that the relationship between the CATE project and Safeguarding was in fact as poor as the relationship had been between Safeguarding and the Clusters. The proposal that CATE awareness should be integrated into the Helpdesk by a CATE officer serving on the Helpdesk came to nothing, and the requirement for the Helpdesk to call a strategy meeting on CATE complaints generated not one such meeting in the 12 month period to September 2008. This reinforces the experience the Inquiry has heard from witnesses: that the CATE Team largely had direct referrals, by word of mouth and through intelligence from children it was already working with, rather than referrals from the Helpdesk.

3.952 Procedures were subsequently put in place to mandate CATE referral through the Helpdesk. This led to the response by Safeguarding that too much was being referred through the Helpdesk, which seems to me to show a failure of understanding of Safeguarding's proper role in triage and/or initial assessment. In any event, as I have noted, CATE contacts initially developed by word of mouth rather than by formal referrals and Safeguarding was therefore dependent on CATE referrals to Safeguarding being accepted. It appears that CATE's referrals to Safeguarding were met by an uninformed Helpdesk and where accepted, were not progressed quickly. The demands on the CATE service continued to grow, though the growth in use of the service was not met with increased funding.

3.953 It is apparent that CSE was either not understood or not regarded sufficiently seriously by Safeguarding. The CATE project's workload grew in an uncontrolled way and the effective separation from, and lack of support from, both the Helpdesk and Safeguarding meant that CATE practitioners endured difficult working conditions, often working at personal risk, on their own time, and – with the best of intentions – making it up as they went along.

3.954 Although there was an established and effective model in the Sheffield scheme, the Council did not adopt it in any meaningful sense. Rather the CATE Team itself adopted some of its terminology but this brought its own dangers in that while the terminology reflected *Working Together*, the CATE procedures did not. This shows that there was an acute need for Safeguarding to consider the form of the CSE response. Instead it was left to youth workers who did what they could with the skills they had.

CATE funding

3.955 It is not clear when work directly with victims/survivors, which would later be seen as CATE work, began but it was certainly before any formal project was formed and prior to July 2006 when the initial CATE report was prepared. Following the report there was then an inordinate delay in formal action, apparently due to an uncertainty over how the project would be funded. In what must have been a response to funding concerns, the scope and ambition of the proposal was repeatedly reduced, notwithstanding the LSCB regarding CSE as a "*very real and ongoing issue*".[877] It was well over a year before funding for a much-

[877] [redacted] pg 2

diminished project was found within Connexions and that funding appears to have been carved out of existing resources. It is not clear what happened to the suggestions of lottery or third sector funding or whether either was pursued; this would not be the first time that the Council appears to have been reluctant to engage with outside bodies to provide services and the reason for that reluctance is not clear.

3.956 The Inquiry has seen no evidence that the request for CATE funding went to Directorate level within the Council or that elected members had any involvement. It is difficult not to conclude that the CSE risk was simply either not known about or not taken seriously by the higher echelons of the organisation.

3.957 The issue of funding was not resolved with Connexions taking responsibility, as the solution was temporary and because the source of the funding excluded CATE dealing with children 13 years old and under. There was, throughout 2008 and 2009, continued debate over sources of funds with talk of recourse to parish councils and "*partner agencies*"[878], though none was made despite obvious urgency: the demand on the project was such that there was talk of capping capacity.

3.958 There was a reprieve of the CATE project in January 2009 with funding secured for a further year from Connexions. It is worth remembering that by this point Connexions, and its predecessor the Youth Development Service, had been essentially alone for over ten years in trying to make positive steps to address CSE, and CATE was still a temporary project with no stand-alone budget, and dependent entirely on the goodwill and commitment of its practitioners.

3.959 It seems clear that the LSCB's designation of CSE as a priority had the positive effect that the CATE project – now, in reality, one practitioner - was to be managed by Safeguarding. A further practitioner was recruited and a senior social worker included in the team for the first time. However, the project was still without a budget of its own, with funding again on an interim arrangement and staff being abstracted to CATE from other areas without compensatory cover. All the while the CATE Team was expected to provide cover for other staff.

3.960 Although the LSCB and CATE subgroups both declared there to be a need for sustainable funding, none was found. In October 2010 it was noted that a "*plan for sustainable management not yet identified*".[879] Once again, the suggestion was made that there should be third sector involvement in CSE provision but no apparent follow up; this suggests –an approach of continued institutional dislike of devolving responsibility, combined with reluctance to commit funds to an in-house solution. I am fortified in that conclusion by reminding myself that, at the same time, exactly the same discussions were being had about funding for RHIs.

3.961 At this time, which was at the height of the Chalice investigation, the Council's restructure plans were being finalised and within them the proposal to "*mainstream*"[880] CATE work. There should be no doubt about what was meant by "*mainstreaming*": the dismantlement

878 [redacted] pg 13
879 [redacted] pg 1
880 [redacted] pg 17

of the CATE project. There was no role for the existing practitioners and no training budget for new ones. I have seen clear indications that Telford CSE was broadly regarded as coterminous with Chalice; and this conclusion has been confirmed to me by the decision to scatter the project to the winds. Furthermore, and astonishingly, the planning for CATE's stand-down must have taken place before the first aborted Chalice trial. Had there been any true understanding of the nature of the skilled work done by the CATE project members, or its importance, then the idea that such work could be continued by others untrained would have been dismissed in an instant.

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

3.963 The suggestion that the retained CATE officer would train an entire cohort of youth workers to undertake CATE work fails to understand the support workload, and the fact that the CATE practitioners had hitherto been essentially volunteers. The history of the team itself shows that such work is not for everyone. The idea that it could simply be added to everyone's skill set, as one might mandate a half-day course on timekeeping software or safety in the workplace, is utterly inadequate.

3.964 I am of the view that the Council simply did not see CATE as an enduring part of its Children's Services (in its widest sense) offering. To "*mainstream*"[881] CATE was an 'easy win' in terms of saving money by a Council leadership that regarded Safeguarding as a "*poor* relation"[882] - or in one witness's memorable phrase, a "*screaming baby*"[883] - and which had, contrary to all good sense, viewed the Director of Children's Services role itself as not requiring a qualified or full time occupant. This attitude to CATE explains the astonishing lack of mention of the team in the 2011 review of services; moreover, all of the criticisms made by Safeguarding's employees in that review were, in respect of the CATE Team, imposed or exacerbated by the restructure. As noted, I am driven to the view that the Council thought CSE had ended with the listing of the first Chalice trial and that no further response was necessary.

3.965 Another aspect of this episode is the lack of transparency that it demonstrates. As I have noted, CATE was not mentioned at all in the review of services. The Inquiry heard evidence that the CATE Team was kept confidential, or "*cloak and dagger*"[884]. This secrecy is, of course, at odds with the proper operation of the CATE service, though it may have, wrongly, been thought desirable in that it served to reduce demand. Combined with the evidence that the Inquiry has been provided with about the widespread ignorance of the long made

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881 [redacted] pg 3, [redacted] pg 17
882 [redacted] pg 19
883 [redacted] pg 14
884 [redacted]

plans for Family Connect, and the attitude to successive chairs of the LSCB, I conclude that those responsible for managing structures in the Council were not open or transparent about their intentions.

CATE Pathway

3.966 The move to set up the CATE Pathway, a new process which fell outside of Working Together 2006 and the Assessment Framework guidance was something the Inquiry understands to have been put in place by other local authorities to try and address the needs of children impacted by CSE. There was a belief that these children would not engage with statutory services. At this point there was not a complete national evidence base about what would be helpful to address the needs of children impacted by CSE. There was a lack of a clear outline of the risk assessment process, though there was a form with key risk areas outlined.

3.967 As I have remarked earlier, I consider that the CATE Pathway and its use of child protection language (for example "*strategy meetings*" and "*risk assessments"*) to describe processes which fell outside the statutory process was unfortunate. The CATE strategy meetings and risk assessments did not meet the statutory definition of these crucial child protection processes. However, the use of similar language for two different processes created a risk, as it gave the impression that child protection procedures had been followed, when this was not the case. It is unclear what was done to ensure that there was no confusion about this dual usage of terms.

3.968 *Working Together* allows for a preliminary assessment of referrals and diversion to more appropriate services even prior to an initial assessment. However, children were taken into CATE without consideration of an alternative. I consider that the CATE Pathway should have complimented the child protection procedures. It should never have been a replacement. While I have immense sympathy for those who took children into CATE because of the slowness of the Safeguarding response, it was not satisfactory to have dual and unequal provision, one working upon a statutory basis and one not.

2012 to Date

Key Developments

3.969 In the early part of this time period there was significant guidance for LSCBs. In 2013, the Children's Commissioner published the '*Inquiry into Child Sexual Exploitation in Gangs and Groups*'.[885] The report criticised services for persistently failing to safeguard children and being in denial about the scale of the issue. The Children's Commissioner's Inquiry had found that less than 6% of LSCBs were complying with the 2009 Sexual Exploitation Guidance in full, with one third not meeting half of the requirements. It said that substantial gaps remained in the availability of specialist provision for the victims/survivors of CSE.

3.970 In Telford, a new LSCB Chair had been appointed in 2012 and there was a review of the LSCB's structure and priorities. The LSCB grew still further, to a size that I regard as quite

[885] 'If only someone had listened' | Children's Commissioner for England (childrenscommissioner.gov.uk)

incompatible with useful work being done. Subgroups proliferated to an extent where it is virtually impossible to delineate their purpose or function. Inevitably, given that attendees were duplicated across so many different meetings, attendance was poor and substitutes often sent by key participants. Issues were raised repeatedly with no clear indication of action or resolution.

3.971 In May 2013, the LSCB decided that that CSE would "*no longer need priority status*"[886] as CATE work had been "*successfully embedded and mainstreamed*".[887] This was, in my judgment, a mistake for two reasons – first, because it gives the impression that the LSCB regarded CSE as 'over'; and second, because the reality was that CATE had been reduced to a team of one in 2012, and its subsequent performance under Cohesion was troubling and demanded close LSCB scrutiny.

3.972 It is important to remember that Cohesion was not Safeguarding. Although CATE had briefly been brought within Safeguarding in 2010 – in my view an important move which reduced the distance between the two separate CSE intervention pathways, and allowed for consideration of which was more appropriate for an individual child – in Cohesion it stood apart once more.

3.973 Furthermore, the Inquiry heard that those with management responsibility for CATE were inexperienced in child protection and inadequately briefed. A Cohesion manager wrote to a senior officer in Safeguarding with reference to CATE: "*I think I am now unclear as to my role. What responsibility do I have – Practice? Supervision?*".[888]

3.974 The CATE practitioner's task was, in my view, impossible. Not only did the single practitioner have a large number of cases, the Inquiry heard that they were expected initially to undertake all risk assessments and produce policies and procedures which hitherto did not exist. The case load was such that CATE was seeking untrained, unqualified help; at a TYS team meeting on 19 April 2012, a plea was made: "*if you have spare room on your case load, please see* [the CATE practitioner] *for CATE allocations...*" and noting, "*...training for this will be arranged in June*".

3.975 In November 2012 the CATE Team was told that there was no funding available for training.

3.976 The Inquiry has seen evidence that suggests that at this time of high demand, other features were regarded as more worthy of comment: a note reads:

"*... a CATE case was recently presented to Management Team that included two chronologies. What concluded from it was the use of language. Saying Asian male and if not always able to put to something specific, do not record*".[889]

3.977 This seems to suggest that unless greater specificity as to racial or ethnic background can be achieved, "*Asian*" should not be used; this is plainly nonsense as ethnicity of perpetrator may help to identify perpetrators, and therefore understand risk, and to map activity. Happily, I have not seen a general failure to record relevant data in the course of this

886 [redacted]
887 [redacted] pg 18
888 [redacted] pg 3
889 [redacted] pg 4

Inquiry, though mapping of offending was repeatedly raised as an issue throughout innumerable committees and groups and yet there appears to have been little resulting action.

3.978 The Inquiry has seen material in which reflection was made upon the state of a CATE Team staffed largely by new practitioners with inadequate training:

"My concern is… how dangerous this practice is (and how this mirrors the same situation we found ourselves in back in 2007 and what a scary place the Council found itself in with inappropriately supervised staff working CSE - which called for urgent action by [a senior official] *due to the risk to both yp* [young people] *and staff)".*[890]

3.979 In 2014 there was, almost unbelievably, another proposal to remove the senior CATE practitioner role, leaving the incumbent to move into management of a different team or to take a salary cut. It seems that representations were again successfully made for the retention of the role, but I regard it as quite astonishing that the Council should have again thought to risk losing such expertise; it speaks of placing cost saving above all else, and again of a lack of understanding of the importance of the CATE Team's role and work.

3.980 As a result of high demand, Cohesion looked to "*step down*"[891] CATE cases to other services. By 2015, there were only a small number of CATE practitioners, but their caseload was as big as the wider Cohesion team. It was insufficient capacity for caseload: it was simply not possible to do all that needed to be done. The NWG recommended an ideal caseload per worker of eight to ten cases; CATE practitioners had 15 to 18 cases. It was overwhelmed; it had never been expected to survive beyond 2012 and its reprieve was ill thought out. The Inquiry heard that the expectation was that CATE was "*a bit of a pet project, and probably not something that would go a long way beyond Chalice*".[892]

3.981 In 2016 Cohesion was abolished. CATE returned to Safeguarding. The Inquiry has heard a number of witnesses express the view that Cohesion had been a bad fit for CATE:

"*Upon hindsight… absolutely it should have sat somewhere else and it should have had different people managing it and managing the risk, just simply because of the understanding that's required... You needed to have a really experienced service delivery manager that was a social worker. I don't think we gave it the priority that it needed.*"[893]

"*I think of the end of the day it's child protection business, what they're doing is child protection. What they're skilled at is being able to reach young people that are very difficult to reach, really reach, very, very difficult. What they're also very good at is they form relationships, they assist the young person to gain access to people, other professionals that will be supportive to them, whether that's housing, whether that's police and whether that's social workers. So all of that skill and those engagement skills comes with managing a lot of risk because alongside that you've got young people that are being abused, on the*

890 [redacted] pg 1
891 [redacted]
892 [redacted] pg 25
893 [redacted] pg 28

fringes of being abused or are vulnerable. You need the social work element of it… They wouldn't have that in Cohesion."[894]

"[CATE] *came back* [to Safeguarding] *in 2015/16 because that's where it should sit. It probably should have sat within children's safeguarding. It's not a decision I would have made* [putting CATE into Cohesion] *if I had been in a position to influence anything."*[895]

3.982 Since 2016, the CATE Team has increased in size and acquired a Missing Children Co-Ordinator. The Inquiry has read that the team is now "*comfortable*"[896] with capacity and workload. I have seen material which shows that there are 11.6 workers currently in the CATE Team, comprised of two managers, one senior practitioner, 7.6 FTE (full time equivalent) CATE practitioners and one senior social worker[897]; the team dealt with the same number of referrals in 2019/2020 as the (much smaller) team did in 2010/2011, which gives an indication of the pressures in earlier times.

3.983 It is undoubtedly positive that the CATE Team appears, finally, to be on a sustainable footing. In my view, though, the story of its ad-hoc beginnings in the Youth Service and its creation of its own processes meant that there had not been a philosophical reflection on its processes and ethos until it came within Safeguarding in 2016. The CATE process is not, and was never, a safeguarding process; but had continued to use the language of *Working Together* and to map response largely in terms of victim behaviour modification. Since then, there have been changes to its terminology, removing any scope for confusion with statutory safeguarding processes, and a change in risk assessment which places a greater emphasis on contextual risk. The CATE Team's pathways interact fluidly with the statutory safeguarding system.

3.984 In 2020, Ofsted[898] assessed Telford's response to children facing risks outside the family as "*very strong*" and the Council's Children's Services offering as a whole as "*outstanding*".

The National Landscape

Guidance for responding to Child Sexual Exploitation 2012-2013

3.985 A step-by-step guide was published in 2012 by the Department of Education titled, "*What to do if you suspect a child is being sexually exploited"* (the "2012 DfE Guidance").[899] This was to be read alongside the 2009 Sexual Exploitation Guidance and outlined the actions that should be taken by professionals. It makes clear the central role that LSCBs should play in ensuring that appropriate local procedures were in place. The key points were:

3.985.1 Making sure professionals understood the legal framework for consent;

[894] [redacted] pg 20
[895] [redacted] pg 13
[896] [redacted] pg 1
[897] [redacted]
[898] [redacted]
[899] https://www.teescpp.org.uk/media/1248/what-to-do-if-you-suspect-a-child-is-being-sexually-exploited.pdf

3.985.2 Clarity that a referral of a child to Safeguarding is necessary where need or harm has been identified;

3.985.3 Importance of ensuring the use of existing frameworks for assessment where there are concerns about CSE;

3.985.4 Ensuring there are support services for CSE victims/survivors on the road to recovery;

3.985.5 Ensuring there are systems in place to identify and prosecute perpetrators and that all professionals understand their role within this; and

3.985.6 Ensuring child victims/survivors are supported through legal proceedings.

3.986 The '*Tackling child sexual exploitation action plan: progress report*'[900] was published by the Department of Health in July 2012 (the "Department of Health Report"). The report itself highlights a range of progress across government departments and multi-agency professional organisations. It promotes the use of the data monitoring tool developed by the University of Bedfordshire as a self-assessment tool that all professionals could use in assessing their progress in tackling CSE. The plans proposed to ask all local authorities to review their own data collection processes regarding CSE and to also focus on children in public care. LSCBs were asked to consider the findings of the early report of the Office of the Children's Commissioner Inquiry when published.

3.987 The Department of Health Report highlighted that:

"*Telford & Wrekin Safeguarding Children Board made tackling child sexual exploitation a Board priority in 2009. This enabled concerted action to be taken requiring a transformative redesign of the existing partnership approach, especially between the police and Children's Social Care. Anecdotal evidence suggests that children and families feel better supported and staff feel more confident in identifying and tackling child sexual exploitation, the network of organised criminality has been disrupted with prosecution ongoing and there is increased community engagement in tackling child sexual exploitation….*"[901]

3.988 The Office of the Children's Commissioner launched a two-year inquiry into CSE in gangs and groups. The interim report was published in 2012.[902] This report concluded there was a need for urgent action to ensure that professionals are recognising the warning signs of children being subjected to CSE at the hands of gangs and groups; there remained concerns about poor data collection. The early recommendations suggested:

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[900] Department of Health (2012) Tackling child sexual exploitation action plan Progress report. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/200107/DFE-00072-2012.pdf

[901] [redacted], pg 10

[902] Berlowitz (2012) "I thought I was the only one. The only one in the world" The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation In Gangs and Groups Interim report November 2012 https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/07/I-thought-I-was-the-only-one-in-the-world.pdf

3.988.1 Directors of Children's Services and other senior leaders from partnership agencies should circulate information about the warning signs of CSE and ensure they understand them and act on them;

3.988.2 LSCBs should use the University of Bedfordshire self-assessment tool to conduct audits of CSE;

3.988.3 There should be an increased focus on the perpetrators of CSE;

3.988.4 Local data gathering should be improved;

3.988.5 LSCBs should ensure that the core training they deliver included the warning signs of CSE and impact; and

3.988.6 LSCBs should outline an implementation plan for training delivery regarding CSE as part of their 2013/2014 business plan.

3.989 The All-Party Parliamentary Group produced a report in 2012 into Children who were missing from care.[903] This focused on issues of CSE, and similar recommendations were made to those of the recent Children's Commissioner report. The importance of data collection and local knowledge was highlighted. The Government accepted all recommendations and agreed to immediate action.

3.990 In May 2012 a criminal trial was held in Rochdale and nine men were found guilty of child abuse and localised grooming. The Home Affairs Select Committee started taking evidence regarding CSE and localised grooming. This led to a report being published in June 2013.[904] This reinforced the need for children subject to CSE to be seen as victims of abuse and the notion of consent to be challenged. Concerns were expressed about lack of professionals' awareness and action, continued poor data collection, poor leadership and the need for more training to be provided.

3.991 The final report from the Office of the Children's Commissioner's '*Inquiry into Child Sexual Exploitation in Gangs and Groups*' was published in November 2013 (the "Gangs and Groups Report").[905] The Gangs and Groups Report criticised services for persistently failing to safeguard children and being in denial about the scale of the issue. The Children's Commissioner's Inquiry had found that less than 6% of LSCBs were complying with the 2009 national guidance on CSE in full, with one third not meeting half of the requirements. It said that substantial gaps remained in the availability of specialist provision for the victims/survivors of CSE.

3.992 The Gangs and Groups Report outlined the need for significant improvements in the response to CSE and outlined seven principles that should underpin any change. These principles included a child centred and inclusive approach, comprehensive data collection and analysis, effective information sharing within and between agencies, supervision,

[903] https://www.gov.uk/government/publications/report-from-the-joint-inquiry-into-children-who-go-missing-from-care
[904] https://publications.parliament.uk/pa/cm201314/cmselect/cmhaff/68/6802.htm
[905] Berelowitz et al (2013) "If only someone had listened" Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report; https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/07/If_only_someone_had_listened.pdf

support and training for staff and clear evaluation and review of the multi-agency response. It concluded that dynamic and consistent leadership in every part of the system was critical for success.

3.993 The Gangs and Groups Report proposed a new framework, *'See Me, Hear Me'*, for those who commission, plan or provide protective services. It was accompanied by two other reports from the Children's Commissioner's Inquiry, which highlighted the risk to children and the complexities around their understanding of sexual consent.

Working Together to Safeguard Children – 2013

3.994 In 2013, a new version of Working Together was published ("Working Together 2013"),[906] which replaced Working Together 2006. This had a whole section on early help and suggested that local agencies should have in place effective ways to identify emerging problems and potential unmet needs for children and families. This would require all professionals to understand their role in identifying emerging problems and to share information with other professionals to support early identification and assessment.

3.995 This guidance also introduced changes to the governance arrangements for the independent chairs of the LSCB. They were now to be appointed by, and held to account by, the Chief Executive of the local council. There was a proposal to set up a national panel to hold LSCB chairs to account when conducting SCRs and there was a strong reiteration of the need for all SCRs to be published in full. There was a requirement for LSCBs to develop a local framework for learning and improvement, including a regular review of cases that might not meet the criteria for a full SCR but could be reviewed locally and increase local learning. LSCBs were also asked to monitor and evaluate the effectiveness of training, including multi-agency training, for all professionals in the area. The guidance regarding CSE remained unchanged.

Rotherham Inquiry

3.996 In August 2014, the report of the Independent Inquiry into CSE in Rotherham, chaired by Alexis Jay, was published (the "Jay Report").[907] This was a comprehensive and critical report regarding addressing the safety and wellbeing of children subject to CSE. The section which focused on the LSCB/ACPC function noted that they had overseen the development of good inter-agency policies and procedures to address CSE. The weakness had been that members of the LSCB rarely checked whether these were being implemented or working in practice. The Jay Report noted there were poor processes for data collection, lack of file audits and performance reporting. The challenge and scrutiny functions of the LSCB and leadership within the local authority itself had also been lacking. It also highlighted ongoing concerns about risk assessment processes and the provision of effective long-term support for child victims/survivors of CSE. This was an important finding and, given the number of differing CSE reviewing mechanisms, reports and audits with action plans at the Council, there were some parallels.

[906] https://www.workingtogetheronline.co.uk/documents/Working_TogetherFINAL.pdf
[907] Jay A (2014) *Independent Inquiry into Child Sexual Exploitation in Rotherham: 1997-2013.* Rotherham: Rotherham Metropolitan Borough Council.

3.997 In October 2014, the Inquiry into Child Sexual Exploitation, chaired by Ann Coffey, MP for Stockport (and Chair of the All-Party Parliamentary Group for Runaway and Missing Children and Adults) report was published. Under the title '*Real Voices*',[908] the report gave prominence to the voice of children. It looked at what changes had been made in safeguarding children from sexual exploitation since the Rochdale grooming case, and what more needed to be done. Although the focus of the report was on Greater Manchester, the report contains several national recommendations. A few were for the national government, but many were for local authorities to consider their response, with other local agencies, to CSE and improving the safeguarding of children. The Real Voices report highlighted the important role of communities and school in tackling CSE. It noted that there was a continued gap in services to address the needs and circumstances of the victims/survivors of CSE.

3.998 In November 2014 Ofsted published a report on its thematic inspection of eight local authority responses to CSE(the "2014 Thematic Inspection").[909] This was prompted by the Jay Report. The findings showed that professionals continued to fail to properly apply child protection processes to address CSE. LSCBs were considered to have shown poor leadership and had failed to adequately challenge the slow progress being made in developing strategies and meaningful action plans. There were continued concerns about poor data collection and a lack of local knowledge about the extent and patterns of CSE. Many areas had been slow to implement the 2009 Sexual Exploitation Guidance. The inspection found huge variability in front line practice, with some excellent practice and others failing to safeguard children, leaving them at risk of ongoing harm. There was poor attention being paid to the disruption and prosecution of the perpetrators of CSE. The review called for more action by LSCBs and the ongoing need for training and awareness raising. The recommendations were that:

3.999 All local authorities should:

3.999.1 Ensure good management oversight of CSE cases including assessments, plans and case review arrangements;

3.999.2 Ensure missing from home interviews were completed to a high standard and there should be cross referencing to missing from school data;

3.999.3 Establish a targeted, preventative programme for children in local authority care;

3.999.4 Develop and publish an action plan regarding their response to CSE that is shared with the Chief Executive of the Council, the LSCB, the Community safety partnership and the Police and Crime Commissioner; and

3.999.5 Share information and intelligence about CSE in their area across the partnership.

[908] https://www.basw.co.uk/resources/real-voices-child-sexual-exploitation-greater-manchester
[909] Ofsted (2014) The sexual exploitation of children: it couldn't happen here, could it? https://www.gov.uk/government/publications/sexual-exploitation-of-children-ofsted-thematic-report

3.1000 It further recommended that LSCBs should:

3.1000.1 Ensure that the local authority and its partners have a comprehensive action plan in place to address CSE; the LSCB should critically evaluate the action plan;

3.1000.2 Hold partners accountable for the plan and monitor progress or the lack of it;

3.1000.3 Ensure that all partners routinely follow the child protection procedures in CSE cases, children missing from home procedures and that the local threshold document be reviewed to ensure that CSE is adequately addressed; and

3.1000.4 Ensure appropriate training is available and to evaluate the difference it is making in practice.

3.1001 The Government was also asked to review and update the national 2009 Sexual Exploitation Guidance.

Guidance for responding to Child Sexual Exploitation 2014-2017

3.1002 In December 2014, the Local Government Association ("LGA"), in conjunction with Barnardo's, produced a resource pack focused on CSE for councils.[910] This report summarised the 2013 Inquiry by the Children's Commissioner into CSE in Gangs and Groups and the 2014 Thematic Inspection by Ofsted and brought together the key principles that should underpin the response to CSE by councils. These were as follows:

3.1002.1 Focusing on victims;

3.1002.2 Engaging with all communities .

3.1002.3 Better awareness raising and education for professionals and the wider community;

3.1002.4 Training for all professionals;

3.1002.5 Professional attitudes and use of language;

3.1002.6 Leadership, challenge and scrutiny;

3.1002.7 Coordinated, strategic responses and performance management; and

3.1002.8 Disruption and prosecution.

3.1003 The resource pack suggested a number of key lines of enquiry for all Councillors, such as:

3.1003.1 *"What is the extent and profile of CSE in our local area? How do we know?"*

910 [redacted]

3.1003.2 *"Do we have a local CSE strategy and action plan? Are these multi-agency and how is progress monitored? How does this link to other plans and strategies?"*

3.1003.3 *"How effective is the Local Safeguarding Children Board? Are all agencies engaged at a senior level, and is CSE an area for priority focus?"*

3.1003.4 *"Does the relevant scrutiny panel receive the LSCB's annual report, and use this to challenge local priorities and outcomes?"*

3.1003.5 *"What other multi-agency forums exist to facilitate joint working?"*

3.1003.6 *"How is CSE incorporated into local training programmes, and who is able access this training? Does this include training for a wider cohort than just those professionals working directly with children and young people, such as licensing officers, environmental health officers or elected members? Are outcomes measured, and are changes made as a result?"*

3.1003.7 *"Is an awareness raising programme in place for children, families and the wider community? Is this reaching the right people?"*

3.1003.8 *"What support is available to current, potential and historic victims of CSE?"*

3.1004 In 2015, the Office of the Children's Commissioner published an updated report to the Gangs and Groups Report, entitled '*Inquiry into Sexual exploitation in Gangs and Groups: one year on'*.[911] This reported that there remained concerns about the identification of those experiencing CSE. It found that 92% of LSCBs had a CSE strategy and there had been an improvement in the level of compliance with statutory guidance regarding CSE. However, it considered that progress at a strategic level had not filtered down to front line practice. There remained concerns about the quality of data collection, the analysis of local information and there was variable practice regarding audit activity. There were no new recommendations.

3.1005 In 2015, Working Together'[912] was reissued again ("Working Together 2015") to replace Working Together 2013. The guidance regarding early intervention/early help and addressing CSE remained unchanged. It focused on clarifying when local authorities should report incidents involving harm to children to Ofsted and the concept of what constitutes significant harm. The criteria for a SCR was also broadened. The key principles underpinning this document were outlined as:

3.1005.1 Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and

3.1005.2 A child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

[911] Office of the Children's Commissioner (2015) "If it's not better, it's not the end" – Inquiry into Child Sexual Exploitation in Gangs and Groups: One year on. London: Office of the Children's Commissioner.
[912] http://www.safeguardinginschools.co.uk/wp-content/uploads/2015/03/Working-Together-to-Safeguard-Children.pdf

3.1006 In September 2017, '*Working effectively to address CSE: an evidence scope*'[913] was published by Research in Practice. This highlighted that across the child welfare sector there was increased knowledge and awareness of CSE but addressing it in practice remained a significant professional challenge. This evidence scope suggested that work regarding CSE needed to be unified with approaches to intra-familial sexual abuse, harmful sexual behaviours and peer sexual abuse. It suggested there had been insufficient focus on the role of social media and the internet, continued concern about victim-blaming and language, and the understanding of early trauma.

3.1007 The evidence scope concludes with a reminder of the complexity of working with CSE and the need for professionals to be sufficiently supported.

3.1008 In 2017, the 2009 Sexual Exploitation Guidance was reissued and updated, entitled '*Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from CSE, 2017*' (the "2017 Sexual Exploitation Guidance").[914] The advice was non-statutory, and was produced to help practitioners, local leaders and decision makers who work with children and families to identify CSE and take appropriate action in response. The 2017 Sexual Exploitation Guidance included the disruption and prosecution of perpetrators. There was a reminder that it needed to be read alongside Working Together 2015.

3.1009 The 2017 Sexual Exploitation Guidance contained a new definition, and notes that a common definition of CSE was critical to identification, monitoring and effective multi-agency practice. The definition makes it explicit that CSE is a form of child abuse, which is not the victim's fault, and there was also a renewed focus on coercion and control:

"Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology."

3.1010 It further provided guiding principles for those working with children and their families affected by CSE. It also provided a framework for managers and strategic leaders to ensure an effective response to CSE, highlighting:

3.1010.1 The importance of an effective multi-agency plan which is supported through clear leadership;

3.1010.2 The need to move beyond a reactive response to CSE to one that actively prevents harm;

[913] Eaton J & Holmes D. (2017). Working Effectively to Address Child Sexual Exploitation: Evidence Scope (2017). Dartington: Research in Practice: https://www.researchinpractice.org.uk/children/publications/2017/october/working-effectively-to-address-child-sexual-exploitation-evidence-scope-2017/#32f

[914] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/591903/CSE_Guidance_Core_Document_13.02.2017.pdf

3.1010.3 The need to collect data and intelligence in the local area and use this for planning; particularly regarding perpetrators of CSE;

3.1010.4 The need for an increased engagement with diversity;

3.1010.5 The need for there to be continued improvements in inter-agency working, including information sharing guidance, common risk assessment processes, clarity regarding professional roles and responsibilities and consistency in the application of thresholds for different action across the safeguarding continuum; and

3.1010.6 The importance of ensuring the workforce were equipped to work effectively with CSE and were appropriately supported.

3.1011 An extended version of the 2017 Sexual Exploitation Guidance was commissioned by the Department for Education[915] in the same year of its publication. The extended version brought together the existing evidence base around CSE with the intention of identifying issues that had proved challenging to address in practice and to draw out lessons learnt in relation to this. It provided a high-level framework for building a locally informed enhanced response with the intention that this response would concurrently addresses prevention, and responses to victimhood and perpetration, and supports the exercise of "*professional curiosity*" within this.

Safeguarding Partnership

3.1012 In March 2016 the Wood Report was published[916]; its remit was to review the role and functions of LSCBs. It concluded that in the LSCB model "*the pendulum has locked itself too close to a belief that we should say how things should be done as opposed to what outcomes we want for children and young people*" and proposed fundamental change.

3.1013 Wood's findings were accepted; in 2017 the Children and Social Work Act 2017[917] provided for the abolition of LSCBs and set out new requirements for the safeguarding partners to make any arrangements, that they and any relevant agencies considered appropriate, to work together in exercising their functions. This included arrangements for the safeguarding partners to work together to identify and respond to the needs of children in their area. This Act created three safeguarding partners. In relation to a local authority area in England these partners are:

3.1013.1 The local authority;

3.1013.2 A clinical commissioning group for an area any part of which falls within the local authority area; and

[915] Beckett, Holmes and Walker (2017) Child sexual exploitation: Definition and Guide for Professionals - Extended text. https://www.researchinpractice.org.uk/media/2492/child_sexual_exploitation_practice_tool_2017_open_access.pdf
[916] www.publishing.service.gov.uk
[917] Children and Social Work Act 2017 (Get in on the Act) (local.gov.uk)

3.1013.3 The chief officer of police for a police area any part of which falls within the local authority area.

3.1014 The Children and Social Work Act 2017 also created the role of a relevant agency.

3.1015 It defines these as organisations and agencies whose involvement the safeguarding partners consider is required to safeguard and promote the welfare of local children. Local arrangements need to engage these bodies to work in a collaborative way to provide targeted support to children and families as appropriate. *Working Together* offers clear advice on how the statutory safeguarding partners can ensure relevant agencies are fully engaged and consulted about the local arrangements to effectively safeguard children. This category includes schools, colleges, GPs, probation services and providers of childcare. The full list is laid out in the Relevant Agencies Schedule of The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018.

3.1016 Working Together guidance[918] was again reissued in 2018 ("Working Together 2018"). Chapter Three details clearly the leadership role to be played by the statutory safeguarding partners. It states that, "*Strong leadership is critical for the new arrangements to be effective in bringing together the various organisations and agencies*". Working Together 2018 had nothing new to say about early help or early intervention. These concepts have developed individually within each local authority and LSCB. Although successive versions of *Working Together* have highlighted the importance, there has been no clear mandate or statutory authority.

Ofsted Inspection - 2012

3.1017 Between 25 June and 6 July 2012, Ofsted carried out an inspection of safeguarding and services for looked after children in Telford & Wrekin.[919] The overall effectiveness of the Council and its partners in safeguarding and promoting the welfare of children was considered to be "*adequate*", meaning that it was a service that only met the minimum requirements. It was noted that some progress had been made in relation to the quality of assessments but that reflective supervision and the consideration of children's diverse needs in assessments remained areas for development. The inspectors considered that the previous good quality provision in response to CSE and the multi-agency 'Team Around the Child' and family was sustained.

3.1018 Safeguarding services were rated "*adequate*", with mature partnerships and links with the LSCB and the local strategic partnership providing a platform on which to further develop strategic direction. The "*fully established*" LSCB successfully demonstrated a culture of appropriate challenge resulting in effective governance of safeguarding issues by the Council and its partners, but was yet to evidence improvements in frontline social work practice. Partnership working was also judged to be good with the result being that children reported that they felt safe in Telford & Wrekin.

3.1019 Thresholds to services were clearly defined and understood and there was a prompt diversion of contacts not requiring social work intervention to early intervention services

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prior to the inception of the Family Connect service in September 2012. Arrangements for children who went missing were also deemed to be effective.

3.1020 The quality of provision of safeguarding outcomes for children was rated "*inadequate*". It was noted that, although early intervention services were embedded and provided an effective lower level multi-agency response, the provision of targeted services was less well developed. Contacts and referrals were not being progressed in a timely manner because of lengthy information gathering by the Helpdesk. The quality and timeliness of assessments was variable.

3.1021 Contrary to what I have seen in documents provided to the Inquiry and witnesses who were dealing with the issue in 2012, it was stated that robust measures were in place to identify the cause of children persistently missing from education or reported missing from home, and that effective multi-agency working ensured responsive services. If it was suspected that a child was being sexually exploited, they could be referred to CATE.

3.1022 Partnership working was rated as "*good*" with the governance provided by the LSCB's CATE subgroup considered to be "*highly effective*"; with, "*excellent partnership working that protects young people abused through sexual exploitation and prostitution*".[920] It was noted that:

"… *the approach steps away from traditional models of escalation and enforcement on the victim, to one of care pathways involving the young people and their parents in breaking the cycle of abuse. Partnership working includes the involvement of dedicated workers within the targeted youth support service, who are recognised as having the most appropriate skill set to engage young people in positive behaviours and also the police. They use the CATE process to gather intelligence and appropriately focus enforcement on the perpetrators*".[921]

3.1023 Also that:

"… *specialised CATE training is provided and this includes to staff of private children's homes in the area from which children frequently go missing and are at risk of sexual exploitation and prostitution*".

3.1024 Leadership and management was rated to be "*adequate*". There was reference to the upheaval caused by the recent restructure in April 2012, which it was noted had resulted in considerable changes to the workforce and line management arrangements, which were still bedding in. There was a secured financial commitment to increase staffing levels, however, the social work vacancy remained high as did the use of agency staff to backfill vacancies and absence. It was noted that this had impacted on the provision of timely services resulting in the inappropriate deployment of non-qualified workers at the Helpdesk during busy periods. Additionally, capacity issues within the Independent Reviewing Officer ("IRO") team were impacting on the ability of child protection chairs to monitor child protection plans between reviews. However, it is noted that work done to target support to vulnerable groups, particularly children who were sexually exploited, was well established

920 [redacted] pg 26
921 [redacted] pgs 26-27

and that those services were embedded.

3.1025 In the areas for improvement, there were no references to CSE. However the areas identified would have had a direct consequence in relation to all cases (which would include CSE); ensure the outcome of child protection enquiries are recorded promptly; and end the unsafe practice of holding cases as contacts and referrals for long periods while information gathering.

3.1026 The Inquiry recognises that young people's experiences can often be too complex to categorise under single, discrete headings and that they will often experience multiple forms of abuse and adversity including exploitation. Ofsted informed the Inquiry that it would expect a local authority to consider how areas for improvement relate to all children that needed help and protection. Addressing wider practice issues in supporting children's needs is more effective in driving improvement within a local authority.[922]

3.1027 The Ofsted inspections are relevant to this period of time. Although it is important to note that the Inquiry has broader Terms of Reference and has had greater access to documentary and witness evidence; the Ofsted inspection is a snapshot and not an audit of every case and activity within a local authority. I have set out what I regard as real difficulties with CATE provision at this time, with which this inspection does not deal, understandably given the scope and purpose of the inspection which was not intended to be a deep dive into CATE and CSE specifically.

The LSCB

A new broom

3.1028 The LSCB Executive meeting on 13 December 2012,[923] welcomed a new LSCB Chair. I understand from the evidence I have seen that he did not share his predecessor's preference for a small LSCB membership or the view that larger meetings were ineffective.[924] It was felt that the outgoing Chair, due to his career experience, had focused on the operational detail of the Council's work, rather than the larger picture, and the emphasis needed to move to the overall strategic direction and guidance.[925] Evidence suggests that the incoming Chair saw his role as being a facilitator and as someone who helped the partnership to "*raise its game*".[926] There was a review of the LSCB's structure and an intention expressed to "*streamline its governance*", it being thought that the LSCB's structure had become "*clunky*".[927]

3.1029 A meeting of the LSCB in 2013[928] had 37 people scheduled to attend. Over one third of potential attendees did not attend. Very soon afterwards the LSCB (though not subgroups) amended the way in which apologies were recorded, so attendance is difficult to gauge. During the Maxwellisation process, the Safeguarding Partnership suggested a reason for

922 [redacted]
923 [redacted]
924 [redacted] pg 9
925 [redacted] pg 3
926 [redacted] pg 4
927 [redacted] pg 4
928 [redacted]

differing and sometimes poor levels of attendance at LSCB meetings.[929] It stated that this was:

"… *due to the environment in which the LSCB operates. It is inevitable that frontline staff, across all partners, will be unavailable at times due to the need for priority to be given to dealing with critical incidents and that this is one of the reasons why there may be more than one attendee from each partner and that each meeting will often comprise a different group of people from the last*".

3.1030 I accept that this accounts for some, but not all, of the evidence that I have seen of poor attendance.

3.1031 At the LSCB on 23 January 2013,[930] the newly instituted standing agenda item, "*How has the work of this meeting contributed to keeping children and young people safe*?" was answered with, "*continued learning from CATE will have a huge impact on young people in Telford and Wrekin.*" The reality is that standing questions of this sort are empty and the answer is meaningless. Every member of the LSCB should know its function and terms of reference. Their time should not be filled by composing trite answers to unnecessary questions.

3.1032 The LSCB Executive on 28 March 2013,[931] considered the costs of SCRs and remarked that, "*there are also costs implications for the Neglect Model and CATE*" though those implications were not elaborated. Whilst the Safeguarding Partnership has, during Maxwellisation, invited me to accept that minutes are not intended to be a verbatim record of what has been said, but rather a summary of discussions,[932] I consider the raising of costs implications to be significant, given the decision not to conduct a SCR post-Chalice.

3.1033 On 17 April 2013, the LSCB Executive 'Board Governance Working Group' met for the first time to approve a strategic business cycle.[933] The cycle was summarised in the diagram below:

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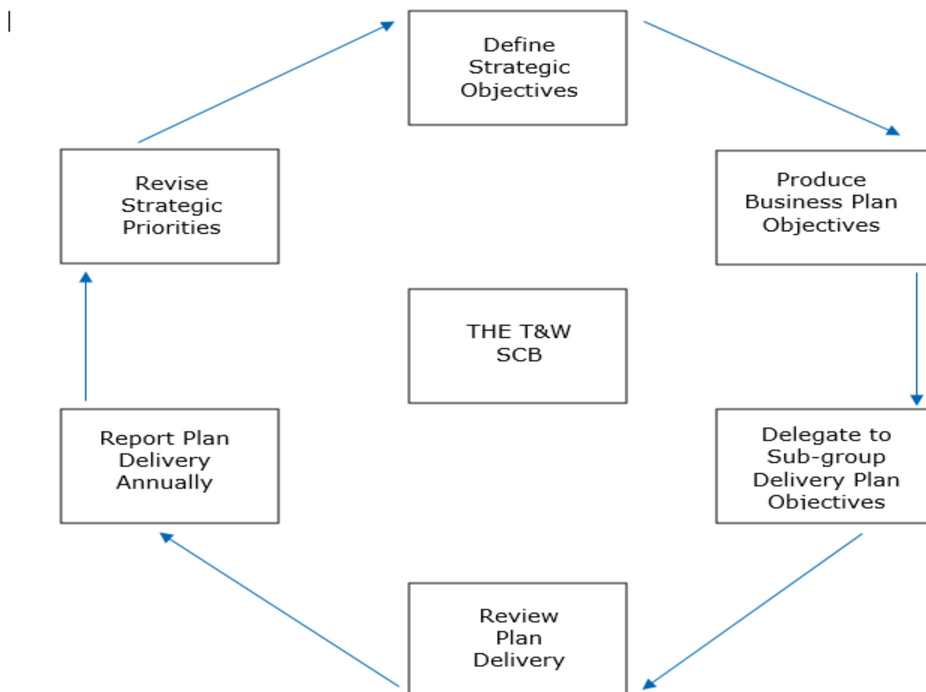
Figure 3B:



3.1034 The proposal contemplated that the circular path would be traced on an annual basis and that the LSCB would "*review its strategic priorities and revise its strategic objectives for the following year".*

3.1035 It was also contemplated that the LSCB Executive would be abolished, and replaced by the QPO group, to be made up of LSCB subgroup chairs. A final decision was deferred to a LSCB Governance working group, which in my experience usually means that unexpected resistance has been met, but the nature of the resistance, if any, is not apparent.

3.1036 On 1 May 2013, the LSCB Governance working group[934] report recorded that:

"… *the majority accepted the case for disbanding the executive and creating a streamlined, "whole system" approach to Board Governance, a number of concerns and reservations were recorded to be addressed at the next stage in the development process,"*

3.1037 This seems remarkably similar to the formulation used on 17 April.

3.1038 The inevitable occurred in 2014 with the establishment of the QPO subgroup; essentially replacing the previous LSCB Executive committee, and responsible for the work of the subgroups including the CSE Thematic subgroup (and its subgroups).

3.1039 Changing the name of the group did not change the underlying problems; at the LSCB on

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21 January 2015,[935] concerns were raised about attendance at the QPO subgroup; often the "*right*" person did not attend from services and the group could not be productive. Board members were asked to "*review who represents their agency at the subgroup to ensure they are the right person and that they can attend in order for the group to be more productive*", which seems to me to be the plainest indication that there were concerns both that the "*right*" person did not attend from services and the group was not as productive as it should be. Concerns over attendance and productivity were not new.

CSE stood down as a LSCB Priority

3.1040 At the LSCB in May 2013,[936] a working group looking at priorities had decided first not to use the term "*priorities*" but rather "*key areas for development.*" More significantly, the existing priority subgroups (including CATE Pathways) were asked to "*feed back on whether the work undertaken means that the approach they have developed is embedded in current working practice and whether their priority group can therefore be stood down.*" The Council told the Inquiry[937] that the purpose of these decisions was to ensure that resources were dedicated to things that needed attention. I further understand from the Council that the 'finishing' of a group was not intended to be an execution, but rather a recognition that its purpose (as set out in its terms of reference) have been served. The dissolution of the group was also said to be conditional on the group achieving completion of the learning exercise and the creation of a performance framework with a requirement that the final report from the subgroup be presented to the LSCB at the next meeting to ensure that this had been done.

3.1041 So far as CSE/CATE as a priority was concerned the working group considered that:

"… *the group feel that there is information to show that processes, training and resources are embedded in partner agencies and therefore the work is no longer a project… However there is evidence to show that although work is good there is still more to do and although much has been learnt, the group have not yet been able to obtain feedback from young people or their families. Therefore, the group proposed that their work continues as a KAD for a limited period in order to finish these two pieces of work.*"

3.1042 This seems to have amounted to a temporary stay of execution.

3.1043 At the LSCB on 17 July 2013,[938] the Chair considered the LSCB Priorities Report[939] which had indicated:

"*... the* [CATE] *work had been mainstreamed and so it would no longer need priority status once the current learning exercise has been completed and a performance framework finalised….*"

3.1044 In a related field, the Chair noted that while "*significant progress had also been made with Missing Children, although the new arrangements needed… more time to become*

935 [redacted]
936 [redacted]
937 [redacted]
938 [redacted]
939 [redacted]

embedded".

3.1045 On 15 January 2014, the LSCB accepted the proposal that the CATE subgroup be stood down and reformed as the 'CSE Strategic Development Group'; simultaneously the reformed subgroup would also be stood down as an LSCB priority.[940]

3.1046 The Inquiry heard from a senior figure that the decision was taken because the developmental work to ensure the necessary procedures and processes in place was complete, rather than there being a sense that CSE as a crime was less of a priority. It simply did not require the same level of scrutiny by the LSCB, due to the necessary learning having been successfully embedded and mainstreamed.

3.1047 An LSCB member told the Inquiry that some LSCBs identified brand new priorities every year, whereas the then view of the Telford & Wrekin LSCB was that if an area was particularly complex it should remain as a priority.[941]

3.1048 A manager told the Inquiry:

"*I think they felt that that was working but then it* [CSE] *should never have not been an LSCB priority... it always should have been, it should have remained an LSCB priority."*[942]

3.1049 I regard it as important to remember that CATE had in fact in no real sense been successfully mainstreamed. It had been reduced to a team of one and, as we shall see, the service was struggling to regroup. In my judgment this decision to stand down the priority group had no foundation in reality.

LSCB Consideration of CSE issues

3.1050 On 15 January 2014, analysis of the LSCB Performance Report[943] showed that the percentage of referrals leading to Safeguarding involvement had decreased to 50% at 2012/2013 year end and to 37.3% by the end of the second quarter of 2013. This was significantly lower than the national average of 74.7% and seen as a failure of the system but it was noted, "*since, the 6 month monitoring arrangements have changed in Family Connect to improve performance*". Further:

"*... the percentage of Initial Assessments carried out within 10 working days was 52% at year end and has stayed the same at the end of quarter 2. This is significantly lower than the national average of 75.47%."*

3.1051 The meeting received a RHI report[944] which reported that there were still gaps in the collection and recording of data. There were only ten outstanding RHIs but there was "*a concern about the chasing of these results*" – which presumably means that they were not being chased or that the chasing was being ignored.

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3.1052 Notes of a Strategic Partnership meeting for CSE bringing together representatives of various local authorities, including Telford, held on the 19 January 2015,[945] reveal:

"*Telford had been subject to an LGA peer review of the LSCB with regard to CSE who stated their strategy was too ambitious and the group agreed that strategies for CSE therefore needed to be SMART.*"[946]

3.1053 At the LSCB on 17 September 2014,[947] an update on exploitation was provided and the members were reminded of the success of Chalice. They reminded the LSCB that CSE was no longer a developmental priority but remained "*a*" priority; and noted that many agencies, including the CSP, were looking for reassurance that the issue was still receiving the attention it warranted. The Chair indicated that, at a PCC meeting, it had been suggested that a strategic regional subgroup focusing on operational priorities should be formed and that CSE could provide its first workstream; this was agreed. The QPO subgroup was to demand a statement from the CSE Pathway group and a copy of its action plan.

3.1054 The relevance of this meeting is clear. The stand down of CSE as a priority subgroup was, if not a mistake, then a presentational disaster. The LSCB had managed to give the impression it regarded CSE as yesterday's problem; and it was now scrambling to cure that by effectively reinstating the abolished priority group – with, it should be noted, some extra areas of responsibility that, while serious, did not have the same history in Telford as CSE.

3.1055 A meeting of the Children Young Persons and Family Board in 2014,[948] considered the "*partnership landscape*" though without any mention of the LSCB, leading to protest from the LSCB Chair and the reassurance that there must be strong links between the two bodies. The Children and Young Persons Family Board, which had not considered CSE in several previous meetings,[949] was to become a "*Commissioning and Transformation Partnership*" while remaining a "*critical friend*" to the LSCB.

3.1056 At the LSCB on 19 November 2014,[950] WMP indicated that a dedicated CSE team – a Detective Sergeant and four Detective Constables – would be in place from January 2015. The Inquiry heard:

"… *so it was like Chalice was put to bed, Chalice and the perpetrators seemed to go quiet for a period of time but now the same names were all cropping up again and I think at that point, I obviously wasn't party to the Police discussions, but I think at that point the Police said this is rising again now.*"[951]

3.1057 At the LSCB on 21 January 2015,[952] there was discussion about Family Connect: it was suggested that "*reductions in appropriate referrals would be best achieved through bilateral initiatives between Family Connect and individual agencies*" and it was noted that "*this approach was starting to show some benefits*". Further, the Chair "*stressed the importance*

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of all partners ensuring that they continue to examine what action they can take locally before referring cases to Family Connect", which tends to suggest that Family Connect was taking informal steps to reduce an unmanageable workload and echoes the efforts to reduce Helpdesk referrals in the late 2000s.

3.1058 Following a questionnaire, the decision was taken not to stand down the Missing subgroup. At this point in time, I understand that missing children and the links to CSE were becoming more prominent on a national scale following various reports and criminal cases so it is logical that the importance of the Missing subgroup would be recognised and the decision taken for it to remain.

3.1059 At the LSCB on 18 March 2015,[953] CSE initiatives were discussed, and it was suggested that work would be undertaken to determine whether voluntary youth workers could be accredited for CSE work.

3.1060 At the same meeting it was agreed that the CSE subgroup be reinstated as a priority subgroup of the LSCB. A senior figure in Education said of the decision that there had been a "*drift in focus*"[954], which she attributed to poorly attended meetings and delegation of attendance responsibility, even amongst the most senior members of the LSCB. The Inquiry was told that this reinstatement was in part because of an understanding that Ofsted would not rate a partnership as "*good*" unless a priority CSE subgroup existed.[955] This seems to me to be a disappointing focus on appearance rather than substance.

3.1061 On 18 November 2015,[956] a Councillor told the LSCB that the budget cuts faced were the most difficult to date and that there could be no guarantee that they would not affect the safeguarding budget.[957] The same meeting recorded that "*ensuring all schools are up-to-date and following training requirements in respect of CSE is a challenge*". Further, "*keeping unwelcome visitors linked to CSE out of education facilities*" was a "*key challenge*". Key challenge it may have been, but this issue was hardly new.

3.1062 At the LSCB on 7 September 2016, it was noted that although numbers of CAFs had been increased (from 552 to 595), the number of those progressing to TAC had decreased. There was a suggestion that this was due to professionals feeling able to manage the case within a single agency.[958]

3.1063 In a report of the LSCB dated 7 September 2016,[959] it was recorded that an independent member of the LSCB remarked that they had challenged an Assistant Director about the impact a proposed restructure would have on safeguarding and early help; but the nature of the concerns is not set out in this report. It is not clear whether this person had been pre-warned about the restructure in the same way the Chair of the LSCB had not been in 2011.

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3.1064 A membership list for the LSCB, dated August 2016, showed a total cohort of 39 members of the LSCB and 68 members (with significant repetition of names) of standing committees.[960]

3.1065 Following a decision that the LSCB and its Adult Safeguarding equivalent, chaired by the same person, should sit on the same day with a conjoined section of the agenda[961], a meeting of the "*TWSCB & TWSAB*" was held on 21 March 2018[962] and heard grievances by senior members about the press interest in Telford's CSE history and situation. No doubt reports could affect service provider morale; but there is a sense of 'bunker mentality' in these minutes. Subgroups – this time in respect of children harming children – were being readied still for step down.

Structures within the Council with responsibility for CSE

Overview

3.1066 As I have identified in previous relevant time periods, from 2012 onwards, a number of groups were in existence, or came into existence, which were said to have responsibility for dealing with CSE. Identifying these groups and their roles, responsibilities and governance structures has been a Herculean endeavour. Even now it is difficult to discern coherence or purpose in the structures. A number of witnesses acknowledge this. I consider each of these groups, their remit and effectiveness below.

3.1067 The role of the CTB was reviewed as part of the 2012 restructure and became the Children & Young Families Partnership Board ("CYFPB"). This subgroup linked in with the Local Strategic Partnership Executive, the Shadow Health & Wellbeing Board, the LSCB (as a "*critical friend*") and the Safer Cohesive Communities Board.

3.1068 The Gold group ended with Operation Chalice coming to a close.

3.1069 It was recommended in 2013 that the Missing Children subgroup should progress its work but no longer be a priority of the LSCB, instead reporting to the LSCB by exception.

3.1070 From 2014, the work of the CATE subgroup appears finally to have been subsumed into the CSE Care Pathway early in this time period. The CATE Care Pathway subgroup (referred to sometimes as CSE Care Pathways) was no longer a priority subgroup of the LSCB in 2014 and reported to the LSCB via the Quality Assurance subgroup. If this is difficult to follow at a distance, it appears that it was no easier at the time; the minutes from the CATE Pathways group dated 5 November 2013 show that there was a debate about whether the group was strategic (favoured by Safeguarding) or operational (favoured by Cohesion); some questioned whether a partnership group was needed at all.

3.1071 In 2014, the CYFPB became a subgroup of the Health & Wellbeing Board.

3.1072 Also in 2014, the QPO subgroup was established, stated to be a slimmed down version of

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the LSCB and possibly taking over some of the work of the LSCB Executive committee.

3.1073 The Multi-Agency Operational and Strategic subgroups were both created in 2014, reporting to the LSCB.[963] After one year, the Strategic Group became the CE Thematic subgroup (still reporting to the LSCB)[964], with two further subgroups accountable to it, these being the CE Operational subgroup (the previous Multi-Agency Operational subgroup) and a new CE Prevention subgroup.[965] Perhaps in light of the increasing prevalence of the importance of the links between missing children and CSE on a national level, Missing Children became part of the CE Operational subgroup. The QPO subgroup took on responsibility for the work of the new CSE Thematic subgroup (and its subgroups). In addition the CE Thematic subgroup was accountable to the LSCB.[966]

3.1074 The CE Thematic subgroup was closed down briefly in 2016 (as were the two working groups), its work being taken over by the new Joint Exploitation subgroup and a temporary Task & Finish Group.[967] However, after approximately one year this was reversed and the CE Thematic subgroup was reinstated with the two Exploitation Boards returning to their former iterations. It is noted in one 2019 document that the CE Thematic subgroup was now accountable to the Telford & Wrekin Safeguarding Executive and links in with the Child Exploitation subgroup, Adult Exploitation subgroup, CSP, Serious Violence Strategic Group, Missing Operations Group and the Child Exploitation Risk Panel.[968]

Children and Young People Scrutiny Committee

3.1075 The Children and Young People Scrutiny Committee (the "Scrutiny Committee") was a political body comprising elected members rather than officials. It existed prior to 2014, as a required function of the system of Cabinet Local Government run by Telford, but is of interest to the Inquiry from 2014 as, in November of that year, it was announced that the Scrutiny Committee would undertake a review of multi-agency working against CSE – to be commenced in 2014/2015 and to continue into 2015/2016.[969]

3.1076 Over the next 18 months the Scrutiny Committee engaged with partners, communities and survivors of CSE and their families to provide them with an understanding of "*how well organisations in Telford and Wrekin are working together to prevent CSE, protect and support victims and their families and prosecute perpetrators*". This work concluded in May 2016, with 38 recommendations made.

CSE Multi-Agency Operational and Strategic groups

3.1077 On 25 November 2014, the CSE Multi-Agency Operational group met.[970] It noted that CATE processes were being updated and that the CATE Action Plan should be reviewed in the light of the Jay Report and NWG recommendations. The CSE Pathway roles and responsibilities document was reviewed and it was minuted that this "*needs to be a more*

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complex document". A WMP representative expressed the view that the "*elephant in the room*" is that "*it all appears to revolve around young Muslim men as they are the main perpetrators working in gangs/groups*". The question was raised as to whether prevention work was being done in schools and how best to target CSE through Education.

3.1078 The CSE Multi-Agency Strategic group met on 12 December 2014.[971] The CSE Action Plan had been drafted and was shared with the QPO group. Concerns were expressed in Cohesion about the capacity of CATE to deliver training. The group stressed their view was that a dedicated CSE multi-agency team would be an important step forward. The concerns about capacity and the CATE Team's ability to deliver training are familiar refrains.

3.1079 The CSE Multi-Agency Operational group decided on 20 January 2015[972] to set up a working group to look at information sharing. WMP asked if it would be possible to have a CATE practitioner sitting in police meetings; presently, a Cohesion worker sat in the "*Harm Unit*" (presumably WMP's HAU). The response came that "*in an ideal world this would be a good idea but it's difficult to see it working currently*".[973]

3.1080 At this point, there were 46 children being supported by CATE and four CATE practitioners.[974]

3.1081 Data capture was considered. It was noted that while any referrals that have gone through CATE are held on a central spreadsheet in Cohesion services, CSE victims/survivors dealt with other than by CATE would not be entered onto this record. Even by this stage the problems of central recording and sharing of CSE data had not been adequately addressed. The importance of this failing cannot be overstated.

3.1082 The level of recorded WMP and education referrals to CATE was low; this was thought to be a recording issue so far as WMP was concerned but reflective of a lack of training in schools. No health data was being collected, though the meeting was "*not sure what data Health collect*".[975] In any event, "*system development*" was needed.

3.1083 The number of training sessions delivered by CATE practitioners should be discussed at the next Strategic Group meeting as there was a capacity and resource issue.

3.1084 The CSE Multi-Agency Strategic group met on 13 February 2015;[976] it was noted that Missing data (i.e. data around children who had been reported as missing) was being developed within Protocol. Given a 'Missing' status was a reliable indicator of CSE, the issue of CATE access to Protocol plainly became more acute.

3.1085 At the CSE Multi-Agency Operations group on 17 March 2015,[977] it was noted that all Missing notifications were to come through Family Connect. Any missing child open to Cohesion would have an RHI conducted by their allocated case worker; any not open to Cohesion

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would have an allocation within 72 hours. An issue had arisen with CATE not being notified that missing children open to CATE had returned.

3.1086 Out of authority children (i.e. those in the care of another local authority) placed in the borough could access CATE presently; but to continue to allow this could "*soon lead to a capacity issue*".[978] It is not clear to me whether or how CATE would liaise with the responsible local authorities.

3.1087 The CSE Multi-Agency Strategic group meeting on 17 June 2015[979] agreed to present a proposal to the LSCB for the group to regain its status as an LSCB priority subgroup – presumably to fill the newly reinstated role. The group would then expand its status to cover all child exploitation with an emphasis on sexual exploitation. The CSE Multi-Agency Operational group sought to expand its remit still further[980] to include not only CSE and missing children but also forced marriage, honour-based violence and FGM.

3.1088 WMP raised the issue of RHIs, which it is said "*are becoming a bit of a concern as regards to content as no information is being* received *from them/information not being shared*".

3.1089 The Operations group was noted to be quite a large group and "*more productive when there is minimal attendance*".[981]

3.1090 By 29 February 2016,[982] the CE Multi-Agency Operational group recorded that RHIs were now 100% complete; there had, though, been a spike in the numbers of missing children. Referrals to Family Connect were increasing. Not all victims/survivors of CSE were getting the therapy they needed.

3.1091 Having considered the minutes of both these groups over the period of their existence, the distinction in purpose between the two is not clear. The overwhelming impression is that different, although overlapping groups of people, were discussing the same issues in different committees.

LSCB Child Exploitation (and Child Exploitation Thematic) subgroup(s)

3.1092 At the LSCB on 18 March 2015,[983] it was agreed that the C(S)E subgroup be reinstated as a priority subgroup of the LSCB.

3.1093 The LSCB Child Exploitation subgroup met for the first time on 11 September 2015.[984] There were eight attendees and six apologies. Consideration was given to having a parent representative on one of the groups.

3.1094 The feedback reported from the CE Prevention group was: "*there is a lot of working going*

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on in isolation and there is lots of duplication".[985]

3.1095 Nevertheless, the transformation of the CSE Multi-Agency Strategic group into the LSCB 'CE 'subgroup appears to have suggested a vacancy for another committee: this was filled by the CE Prevention working group, as it was known, the terms of reference for which were fixed on 11 September 2015;[986] namely to "*ensure improvement in identification and support for those subject to child exploitation within Telford and Wrekin and reduce the numbers of those at risk*". Its initial focus would be on awareness raising; supporting families affected by CSE; taxis and licensed premises; online safety and training. The group would link closely with the Early Help Partnership and the CSP.

3.1096 The LSCB Child Exploitation subgroup reviewed its action plan on 13 January 2016.[987] There were 42 assessed criteria; two were marked green as "*achieved*" (both related to taxi driver training) and eleven marked red as "*yet to be addressed or behind schedule*". The latter included awareness raising work through schools, and collation of support services for victims/survivors and families.

3.1097 In what may have been a formal adoption of the divestment strategy described in a 17 August 2015 email ("*We are close to CATE being swamped*" [988]), the Child Exploitation subgroup considered stepping down CSE and missing cases with low level risks[989] to the Youth Innovation Team, a division of Cohesion that appeared to be centred around offering activities for children.[990] It was noted by the Scrutiny Review that these low level cases were often dealt with by Barnardo's in other areas but that no funding had been found for this work in Telford.[991] The CATE caseload had risen from 45 in 2014 to 66 in 2015.[992]

3.1098 The group heard concerns that GPs were still unaware whether a child was open to CATE and that Sexual Health Services required reassurance that information sharing was required for a risk panel and not "*for the sake of it*".[993]

3.1099 The LSCB Child Exploitation 'Thematic' subgroup (my emphasis) met on 9 March 2016.[994] It appears to be the same group and it is unclear to me why "*thematic*" was adopted. Apologies outnumbered attendees. No Assistant Director or Service Delivery Manager attended (two of each were due). The Chair reinforced the need for attendance, I assume plaintively. The subgroup received feedback from the Prevention group and heard that the CSE Pathway was under review. A therapeutic package was needed for victims/survivors of CSE; a 'scoping' exercise was agreed upon. The SARC required a clear pathway into the CATE service; the matter was to be discussed at the next meeting.

3.1100 RHIs were now all being sent to the HAUs and Family Connect, and were being recorded on

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Protocol. I deal with HAUs in further detail in Chapter 5: The Policing of CSE in Telford.

3.1101 On 18 April 2016, attendance at the LSCB CE Thematic subgroup was relatively healthy;[995] only a third sent apologies. It was reported that HM Inspectorate of Constabulary had completed a vulnerability inspection of West Mercia and Warwickshire in alliance and were given a grade of "*requires improvement*" with regard to missing people. One of the main failures was using information from previous episodes to prevent repeat, with completion and sharing of RHIs a significant feature. The subgroup noted that of 383 missing episodes between April 2015 and March 2016, only 57 RHIs were shared with WMP.

3.1102 It was agreed that medical notes should reflect a risk of CSE and that CATE should write to GPs.

3.1103 The CE Multi-Agency Operational group met on 3 May 2016.[996] It was noted that all RHIs were being sent to WMP's Missing Coordinator. It is further noted "*looking to remove under 18 events from night clubs*". There was now a police officer situated at Telford College of Arts and Technology which was "*received really well by students and has... already made a real difference*".

3.1104 A review of the effectiveness of the groups decided that the CE Operational and Prevention groups were no longer required "*as any* work *from the thematic groups can be picked up by task and finish groups*".[997] This was approved by the LSCB on 15 June 2016.[998] The comment was made that it was "*a difficult time with services moving around, but that moves were heading in the right direction*".[999]

3.1105 On 7 September 2016, the LSCB reviewed attendance for the Child Exploitation subgroup; it was at 55%, further, there had been three chairs of the group during the year.[1000]

3.1106 On 9 September 2016, the CE Thematic subgroup noted that CATE caseloads were increasing and that referrals from health were still low.[1001] An audit of RHIs revealed that the quality of the RHI depended heavily upon what service area the person completing came from but that only half audited were classed as "*good*". The RHIs were generally weak on parents' views. All those RHIs with a CSE marker were sent to WMP. There were to be visits from the Principal Officer Child Protection and the WMP Missing Co-Ordinator to explain the importance of RHIs and the information thought to be useful.

3.1107 On 6 February 2017, the CE Thematic subgroup[1002] noted a rise in CSE and suggested that this might be a feature of "*awareness and recording*". A happy feature was that during 2017, following a decade's wait, CATE was finally granted access to Protocol workspace.[1003]

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3.1108 On 25 April 2017, the CE Thematic subgroup[1004] (9 attendees, 14 apologies) considered CATE workload and it was agreed that the next meeting would be furnished with information about numbers of live cases. Undoubtedly data was being collected: I have seen comprehensive reports charts[1005] for the preceding five quarters from December 2016 and December 2017, but this may have reflected a desire for data covering a shorter timespan – later in the year a single sheet "*performance highlights*" document was created,[1006] but ostensibly for the risk panel not the subgroup. Notably, that document showed, in this first year of CATE returning to Safeguarding, an increase in the number of CATE cases open as child protection cases.

3.1109 In June 2017, it was noted that the CE Thematic subgroup had had four chairs since January 2016 and that attendance had dropped again.[1007]

CSE Task and Finish Group

3.1110 On 25 June 2015, the CSE Task and Finish group met for the first time with an ambition to meet monthly.[1008] Its purpose was to "*bring together work streams that span across a number of departments and agencies*" and to "*gain a greater understanding of what is being delivered, who the leads are and any gaps*". There were 12 attendees including the note taker and 8 apologies. The primary objectives of the group were, (oddly listed as objective 2, 3 and 4):[1009]

- *"Support young people affected by CSE and their families;*
- *Empower communities to address CSE; and*
- *Collect, manage and use data well."*

3.1111 Specific points raised related to lack of clarity on the part of public health and housing about the pathway for CSE referrals; and lack of consistency in schools' approach; no plan was formulated to address this. Training was discussed; it was noted that large gaps remained in training coverage, with examples being given of the hospitality industry, and the YMCA. The group resolved it needed to be in a position to deliver training "*across the board*".

3.1112 The CSE Task and Finish Group met again on 28 July 2015.[1010] The meeting noted the group's place reporting to the (presumably CSE Multi-Agency) Strategic Group. Attendees outnumbered apologies only through the presence of the note-taker. The relevant issues for the group were said, following a survey, to have been those identified at the last meeting: training, particularly in schools, and awareness raising amongst colleagues. Capacity for trainers was an issue noted; the group also resolved to work with school governors to attempt to underline the importance of training in schools, as take-up had been poor – only three or four schools. In this regard it was further noted that capacity was

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an issue: it was suggested that members of affected communities could be prevailed upon to deliver training.

3.1113 The group discussed the change to incorporate FGM, and honour-based violence within the exploitation groups – it was said that this was a useful move forward, but there was a piece of work underway to "*identify what this means*".[1011]

3.1114 It was suggested that the group may become a subgroup of the Child Exploitation Strategic group. The next meeting date was not fixed.

3.1115 The Task and Finish group appears not to have met again.

CE Prevention Group

3.1116 On 2 November 2015, in its first meeting, the CE Prevention group[1012] minutes note:

"[The] *strategic group has become* [a subgroup of] *the LSCB and widened its remit to Child Exploitation. The Operations Group and this prevention group will feed into the CE subgroup and all will work to the same action plan.*"

3.1117 The attendees agreed that FGM, honour-based violence and forced marriage should be rolling agenda items. It remarked that many schools were not providing relationship and sex education because of budget cuts; there was no action agreed to address this.

3.1118 On 5 January 2016, the CE Prevention group[1013] met. The first two pages of its minutes were virtually identical to those of its previous meeting; I take it that is what is meant by a "*rolling agenda item*". So far as training was concerned, there was a large waiting list and the LSCB needed to review who was funding training after March 2016.

3.1119 In another illustration of the eternal truth that creating a new group with a new name does not change the underlying issues, the CE Prevention group on 11 March 2016[1014] complained that attendance was poor. (There were eight attendees and three apologies). It was noted that Safeguarding now also had responsibility for 'Missing' and had concerns regarding RHI and Interagency Meetings. An attendee was tasked with exploring this. Further, it was noted in a Child Exploitation Thematic Sub-Group meeting dated 18 April 2016 that:

"*RHIs were not being shared with the WMP; out of 383 missing episodes only 57 RHIs were received. These figures relate to 1 April 2015 to 31 March 2016. The RHI process changed in Telford in November 2015 and all RHIs should now be sent to HAU and Family Connect*."[1015]

3.1120 The CE Prevention group met again on 10 May 2016.[1016] There were nine attendees,

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including a note-taker, and eight apologies. The following items were marked as *"areas of concern not covered"*:

3.1120.1 CSE;

3.1120.2 Children Missing from home care or education;

3.1120.3 FGM;

3.1120.4 Honour based violence; and

3.1120.5 Forced marriage.

3.1121 This would seem to cover all the group's *raisons d'être*. There was scheduled to be a further meeting on 28 June 2016; I have not been provided with minutes of that or any later meeting.

Missing Children

3.1122 As I have shown, aspects of children missing from home were dealt with by a number of CSE groups; there continued to be a Missing subgroup of the LSCB. A subgroup on 5 June 2015[1017] suggested that the target of 90% completion of RHIs was "*on track*" but that some officers who had been identified as regularly not completing RHIs continued not to complete them despite email alerts. The RHI was being imported into Protocol which it was hoped would aid matters – though not, presumably, in respect of those officers who did not have access to Protocol.

3.1123 The Missing Children priority subgroup of the LSCB published its closing down action plan in September 2015.[1018] Despite the close down as a priority group, RHI statistics were getting worse.[1019] Once again, close down of the subgroup seems unrelated to the urgency of the underlying subject matter of the group. In response to the Maxwellisation process, the Safeguarding Partnership submitted that this action was reflective of how task and finish groups operate and in no way demonstrated the seriousness or otherwise of the subject matter in hand; rather, it demonstrated a "*coordinated and streamlined approach".*[1020]

3.1124 In my view, this comes down to a fundamental point; bureaucratic process was master. The need to close down groups to show progress meant that a dedicated group for missing children was closed at a time when the issue with which it dealt was still live: as shown by the fact the issue continued to be discussed in multiple groups and by the fact that a dedicated group was reinstated barely a year later.

3.1125 On 14 July 2016, a Missing Children group met and discussed its draft terms of reference[1021] – less than 12 months after the Missing Children subgroup of the LSCB published its closing

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down actions.[1022] The group noted that first, not enough RHIs were being done and some were of poor quality; second, that Ofsted may take the view that RHIs should be offered in all missing cases, whereas Telford only offered them for missing episodes after the first - nevertheless, no change was suggested; third, that RHIs for children not open to a service were currently carried out by Cohesion, which had been stood down - it was hoped that PCC funds would be made available to allow an agency to step in.

3.1126 The Missing Operational group was reinstated, though prior references are scant, in June 2017[1023] to meet monthly to review children who have gone missing and to provide reports into the Child Exploitation subgroup.

3.1127 At a meeting of the Corporate Parenting Strategic group on 7 December 2017,[1024] there was a Missing Multi-Agency core group proposal to:

"… meet monthly to consider specific children and young people who go missing and to also identify patterns and missing trends. The Chair of the CSE pathway attends providing the link between the two different but connected areas."

3.1128 Once again, we have seen a multiplicity of groups, which appear to all cover the same basic area of responsibility, while as I have noted, groups not dedicated to 'Missing' were also considering the issue. While it may be tempting to say that these matters should be everybody's responsibility, it is difficult to avoid the conclusion that a settled, focused group would have been best placed to deal with them.

Joint Exploitation subgroup

3.1129 In 2017, the Independent Chair chaired both the Children and Adult Safeguarding Boards,[1025] after an annual progress report presented to the CSE Pathway subgroup highlighted that the transition for children subjected to CSE into adult services was a key issue and that safeguarding was not just about adults or children but about families as a whole. I understand that there remained two boards, but they sat on the same date with a conjoined section of the agenda in an effort to more effectively address the increasing number of family issues across children's and adult's safeguarding services and improve the effectiveness of Board meetings. It was agreed that the Child Exploitation subgroup become a joint subgroup for child and adult sexual exploitation, FGM, honour-based violence and forced marriage. The Missing element of this subgroup was stepped down as it was felt that the action were being picked up appropriately through the Council's improvement plan and through operational joint working with WMP.[1026]

3.1130 On 28 November 2017, at the first joint meeting of the Telford and Wrekin Safeguarding Children Board ("TWSCB") and Telford and Wrekin Safeguarding Adults Board ("TWSAB") Exploitation subgroup, the group divested itself of responsibility for forced marriages and honour-based violence.[1027] At the Children's Board section of the meeting, the group

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considered whether its title should refer to "*sexual* exploitation" but it was concerned that modern slavery could not then sit within it. There was a discussion about which group should have responsibility for FGM; the question was adjourned. The next meeting was poorly attended[1028] and a decision was taken to focus the next meetings on modern slavery.[1029]

3.1131 At the TWSCB and TWSAB Exploitation subgroup meeting on 10 January 2018,[1030] apologies outnumbered attendees. It was recorded that multi-agency risk assessment conferences were seeing more cases with a CSE element. At this meeting it was noted that the NWG had asked if the Council wanted to use its benchmark CSE process to evaluate parental participation. It is unclear if this offer was accepted; I have seen no further information about it.

3.1132 The meeting on 9 March 2018,[1031] managed to have a majority of attendees over apologies, by 13 (or 12 if the note-taker was excluded) to nine. There was a discussion regarding the '*CSE Disruption Kit*', a Home Office produced document[1032], which all members were asked to review and feed back on how it was it be used locally by May 2018. On 19 April 2018, the note-taker's presence clinched the tally in favour of attendees.[1033] I have not seen any evidence of discussions around who was missing from the meetings and what the impact of this is on decision making. The meeting of 19 April noted the Council's vote for an Independent Inquiry into CSE.

3.1133 There was also a discussion about existing gaps in service provision including role of schools education and training, therapeutic support and recognition of emotional trauma and children who were either "*perpetrators*" or "*potential perpetrators*" of sexual harm.

3.1134 In May 2018, a CSE Service Review Meeting discussed further gaps in the CATE service, including the lack of support for the family and siblings of children subject to CSE, the need for a family therapist to be employed and the need to widen the CATE remit to address children subjected to County Lines and criminal exploitation.[1034]

3.1135 The gaps in the CATE service were discussed in the TWSAB and TWSCB Exploitation subgroup meeting in June 2018 and further actions were agreed to raise awareness, as well as a proposal for a family therapist to be part of the CATE service.[1035]

3.1136 In a TWSCB and TWSAB joint meeting dated 26 September 2018**,** the Chair suggested that the scope of the Exploitation Subgroup be reduced to its core function (CSE) with the other workstreams being picked up by the CSP; which just about brings the rotation of committees full circle.[1036]

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3.1137 In a report to the Joint TWSCB and TWSAB the view was expressed:[1037]

"*Delivery of the action plan has proved challenging since the joint subgroup was established. Concerns have been raised about the effectiveness of the group and delivery of outcomes has proved challenging.*"

3.1138 In December 2018, the Joint Exploitation CSE subgroup split again to become separate groups. The rationale for this was that multi-agency work regarding CSE and children was at an advanced stage of development in comparison to adult safeguarding. The new children's group would be responsible for the strategic response to CSE, children who were missing and those children subject to criminal exploitation.

LSCB Child Exploitation subgroup

3.1139 The newly revived LSCB Child Exploitation subgroup met on 9 January 2019.[1038] There were 12 attendees and six apologies; by past form, a respectable attendance. The subgroup noted that the rationalising of the group's responsibility would lead to streamlining of the membership.

3.1140 The work of the group was defined as:

3.1140.1 To develop and progress a multi-agency action plan;

3.1140.2 To carry out appropriate development work and identify barriers, trends and gaps in services;

3.1140.3 To consider learning from SCRs.

3.1141 The subgroup thought it necessary to declare that its purpose would be described as seeking to "*address the issues of child criminal exploitation"* (the emphasis is original); which was no doubt well-meant but seems to me to be an unnecessary and potentially narrowing amendment. It certainly shows that the spirit of incessantly meddling with committees was still alive; and someone saw the point, because in the September 2019 terms of reference[1039] the objective is described in this way:

"*To ensure, that as a partnership, we are fit for purpose to respond to all existing and new forms of child exploitation*."

The Safeguarding Partnership

3.1142 In 2019, the LSCB ceased and was replaced by the Telford & Wrekin Safeguarding Partnership. This followed the Wood report (as referred to above) and government changes to the *Working Together* guidance in June 2018.[1040] The new partnership retained child exploitation as a strategic priority – with an associated subgroup. The Inquiry understands that, under the new structure, the role of Chair was diminished and was more akin to "*an*

[1037] pg 1
[1038]
[1039]
[1040] pg 23

executive trouble shooter".[1041]

3.1143 The Inquiry received evidence which indicated that the findings of the Wood Review were not universally accepted. An account saw the changes described as:

"*… change for the sake of change… driven by a government that had endured bad publicity from various SCRs and the need to reduce costs and the time commitment of partners*".[1042]

3.1144 There was also a suggestion that:

"*… due to the impact of paring down and streamlining systems to create efficiencies, the Partnership has lost some of the independent scrutiny that existed under the old system…*".[1043]

3.1145 I confess that I regard Wood's conclusion that LSCBs focused too much on process rather than outcome to be amply supported by the evidence I have seen of how Telford's LSCB operated in the period from 2012 onwards.

3.1146 In response to the Maxwellisation process, the Council informed the Inquiry that a review of the Safeguarding Partnership was undertaken in January 2021 which result in significant changes to the form and function of the partnership. This resulted in the establishment of separate Children and Adult boards and, amongst other changes, the creation of an Independent Chair who also undertakes the function of Independent Scrutineer (as set out in *Working Together*) to act as a constructive critical friend and promote reflection to drive continuous improvement.[1044]

Ofsted Inspection – 2016

3.1147 Between the period 13 June 2016 and 7 July 2016, Ofsted inspected the Council's "*services for children in need of help and protection, children looked after and care leavers*" and "*the effectiveness of the LSCB*", (the "Ofsted 2016 Inspection").[1045] This was an inspection of services conducted in accordance with Ofsted's 'Single Inspection Framework'. The inspection's focus was on contemporary practice; so effectively the six-month period in the lead up to the inspection.

3.1148 Ofsted has noted that "*…inspections is* [sic] *only a window into local authority practice; it will not and cannot represent a forensic examination of the experiences of every child".*[1046]

3.1149 In addition to the inspection, Ofsted conducted a review of the LSCB.

3.1150 The Ofsted 2016 Inspection report did not give any recommendations in relation to CSE (although it should be noted that there were recommendations made in respect of wider

1041 [redacted] pg 23
1042 [redacted] pg 24
1043 [redacted] pg 24
1044 [redacted]
1045 [redacted]
1046 [redacted]

practice that would impact children at harm or at risk of CSE).[1047] It noted that the Council's response and role of partners was "*very strong*" and that "*the local authority has been a champion for tackling the issue*" of CSE.

3.1151 The inspectors noted the following:

3.1151.1 "*Work with children and young people at risk of child sexual exploitation is good. It is well coordinated with partner agencies and this is improving outcomes for children*";

3.1151.2 "*A dedicated… (CATE) team provides good quality risk assessments, planning, and interventions... A tool has been developed to assess risk and protective factors in relation to child sexual exploitation. Inspectors found that the tool was consistently used to both assess risk and inform planning*";

3.1151.3 "*The team is made up of staff from the local authority, who work closely with a police child sexual exploitation team*";

3.1151.4 "*Sexual Health services have been recommissioned to support children to access support*";

3.1151.5 "*Return home interview records are screened by the CATE team to identify any specific concerns relating to child sexual exploitation with a robust and effective process in place*";

3.1151.6 "*Family Connect is providing a timely and appropriate response to children when their needs are first identified. (CATE) is delivering high-quality services to children who are at risk of, or who have been subjected to, child sexual exploitation*";

3.1151.7 *"Targeted work by the local authority has led to improved communication and joint working between children's services and schools in Telford and Wrekin. Schools are positive about the advice and support they receive in several areas. They appreciate the positive difference it has made. This includes work on children missing education and tackling child sexual exploitation*";

3.1151.8 "[The Scrutiny Review] *shows the strong commitment to tackling this issue* [of CSE]";

3.1151.9 "*Partnership working to tackle child sexual exploitation is strong*";

3.1151.10 "*There is A robust multi-agency auditing framework is in place. Three such audits are carried out each year. Audit topics are informed by the board's priorities. The last three have been children at risk of sexual exploitation, children who harm children and children experiencing neglect. The audit process is*

1047 [redacted]

independently chaired and the methodology is robust. Audits undertaken by partner agencies are also reported to the board"; and

3.1151.11 "*The content of the Council's threshold document, 'The Child's Journey', is generally clear and appropriate. It is a helpful guide for professionals making or handling a referral. However, it is not fully compliant with statutory guidance. This is due to a lack of sufficient clarity about the distinction between children in need and those in receipt of early help, and a small number of other omissions. The document lacks enough detail about the thresholds at which it is appropriate to accommodate a child under Section 20 of the Children Act 1989 or to apply for a care order under section 31. The document does not link clearly enough to guidance on CSE, as expected by 'Working together 2015'.*"

3.1152 Despite the above findings, Ofsted awarded a '*Requires Improvement*' rating to Safeguarding in the following three areas:

3.1152.1 Children who need help and protection;

3.1152.2 Children looked after and achieving permanence; and

3.1152.3 Leadership, management and governance.

3.1153 As referred to above, the previous inspection of the Council's safeguarding arrangements had been in August 2012 and had been judged to be '*Adequate*'.

3.1154 The Ofsted 2016 Inspection report noted that services were not consistently good. This was said to be because some developments were too new to have yet made a significant difference, while others were not yet in place, and that gaps remained in the consistency and quality of first line management oversight and scrutiny.[1048]

3.1155 It was also identified that, although acute risks were identified and responded to swiftly, chronic risks were not always identified or responded to as quickly. As a result, some children experienced delay in receiving help or coming into care.[1049] The inspectors were of the view that "*the Council is sometimes too slow in sorting out the right help*".[1050]

3.1156 Another point made was that gaps remained in the quality and frequency of the supervision of social workers, which included case direction and oversight. Where such gaps existed, they led to delays in progressing work and improving outcomes for some children.[1051]

3.1157 The report further noted that whilst performance management and quality assurance systems provided a largely accurate picture of performance, they were not being fully used to drive up standards. This was noted as being because measures being monitored were not always updated to reflect change or new priorities and, further, this work was not informed by feedback from children and their families. It stated that the IRO service was not providing enough scrutiny in driving planning for looked after children and those subject

[1048] [redacted] pg 2
[1049] [redacted] pg 2, pg 17
[1050] [redacted] pg 8, pg 11
[1051] [redacted] pg 2

to child protection plans and it did not have a clear overview of service performance. Caseloads in this service were significantly above statutory guidance which reduced its effectiveness.[1052]

3.1158 It was stated that the work to support children who go missing from home or care was thorough and improving, however noted that RHIs were not always carried out in good time[1053] and that, when they did take place, the quality was variable.[1054] Council figures for May 2016 showed that just over a quarter of children waited for more than three working days to have an interview.[1055] The evidence provided to the Inquiry confirms to me that this inspection provides a more accurate representation of the position with regard to missing than the 2012 inspection did.

3.1159 The inspectors were of the view that the quality of assessments was variable and that most were not good overall. Assessments usually included an account of children's past history but it was noted that this was not always analysed effectively or used to determine future risk.[1056]

3.1160 In child protection conferences, it was noted that advocacy was very rarely used to help children be more involved in child protection conferences or other meetings about them. The inspectors were of the view that this was a significant omission.[1057] It was stated that the views of children, although recorded, were not always well used to understand their experience or to inform planning.[1058]

3.1161 Although it was considered that child protection conferences identified risk effectively, this was not resulting in child-focused child protection plans.[1059] The inspection report noted that the majority of child protection plans lacked sufficient clarity and were not always clear about who is expected to do what, and by when. It was pointed out that this can be confusing for families and professionals, making it difficult to measure progress[1060] and that assessments and plans needed to be clearer so that everyone knew what had to change to make things better.[1061]

3.1162 In terms of information sharing, it was noted that "*strategy meetings do not always include agencies, other than the Police, which sometimes limits information available to inform decision-making*".[1062] Also that information was not consistently good quality.[1063]

3.1163 Further, it stated that the IRO service:

1052 [redacted] pg 2
1053 [redacted] pg 3
1054 [redacted] pg 9
1055 [redacted] pg 14
1056 [redacted] pg 3, pg 10
1057 [redacted] pg 12, pg 21
1058 [redacted] pg 11
1059 [redacted] pg 12
1060 [redacted] pg 3, pg 21
1061 [redacted] pg 8, pg 12
1062 [redacted] pg 3, pg 9
1063 [redacted] pg 11

"… does not provide enough challenge and oversight. The effectiveness of this service is limited by very high caseloads as well as the practice of changing care plans or other important decisions being made outside of reviews without informing the IROs."[1064]

3.1164 It also stated that IROs had caseloads substantially above statutory guidance which, it was stated, significantly limited their ability to keep in touch with looked after children between reviews and to track the progress made.[1065]

3.1165 Partner agencies were said to contribute well to assessments of looked after children. The exception to this was the CAMHS service, which was noted to be less well engaged, (although the Council was aware of this gap in service provision). At the time of the inspection, the Council was working with health partners to commission a new '*Birth to 25*' emotional health and wellbeing service, which was due to start in 2017.[1066]

3.1166 Recommendations made in terms of safeguarding children included:[1067]

"Ensure that all social workers receive sufficiently regular and good quality supervision, oversight and direction from first-line managers to support consistently good practice.

Ensure that the IRO service provides sufficient scrutiny and drive to planning for children and young people. In particular, ensure that IRO's caseloads are in line with statutory guidance.

Develop further the effectiveness of performance management so that it is more responsive to new priorities as they emerge and takes into account feedback from children, young people and their families.

Support improved outcomes for children and young people by making sure that plans contain clear details, actions and timescales and are informed by timely assessments that contain clear analysis.

Ensure that an appropriate range of agencies are engaged and share information within child protection strategy discussions.

Ensure that return home interviews for children and young people who have been missing from home or care are all carried out in a timely manner."

3.1167 In terms of leadership, management and governance, it was noted that the Council's local authority improvement plan for Safeguarding in 2015/2016 had not yet been fully implemented and that inconsistencies remained in the quality of support offered to children. In particular, gaps remained in the quality of first line management oversight and scrutiny and the work of the IRO service.[1068]

1064 [redacted] pg 16
1065 [redacted] pg 21
1066 [redacted] pg 20
1067 [redacted] pg 7
1068 [redacted] pg 30

3.1168 It was further noted that the board responsible for corporate parenting, was regularly attended by the lead member and representatives from Safeguarding, however some key partners only engaged occasionally. The result of this was that opportunities to address wider issues were neglected, for example that care leavers had not yet been provided with priority housing.[1069]

3.1169 The Ofsted inspectors found that agencies were working well together within the Health & Wellbeing Board and Early Help partnership. Although there was no shared multi-agency plan or set of agreed priorities for children's social care needs, against which services could be commissioned or progress measured, this was balanced by close working, a shared commitment to improve and a common understanding of the most important areas for improvement. This had driven the commissioning of the new Birth to 25 service.[1070]

3.1170 The report stated that:

"*An unfortunate consequence of this rigorous focus on child sexual exploitation, is that the Committee has given little consideration to any other welfare and safeguarding needs of children.*"[1071]

3.1171 In terms of missing children, the Council was noted to have ensured that children who go missing were offered and received RHIs. However, the Council was not ensuring that these interviews were carried out in a timely manner, nor had it made best use of intelligence from RHIs to identify themes that could help improve services. The identification of the 'pull' factors that led children to go missing had been a particular gap in the analysis of this information when it was considered alongside information about those who may be at risk of CSE.[1072]

3.1172 While there was a strong focus on performance, the development of the performance culture was considered still to be a work in progress across all areas of the service. For example, senior managers did not have direct line of sight to some key aspects of frontline practice, such as the frequency and quality of supervision, and team managers were not consistently using performance information to support them in understanding their priorities. There was no standard mechanism to collate the information on the views of children who had received services. It was highlighted that the lack of a formal mechanism for gathering feedback limits the local authority's ability to understand the quality of services; and that, in turn, this limited its understanding of what was effective and why. This was stated to be a priority for the Council and it was noted that a pilot scheme was currently under development with the support of the LSCB.[1073]

3.1173 It was further stated that:

[1069] [redacted] pgs 30-31
[1070] [redacted] pg 31
[1071] [redacted] pg 32
[1072] [redacted] pgs 32-33
[1073] [redacted] pg 33

"[The] *local authority audit tool does not provide a clear narrative of what 'good' looks like for individual judgments and follow-up audits are not routinely completed to check the impact of improvement actions".*[1074]

3.1174 Additionally, relating to the LSCB:

"The TWSCB is well organised and effective. It has a clear structure that promotes the delivery both of its core business and its priorities. Membership is appropriate…attendance is good."

"The TWSCB annual report 2014-15 gives a comprehensive account of the board's activity, its achievements and priorities, but lacks a similarly comprehensive analysis of the quality of services to safeguard children. The board receives good quality performance information. However, the range of information is not broad enough to produce a fully integrated multi-agency dataset. The board continues to work on this as a priority".[1075]

"*The board evaluates the application of thresholds through regular audits. Its threshold document, 'The Child's Journey', provides helpful guidance but does not fully reflect current statutory guidance*".[1076]

3.1175 Further recommendations were made in the area of leadership, management and governance, as follows[1077]:

"Revise 'The Child's Journey' threshold document to fully reflect current statutory guidance and to provide greater clarity about the distinction between children in need and those with additional needs and the thresholds for accommodation and court action.

Sharpen the board's focus on looked after children, particularly those living outside the local authority boundary and those involved in offending behaviour.

Establish links to, and work with, the local Family Justice Board.

Strengthen the analysis of the quality and impact of safeguarding services within the annual report 2015-16.

Regarding the TWSCB annual report, it does not clearly reflect improvements in agencies, services and practices that have resulted from challenge by the board.

A thematic subgroup on children harming children has been created. This was based on learning from a MAPPA discretionary Serious Case Review. This subgroup has led to improvements in the conduct of child protection strategy meetings and a review of the children harming children pathway. This is positive but implementation is at too early a stage to have had a significant impact.

[1074] pg 33
[1075] pg 35
[1076] pg 35
[1077] pgs 36-40

Despite the board's 'one minute briefing' bulletins, ongoing training programme and themed training events, a few social workers spoken to did not have a clear knowledge either of the role of the TWSCB or of important learning from local Serious Case Reviews.

The content of the Telford and Wrekin threshold document, 'The Child's Journey', is generally clear and appropriate... However it is not fully compliant with statutory guidance. This is due to a lack of sufficient clarity about the distinction between children in need and those in receipt of early help, and a small number of other omissions. The document does not link clearly enough to guidance on child sexual exploitation, as expected by 'Working Together 2015'... It is important that the document fully delivers the expectations of statutory guidance.

The annual 'Health Watch' survey undertaken in secondary schools focused on young people's mental health. It is planned that next year's survey is enhanced to include specific questions relating to safeguarding."

Overview

3.1176 As with the 2012 inspection, the Inquiry recognises that CSE is not an issue easily considered in isolation and that the inspectors' role was to examine the service more fully, looking across a wide scope of children, including children in need of protection from all forms of abuse and neglect. This inspection identified that the "*rigorous focus*" on CSE appeared to have come at the expense of other welfare and safeguarding needs of children and concerns were identified that impacted a boarder cohort of children, including those at risk or harmed by CSE.[1078]

3.1177 The Ofsted inspectors had the advantage of seeing changes including CATE's move to Safeguarding and MASH co-location in Family Connect; the inspectors noted the Scrutiny Review as evidence of a commitment to tackling CSE.

3.1178 Notwithstanding the positive comments made in respect of the CSE response, the inspection identified a number of perennial problems:

3.1178.1 The lack of clarity in the Council's threshold document as regards children in receipt of early help, particularly with regard to CSE, and children in need, reflecting a theme that had by then persisted for almost twenty years. There were still delays in vulnerable children being taken into care, which, as I have shown, was another enduring aspect of the Council's provision;

3.1178.2 Twenty years after the inception of Telford as a unitary authority, management and supervision of social workers was patchy, leading to delays for children, and quality of assessments was poor; and

3.1178.3 RHIs were not always carried out in good time and their quality was "*variable*"; nor was the Council adequately using the information from RHIs to understand risk or improve services.

[1078] ████████ pg 32

3.1179 It should be noted that it is not clear to me whether the Ofsted inspectors had access to the CATE recording system which of course, until February 2017, was separate to the Safeguarding Protocol workspace.

3.1180 Many of the witnesses who have spoken to the Inquiry regard the Ofsted 2016 Inspection as very positive, and they are in some respects right to do so; but for the purposes of this Inquiry it further illustrates that basic issues went unaddressed for years.

3.1181 Furthermore, the Ofsted 2016 Inspection was – and was intended to be - a snapshot, rather than a historical review; and it inspected CSE services at a fortunate time, so far as the Council was concerned, with very significant changes having been made recently. Nevertheless, it revealed issues in respect of the Council's provision that were long-standing. It is difficult to further evaluate this analysis based on the limited information available and without knowing what information was sought or provided.

3.1182 So far as the LSCB was concerned:

3.1182.1 While Ofsted praised its "*clear structure*", an analysis of the LSCB and its subgroups' construction and restructuring over time, was not in the inspectors' remit; I do not regard the Ofsted findings as in any sense contradictory of my findings – we have looked at different aspects and timescales;

3.1182.2 While Ofsted further praised levels of attendance at the LSCB, it is incumbent upon me to note (as I have repeatedly remarked upon poor levels of attendance at the LSCB and its subgroups) that while absence within the 6-month 'snapshot' period (the meetings of 13 April 2016 and 15 June 2016 - the latter when inspectors were engaged in their assessment) was only 33% and 25% respectively, the two meetings prior to April 2016 and subsequent to the inspection showed absence at circa 50%. It is difficult not to conclude that attendance increases when an inspection is in prospect.

Multi-Agency Safeguarding Hub ("MASH")

3.1183 The Laming review[1079] identified key weaknesses in the way that a range of agencies and individuals, who are separately in contact with a child at risk, share pertinent information with one another. Consequently, it identified that often no individual or team had a complete picture of a child's circumstances. Laming focused on the "*front door*"; he said a key factor in identifying children who need help is ensuring services are designed to encourage contact from members of the public, parents and children as well as by other agencies. In local authorities where callers are directed to call centres that handle a wide range of local authority business, the local authority must ensure that any call relating to the protection of a child is quickly transferred to a trained person with immediate access to an experienced social worker allocated to work with that team for more complex or high-risk referrals.

3.1184 This approach led to the creation of the first multi-agency safeguarding hub, or "MASH", in 2011, in response to failures of agencies to work together to safeguard children. This MASH consisted of a multi-agency team of people who continued to be employed by their

[1079] The Victoria Climbie Inquiry: report of an inquiry by Lord Laming - GOV.UK (www.gov.uk)

individual agencies (local authority safeguarding, police, health services and education) but who were co-located in one office. Co-location was considered the most effective means of building trust and understanding between agencies. There were also virtual links to the early years team in children's centres; the youth offending team; probation; both children's and adults' mental health; housing; and the ambulance service. Information was shared securely within the hub and was gathered from teachers, GPs, health visitors, school nurses, police officers and others. Once information had been collected, a social work manager decided what further action is required.

3.1185 This model generated interest from other local authorities, police authorities and safeguarding specialists nationally. The final report of the Munro *'Review of Child Protection (2011)'*[1080] highlighted the first MASH as an example of good practice and a Home Office report published in 2014[1081] suggested that a MASH is a co-located hub of agencies enabling real time information sharing, decision making and communication. That said, the development of the MASH is a practice-led initiative and is not contained in guidance or legislation.

3.1186 In Telford, the Council hired a MASH consultant to create Family Connect,[1082] and the Inquiry heard from senior officers in the Council who indicated that the purpose of Family Connect was to be a MASH,[1083] and that they regarded it as such from its inception. That may not have been technically correct, as I note that WMP was not fully co-located with the MASH until some years later.

3.1187 As to difficulties with the MASH, the Inquiry heard[1084] in particular that there had been a challenge in gaining the comprehensive support of health services, not least because of the fragmented nature of health provision and the inability to accommodate all relevant health agencies within a MASH. Additionally, there was a feeling that the MASH was a Council innovation and a feeling that other agencies would have preferred to "*own*" it. To this end a MASH group of the LSCB was created with the aim of creating joint "*ownership*".

3.1188 In 2013, a study of five London boroughs by the University of Greenwich[1085] found that, for the areas that could provide data, the implementation of a MASH resulted in a larger proportion of cases being "*escalated*" to a more serious rating, and a smaller proportion being de-escalated to a less serious rating. Similarly, evidence from other areas suggests that the presence of a MASH often identifies greater risks than do single agencies: 27% of single agency assessments were escalated following work by the MASH, and only 7% were de-escalated.

3.1189 Furthermore, the Children's Commissioner's Gangs and Groups Report[1086] cited MASHs as an encouraging development, combining the expertise and resources of several bodies in order to identify children at risk of sexual exploitation.

[1080] Munro review of child protection: a child-centred system - GOV.UK (www.gov.uk)
[1081] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/338875/MASH.pdf
[1082] [redacted] pg 30
[1083] [redacted] pg 11, pg 23
[1084] [redacted]
[1085] https://www.londonscb.gov.uk/wp-content/uploads/2016/04/mash_report_final.pdf
[1086] 'If only someone had listened' | Children's Commissioner for England (childrenscommissioner.gov.uk)

3.1190 A Home Office funded project[1087] to understand better the multi-agency information sharing models that are in place also highlighted the MASH as the most common model which aimed to improve the safeguarding response for children.

3.1191 Back in Telford, on 20 May 2015, at the LSCB[1088] there was a discussion about a MASH. It was reported that Telford did not currently have a MASH, although if WMP were to join Family Connect it would be a MASH. A senior officer stated that the borough would "*have liked* [a] *MASH for some time…* [they] *would welcome MASH sooner rather than later*".[1089] This sits rather uneasily with the earlier documents that speak of WMP joining Family Connect, and it is not entirely clear to me what has happened in the interim: an answer may lie in the minutes of the LSCB of 18 November 2015, where it is stated:

"[WMP] *Harm Assessment Unit (HAU) staff had previously had recently had to withdraw their physical presence from Family Connect due to sickness and staff abstractions*". [1090]

3.1192 Additionally, I heard that one of the difficulties was in accommodating the varying IT systems used by the parties to the MASH.[1091]

3.1193 The target date for WMP staff to locate to the MASH within Family Connect was 7 December 2015, but additional police staff posts had not yet been filled. Temporary team members would fill the roles as an interim solution.[1092]

3.1194 The co-located MASH was live from early 2016. The Inquiry heard from CATE practitioners that while there had been an initial unease about co-located working – given that close working with the police, in particular, could cause suspicion amongst children and families – it was beneficial in terms of information sharing:

"… *you can just literally walk across the office and have that conversation which removes the barriers in terms of communication and really helps working together and looking at how we can proactively reduce the risks.*"[1093]

3.1195 In 2017, Ofsted's National Director for Social Care,[1094] outlined what makes a good 'front door' service that fully protects children. She said that there was a need to move away from the idea that local authorities needed to use a particular front door model, noting that what works in one place will not work everywhere. She highlighted different models in different places, which included MASHs and made the point that providing a good service is about more than adopting a specific model or a name, concluding that the best authorities will continue to develop ways of working that best meet the local challenge, of ensuring that children and their families receive the right help at the right time, as it changes over time.

[1087] Multi Agency Working and Information Sharing Project Final report July 2014
[1088]
[1089] pg 4
[1090]
[1091]
[1092]
[1093] pg 23
[1094] *Creating an effective 'front-door':* Ofsted's National Director, Social Care, Eleanor Schooling, discusses what makes a good 'front-door' service that fully protects children. https://www.gov.uk/government/speeches/social-care-monthly-commentary-march-2017

3.1196 Telford was quick to adopt the idea of a MASH and both the documentary and witness evidence to which I have referred makes it clear that senior officers regarded Family Connect as a functioning multi-agency safeguarding hub from the outset. That overlooked the reality, which was that there was slow buy-in from other agencies, particularly health, and that without police co-location the benefits of a MASH could not be realised. While the Council could not, of course, mandate full participation by other agencies, or cure the staffing problems suffered by WMP, I have seen no evidence that the inadequacies of the system from inception were properly recognised until May 2015. It appears that once the consultant-created structure was put in place, the task was seen as complete. This speaks again of a faith in structures without any real monitoring of effectiveness.

The CATE Team under Cohesion 2012 to 2016

3.1197 The LSCB CATE subgroup's terms of reference were updated in December 2011 to reflect the CATE service's place within Cohesion.[1095] Its terms of reference included:

"*Refining the model of service delivery…*

Developing and ensuring the implementation of a specific project plan for CATE…

… identifying how sustainable funding can be sourced to meet gaps in provision, particularly post exploitation support for parents and young people."

3.1198 There is material which shows that notwithstanding the CATE Team was so depleted in early 2012, it was expected to take on TYS cases in addition to its ordinary caseload.[1096]

3.1199 Although the stated purpose of the CATE restructure was that the service would be delivered from within the TYS model and by more people, the reality was very different. The Inquiry was told that the Cohesion manager with responsibility for the CATE Team, had a team of one, who arrived with 35 cases.[1097]

3.1200 Not only did the single CATE practitioner have a large number of cases, the Inquiry heard that they were expected initially to undertake all risk assessments and produce policies and procedures which hitherto did not exist.[1098]

3.1201 Those with management responsibility for CATE were, according to evidence I have read, inexperienced in child protection and inadequately briefed.[1099]

3.1202 The Inquiry heard the view expressed that to leave CATE in the hands of inexperienced management was a "*very, very risky thing to have done*".[1100] The CATE handover meeting

1095 [redacted]
1096 [redacted]
1097 [redacted] pg 5
1098 [redacted] pg 80
1099 [redacted] pg 7
1100 [redacted] pg 15

notes from 20 March 2012[1101] set out new procedures, to begin from 26 February 2012, as follows:

- *"All referrals to go through Help Desk. This includes any received in CATE Mail Box.*
- *Help Desk staff will put all received CATE referrals on Protocol.*
- *Consideration as to whether the referral requires s47 Social Care response,* [if yes] *Help Desk will follow usual Social Care Child Protection Procedures;* [if no] *CATE Project will be added to Protocol record as CATE open involvement. Help Desk to* [inform CATE team]*.*
- *All CSE work to be recorded on T drive… this recording… to be added to Protocol."*

3.1203 Perhaps the most interesting part of this document is that the words "*CATE Project*" have repeatedly been written in hand over the typed name of the single remaining CATE practitioner – which emphasises the effect of the restructure was at least temporarily to make CATE a one person team.

3.1204 At a TYS team meeting on the 19 April 2012,[1102] a plea was made: *"if you have spare room on your case load, please see* [the CATE practitioner] *for CATE allocations..."* and noting, *"...training for this will be arranged in June".*

3.1205 A TYS worker at the time, confirmed that the TYS team was overstretched:

"… everyone was working to full capacity… me and a colleague were involved in setting up some kind of measuring tool for what we thought was an appropriate case load, because we thought we were overstretched within Targeted Youth Support, but that really didn't go anywhere".[1103]

3.1206 A CATE "*action planning meeting*" was held on the 27 April 2012,[1104] with the stated intention of "*look*[ing] *at the learning of Child Exploitation and the aim is to reflect back*".

3.1207 The meeting noted that there had been pockets of preventative work against exploitation, though there were "*a lot of hot spots*" in the borough. The data available was very basic: professionals needed to work out if what they are collating was the right data. The meeting agreed that there was a need for mandatory multi-agency training in exploitation, as well as training for under-trained groups such as the voluntary and private sector and school staff. Current training was only delivered by the CATE practitioner and a senior officer in Safeguarding and only for four hours. Again, the lack of available support for parents and carers was lamented and the implications for the safety of children not explicitly discussed.

3.1208 A note in the minutes reads:

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1103 pg 23
1104

"[A] *CATE case was recently presented to Management Team that included two chronologies. What concluded from it was the use of language. Saying Asian male and if not always able to put to something specific, do not record*".

3.1209 This seems to suggest that unless greater specificity as to racial or ethnic background can be achieved, "*Asian*" should not be used. It follows on:

"*It is felt to be about challenging despite what race, culture or religion and unless comments are challenged nothing can progress and move forward".*

3.1210 I confess I do not find the meaning of this obvious, either; but if it is a suggestion that a complaint of abuse by an Asian man should be challenged as an unacceptable use of language then I consider that such an approach would first, make mapping of offences more difficult and second, if such comments were indeed "*challenged*", potentially serve to discourage complaint.

3.1211 On 23 May 2012, a CATE Pathways[1105] meeting considered data collection and noted that the referral and assessments did not collect data on the place where CSE was said to have occurred or the address of the child involved. In terms of practical data collection, the relationship between the Cohesion Customer Relationship Management System and Protocol was to be "*resolved outside of the meeting*". As to the extent of failure to collect data adequately, the Inquiry heard:

"*… the statistical information was, as far as I was concerned, nothing. It didn't tell us anything in terms of the number of referrals that came through, the status of referrals that came through, where those referrals came from, what we did with the referrals, what the process was and what the level was when they came in in terms of what degree of risk they came in on, what degree of risk we closed them at and if we closed them, did they get referred onto anyone else. There was just not that breadth of information to help feed back into."*[1106]

3.1212 On 31 July 2012, a Cohesion manager wrote to a senior officer in Safeguarding; the content shows confusion as to role and concern as to wasted work:[1107]

"*We are in danger of duplicating activities if we are not careful.* [CATE was] *going to start looking at Risk Panel and Strategy meetings but if you are doing this too??? I think I am now unclear as to my role. What responsibility do I have – Practice? Supervision?"*

3.1213 The reply came that "*someone from Safeguarding needs to chair the risk panel and strategy meetings as* [they are] *clearly safeguarding responsibilities*".[1108]

3.1214 This fortifies my view that the move to Cohesion was a mistake - and obviously so at the time.

1105 [redacted]
1106 [redacted] pg 27
1107 [redacted]
1108 [redacted] pg 2

3.1215 On 17 October 2012[1109], the LSCB met. The meeting notes further convictions in the Operation Chalice series and it was said that Cohesion were now looking at which "*cases can be stepped down to other services"*. The Inquiry was told:

"I think [CATE] *was seen as a bit of a pet project and probably not something that would go a long way beyond Chalice."*[1110]

3.1216 At the CATE Pathways meeting on 30 November 2012[1111], a CATE practitioner asked about funding for training and was told that none was available.

3.1217 In December 2012 there was a strategy meeting regarding a child over the age of consent about whom there were concerns that they had been groomed for sexual abuse by Asian males and who was visited by children aged 12/13 years old. A referral to CATE was agreed, which would include a strategy meeting involving the child's parents.

3.1218 This should have been subject to the complex child abuse procedures highlighting the need for this when there are multiple victims of harm and multi-perpetrators, as outlined in Working Together 2010, but the Inquiry has seen no evidence that this was the case.

3.1219 The CATE Pathways meeting on 1 February 2013,[1112] confirmed that CATE was working with 28 cases including two male children and that "*this is all new for the staff*". There was concern about CATE training and an enquiry was made as to whether any WMP staff would be able to deliver CATE training, with the caveat "*practical experience is essential*". Despite this apparent recognition of a lack of capacity, the LSCB Annual Report of 1 March 2013[1113] noted "*the CATE service has been successfully mainstreamed*".

3.1220 The CATE Pathways group met on 26 April 2013,[1114] and it was recorded that "*data collection… was identified as not progressing well. This is because there is no one assigned to the task".* Further, while CATE training had been provided there was no confidence that all relevant staff had received it. There were issues raised "*regarding managers and social workers in social care not being aware of CATE pathways,"* and *"not many social workers have attended the training".*

3.1221 The Inquiry heard about the CATE Team that:

"I felt we were playing catch-up a lot of the time in terms of what I felt we needed. I'm not saying that the Council should have gone along with everything that I was asking for and saying, but in terms of the high profile nature of CSE, the high profile nature of all of that, I think there were more resources that could have been made available."[1115]

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3.1222 At this stage, the CATE Team was keen to deliver advanced training; the LSCB had committed to this for the present financial year but there was no certainty the funding would continue beyond that.

3.1223 Analysis of the LSCB Performance Report[1116] showed, so far as CATE was concerned that:

"[T]*he number of CATE Pathway Strategy Meetings has increased from 2 at year end to 8 at the end of quarter 2. The number of children that Cohesion are working with where CSE is a factor has increased as well from 22 at year end to 30 at the end of quarter 2*".

3.1224 The Scrutiny Committee held a meeting with the CATE Team on 5 August 2015.[1117] It was noted that capacity and size of caseload were big issues. There were only a small number of CATE practitioners – three after the 2012 restructure (confirmed by a structure chart I have seen[1118]) and occasional reassignment from others in Cohesion according to caseload - but their caseload was as big as the wider Cohesion team. There was insufficient capacity for caseload: it was simply not possible to do all that needed to be done. The NWG recommended an ideal caseload per worker of eight to ten cases; CATE practitioners had 15 to 18. Therapeutic referrals were difficult for victims/survivors and dedicated support for parents was required.

3.1225 It appears that earlier problems with capacity, which were first raised in 2008, were once again being raised between managers, on 17 August 2015:[1119]

"Re CATE capacity we have 65 current open cases…

With [a worker] *being absent we have reallocated her cases but this has meant those staff in CATE being well over what I would consider a manageable caseload. Especially considering the risk levels and other activities and intensity of what contacts I would like.*

Referrals continue to come in and these will outweigh the cases that are being closed.

We have looked at the point of referral to hive off those that [an officer] *and I would agree could be dealt with in another way and we will by mid September have* [another] *team undertaking some small group work sessions with low risk cases.*

The police have expanded their CSE team in order to provide an improved service to young people in T&W but in reality T&W have borrowed staff from within Cohesion.

We are close to CATE being swamped and not providing the intensive service that we need to provide to protect this most vulnerable group of young people. We don't want waiting lists as all young people are in need.

We have approx 4-6 out of area young people that we are working with too.

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Can you please give some consideration to how we can improve this situation."

3.1226 The use of the words "*waiting list*" is interesting, and the Inquiry's expert witness posed the question: *'What would they be waiting for?'* If waiting for a worker to be allocated, this should not happen in child protection. The child would be considered unallocated but a member of the duty team should have some level of oversight.

Management and Supervision of the CATE Team during Cohesion

3.1227 On 23 January 2014,[1120] there was discussion amongst Safeguarding about CATE and its supervision within Cohesion amidst concerns of a growth in CSE - thought potentially to be the next Chalice - at a time when CSE practitioners were unsupervised and very recently qualified:

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

3.1228 At the CATE Pathways meeting on 29 January 2014,[1121] it was noted that discussions about supervision "*have been had outside the meeting*" - the classic solution, in my view, to keeping awkward conversations out of the documented minutes. This suggestion should plainly have been challenged. I do not necessarily criticise those present at the meeting for not doing so: this could well illustrate that the people at the meeting were insufficiently senior to raise a challenge, which reflects poorly on the Council.

3.1229 It was further reported that "*staff found it difficult to work outside their boundaries"* and that some professionals *"were still traumatised – some were upset in the staff forum."* Concern was also raised *"over loss of networks. The forum stated they were unsure of the referral process now*". This seems to suggest that newly-trained CATE staff had not appreciated the potentially upsetting nature of the work and that existing staff had been unsettled by the transfer from Safeguarding. These were serious issues which should have been escalated.

3.1230 On 28 April 2014, discussions about CATE access to the Protocol system continued:

"… *the CATE workspace is currently being built which will enable CATE to record directly onto Protocol."*[1122]

3.1231 Further serious concerns were expressed in Safeguarding about the management of the CATE Team. It was suggested that the manager, had "*a poor grip on why the Pathway is designed in the way it is, and the implications of it being a safeguarding response*"; there was a suggestion that the manager was ill-briefed about missing people. It was suggested that "*our new structure will improve matters substantially*". [1123]

1120 [redacted]
1121 [redacted]
1122 [redacted]
1123 [redacted]

3.1232 I know very little about a "*new structure*". None of the documents the Inquiry has received cast any light upon it. In reply to very specific requests, the Council has told the Inquiry it retains neither documents nor corporate knowledge of this restructure. I have, however, heard evidence that at this time there was (yet) another proposal "*to save money*"[1124] by removing the senior CATE practitioner role, leaving the incumbent to move into management of a different team or to take a salary cut. It seems that representations were again successfully made for the retention of the role, but I regard it as quite remarkable that the Council should have again thought to risk losing such expertise. In the absence of specific explanation I can only assume this was cost driven; I have seen reference to the stand-down of other services, for example the Family Intervention Team, which offered tailored advice to families on housing, debt, and mental health issues at the same time.[1125]

3.1233 At the LSCB on 16 July 2014, a representative of Safeguarding observed that "*demands on the Safeguarding Service, by Family Connect have been too high*" and that there was "*scope for spreading the load across the partnership*".[1126] Once again, the Family Connect system was not behaving in the way that had been hoped; and Safeguarding was pleading for relief.

3.1234 At a CSE Pathway Operations Group meeting on 15 September 2014[1127], concern was expressed that in terms of CATE performance, children were not being visited, risk assessments were not being updated, and tasks not completed from one CATE strategy meeting to another. The same meeting heard that there were increasing numbers of cases open to CATE – currently 35 - and concerns relating to men who had been known to Chalice. The reasons were thought to be linked to staff sickness and lack of capacity for additional cover. Cohesion management was to seek additional staff cover for CATE.

3.1235 The Inquiry understands that capacity issues affected the ability of the CATE Team to offer the level of support that was needed to the extent that "*I am sure we cut cases where… we hadn't gone through the process of assessment yet".*[1128]

3.1236 Any "*cut*" cases would have been referred to other services; the motive was to protect the CATE practitioners, who were under extreme pressure.[1129]

3.1237 In my view, during this time period, the resource problems were also likely to have been impacted by the "*all-through model*" implemented in 2014/2015 which required practitioners to maintain cases from initial assessment through to closing of the case or adoption. I have heard from at least two social worker witnesses that the model had a negative effect on "*everyone*". When asked about caseload, one social worker recalled:

"When I first joined, very manageable and then we had a restructure where we were working in the "all-through" model and that was [implemented in] *2014 so we didn't have a duty and assessment team and then a Child Protection team. You had a case from section 47, you had it all the way through to adoption and that was unmanageable so that was*

1124 [redacted] pgs 78-79
1125 [redacted]
1126 [redacted] pg 5
1127 [redacted]
1128 [redacted] pg 17
1129 [redacted] pg 17

around 2014, 2015. There was lots of, it was a very, very stressful time because as one point I think I had about 45 cases."[1130]

3.1238 Another one remembers this period as being, "*extremely challenging, extremely difficult*",[1131] and noted that "*we did have high, complex caseloads, I can remember losing quite a lot of permanent staff during this time and having more agency staff."*[1132]

3.1239 On 19 September 2014, a discussion on the issues raised by a prospective Ofsted thematic inspection[1133] noted overall low numbers of CATE cases thought to reflect under-activity by WMP and low numbers of referrals from practitioners, perhaps related to low take-up of CATE training by practitioners and managers. There were still long delays between allocation to CATE and risk panel assessment, as before, because of the non-availability of the panel chair. There were difficulties in identifying cases open to Safeguarding where CSE was an issue – which seems to be one of the situations that the Family Connect 'front door' was designed to address. There was said to be a need for a CATE strategy. It seems that CATE had become synonymous with CSE at this stage; any strategy should quite obviously have been an overarching CSE strategy.

3.1240 Perhaps as a result of the foregoing there was an audit of CATE files on 24 September 2014.[1134] The audit noted:

"*CATE were picking up tasks at assessment panel which appeared to be off scope – e.g. around education issues – when there were other practitioners around the table who would have been more appropriate to undertake this*".

3.1241 A joint report[1135] to the CTB by the Principal Child Protection Officer and the Service Delivery Manager for Cohesion[1136] on 2 October 2014 identified the following points:

- In 12 months prior to August 2014 there had been 23 cases allocated to CATE and there were 31 cases open;
- 26.1% of those were aged 14;
- Only 17% of allocations had a risk panel assessment within three weeks, and 61% had a risk panel between three and six weeks after allocation;
- Overall, risk panels were not completed in a timely fashion and not all services – in particular WMP – were completing the CATE referral form;
- There needed to be an indicator on Protocol that identified the child as at risk of CSE;
- The CAF/TAC approach should be built into the CSE Pathway;

1130 pg 12
1131 pg 7
1132 pg 14
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1136 pg 27

- There needed to be more outreach into school PSHE; and
- The approach pioneered by PACE (formerly known as CROP) should be adopted.

3.1242 Some concern was expressed at senior Safeguarding level, about the CATE Team and the method of working under the Pathway; specifically whether CATE staff should be undertaking risk assessments or gathering information for others to undertake the assessments. An internal communication dated October 2014 noted:

"*Pathway implies CATE staff are only info gathering. Even if panel meeting when it should, some YPs would wait 4 weeks for risk assessment… they should be completing risk assessments – which can be informed by risk panel – but we will need to change the Pathway if that is what we mean.*"[1137]

3.1243 In the same communication there was a complaint about CATE training:

"*CATE training appears no longer to be very visible with the LSCB – when it stopped being a LSCB development priority I think – very odd decision which I am trying to understand better. Whilst of course participants need to understand the Telford model, this doesn't mean training must be all delivered by CATE staff*."

3.1244 This shows that the stand down of CSE as a priority of the LSCB was not without adverse consequences.

The relationship with WMP

3.1245 It appears that the previous close relationship between individuals in the CATE Team and WMP was, by this point, under strain. In May 2014, a CATE practitioner emailed[1138] a WMP Sergeant in these terms (the underlining is mine):

"Over the six years of the development of the local authority response to CSE, the CATE service has, had a close working relationship with the police. During this time the police response to CSE has moved between different departments within the police. Initially CATE and then Chalice sat with reactive CID and the then sexual offences unit. This was a response to the high level of intelligence that was provided primarily from the then CATE workers around concerns in the Wellington area which then became operation Chalice. Chalice then often became confused with CSE, this was in terms of the model of CSE and that once Chalice concluded there was a general feeling that CSE had been dealt with by the police in Telford. The DS [Detective Sergeant] *responsible for the sexual offences team within the police would then attend risk panel/ strategy meetings and would make decisions on who would disrupt/investigate.*

Over the past three years the police responsibility then moved into PPU/PVP [Public Protection Unit/ Protecting Vulnerable People]. *The DS responsible for domestic abuse was then given the responsibility for CSE. Although the officers that have been given CSE have*

1137 [redacted] pg 1
1138 [redacted]

been extremely dedicated and committed to the work this has not been enough in providing the essential dedicated time that this role requires. Gaps are as follows:

- *PVP have no dedicated officers to disrupt and investigate CSE.*
- *All intelligence has been sent to* [a] *DS recently to the HAU for a decision to be made.*
- *Investigations are passed to reactive CID and on occasion uniformed - with CSE the victims are vulnerable children and require officers that are used to dealing with children.*
- *Although trafficking is a huge part of CSE - Trafficking seems to be overlooked in respect of investigations.*
- *If we had dedicated CSE officers we could work as a virtual team to make the disruption, prosecution and the protection from CSE much more effective. This could be effectively managed by* [a] *DS with* [their] *knowledge and expertise that* [they have] *developed in this area of work."*

3.1246 The suggestion that there was a feeling amongst some quarters that Chalice had brought CSE to an end was confirmed to the Inquiry by a very senior official in Education,[1139] who nevertheless refuted that they had ever taken such a view personally. The Inquiry was also told:

"*I think there was too much of a feeling of this* [Chalice] *is a success, we've cracked it, rather than this is the first step, there's more we need to do now."*[1140]

3.1247 On 11 August 2014, a CATE practitioner continued the campaign with WMP, writing:[1141]

"*Following on from the success of Operation Chalice 2008, the police have still not provided any permanent dedicated team to proactively investigate CSE.*

Prior to Chalice and in the lead up to this operation the police response was from the then sexual offences team, [a Detective Sergeant] *and two STO's, the police support is currently an additional role to the DS who is responsible for domestic Abuse. The response can therefore only be reactive rather than proactive.*

There has recently been evidence that referrals are not being put through by the police evidenced by two young people who were exploited in Dec 2013 and who were not referred to CATE, this came to light in the July multi-agency risk panel meeting.

It is apparent that not all police are aware of the police Pathway with regards Child Sexual Exploitation.

Investigations are being conducted by reactive C.I.D which means that the response can be inconsistent due to officers awareness of CSE - (June 2014 a male officer was deployed

1139 [redacted] pg 19
1140 [redacted] pg 51
1141 [redacted]

to an investigation and this deterred the young woman from wanting to engage and continue with a complaint).

There have been many excellent police officers that were involved in operation Chalice who have the expertise to deal with child Sexual Exploitation and have now been deployed elsewhere.

Over the years there have been several police officers who have worked really hard [in] *their role and have worked to disrupt and investigate the offences that are present in this form of abuse I am still somewhat disheartened that West-Mercia police still does not have a resourced response to this*."

3.1248 An interesting response came from a police officer in Warwickshire, a force then allied with West Mercia:[1142]

"*I completely agree with all your points and 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*."

3.1249 I have seen another email dated September 2014 when concerns were raised about the lack of WMP proactive response to information in relation to children being sexually exploited. The CATE officer raised her concerns including the fact that WMP had not referred a reported rape of a child already known to the CATE Team to the CATE Team's attention. The CATE practitioner called for a dedicated WMP response which would, in their opinion:

"… *break down the barriers of distrust from young people towards the police, ensure a proactive rather than reactive response; ensure all referrals reach CATE and are investigated; ensure that disruption is a priority; and build on the knowledge of best practice in dealing with this crime.*"[1143]

3.1250 At a CSE Pathway Operations Group meeting on 15 September 2014,[1144] concern was expressed that WMP were unaware of the CSE Pathway, it was suggested WMP needed to be presented with the Pathway and there were to be discussions within Safeguarding as to how to achieve this.

Case File Audits

3.1251 In November 2014 the LSCB commissioned a case file audit of a random sample of children impacted by CSE as part of the quality assurance processes outlined in Working Together 2013 regarding the multi-agency response to CSE (one of three audits that year). The audit was referred to as a "MACFA" (Multi-Agency Case File Audit).[1145] This was led by an independent reviewer who was experienced in SCRs and case file audits.

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1145 [redacted]

3.1252 It was noted that Safeguarding returns were either incomplete or were not completed at all for some children. I note that no action was noted to address this or to consider the impact on the case file outcome. Further, there was no audit material from CAMHS. It was recommended that CAMHS contribute to the next audit.

3.1253 The themes/outcomes arising from the MACFA were:

3.1253.1 There was insufficient analysis of the concept of "*sexualised behaviour*" and what this meant in the records;

3.1253.2 There was an absence of recording of adults' ages who were suspected of sexual abuse/exploitation;

3.1253.3 GPs were often not included in multi-agency networks and planning;

3.1253.4 There was a lack of the use of genograms (diagrams illustrating a person's family relationships and history), eco-maps and chronologies;

3.1253.5 Insufficient connections had been made between concerns of CSE and links with historic concerns about sexual abuse and neglect;

3.1253.6 There was confusion about children who had child protection plans and were also subject to CATE support. Part of the problem was that information about children who were open to CATE was not included in the system where 'child in need' child protection plans were recorded. This meant that children open to CATE were not included in the data requirements of the Department for Education. Professionals working with dual plan children could not access all a child's records;

3.1253.7 There was poor recording of children's sexual health needs and lack of involvement of these professionals in plans; and

3.1253.8 There was a lack of distribution of CATE meeting notes.

3.1254 An action plan was agreed and it was agreed that there would be a review of where and how CATE plans were recorded.

3.1255 A regular audit of the work to address the needs of children impacted by CSE was important and demonstrated a commitment to learning from practice and creating changes. I have seen a learning briefing dated September 2015[1146] which sets out how concerns and performance issues were to be addressed. Immediate concerns for children identified within the case file audit were to be referred back by the managers immediately. There was an expectation that any performance issues were to be addressed with the professional. I have also seen a MACFA Compilation Action Plan[1147]. However, this does not address all of the themes arising from the MAFCA. As with many of the action plans I have seen, there is no evidence about how the learning was incorporated into practice, and who was responsible

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for tracking these learning points over time. The independent chair of the audit had no role as an external, independently commissioning person, and there is no evidence of who would be responsible or how this linked with the work of the CATE Pathway group (which reported to the LSCB).

3.1256 In January to May 2015 there was a further file audit focused on CSE and missing children, because there were concerns about how the separate CSE Pathway and Missing Pathway were working. There was concern, and rightly in my view, that for this group of children there were four different places where information could be recorded, because of the different pathways these vulnerable children were connected to. Some children had the status of 'child in need' for example, and all the work happening for this was recorded on Liquid Logic (Protocol), but the work with CATE, including risk assessments, day to day work, plans and strategy meetings were recorded separately, and each separate recording system could only be viewed by specific professionals. This indicated a real lack of a joined-up approach. I note that this audit took place without chronologies for the children from the CATE Team. From the Inquiry's review of the documents, there is no sense of why, and what action was taken to address this, given the role of the CATE Team.

3.1257 One recommendation of the MACFA was that "*Social Services are asked to find a way of ensuring children open to the CATE team are recorded on the IT system as Children in Need*"[1148]. This was not actioned until sometime later.

3.1258 In November 2015 there was a further audit of CSE cases chaired by the same independent person from outside the authority; seven children's circumstances were reviewed, and the professional response scrutinised. The findings were:

3.1258.1 Concerns about information sharing, and particularly from GPs;

3.1258.2 Still limited evidence of the use of genograms and chronologies;

3.1258.3 Still confusion about overlap between children who were open to CATE and had child in need plans;

3.1258.4 Concerns that social workers and WMP could miss CSE when sexual abuse is an issue of concern;

3.1258.5 There was evidence of delay, drift and lack of recognition of CSE; and

3.1258.6 It was noted that the capacity of the CATE Team remained a concern, with a rise in demand. It was noted that a review of the CSE Pathway was underway.

3.1259 Once again, there remained no recorded processes for addressing each of these findings and checking the status of progress.

3.1260 This was the third audit in a 12-month period (2014 to 2015) and there was also, during this period, the NewStart Review (2013) and Principal Officer for Child Protection's report (2014), as well as the fact that the Scrutiny Committee were in the middle of a review of

[1148] [redacted] pg 11

the multi-agency response to CSE. Despite this, I am not persuaded by the evidence that any of these activities were used to the best of their ability to improve the circumstances of children, their families and siblings who were impacted by CSE.

Other Local Authority ("OLA") Children

3.1261 I pause to consider the situation as it applies to children who are under the care of a local authority, either where the Council is the corporate parent or in circumstances where another local authority is the corporate parent but the child is placed within the Telford area, as I have read that "*the issue about the risk of CSE for a child placed out of authority was a national issue*".[1149]

3.1262 The 'Children Abused Through Exploitation' protocol discussed earlier in this chapter provides that a child found outside the local authority area, remains the responsibility of their "home" authority, although it notes that the authority in which the child is found may need to provide immediate protection.[1150] In relation to an OLA child being found in Telford, the local police would be under a duty to inform the local authority, whose responsibility it would then be to inform the home authority, who would in turn have a duty to collect the child and give an assurance of wellbeing.[1151]

3.1263 One witness to the Inquiry, who worked in residential and educational provision for looked after children in the period around 2006, told the Inquiry that:

"… *it was apparent very quickly that there wasn't a reporting protocol or procedure back to the local authority… there wasn't any formal notification back from the local authority when a child arrived in placement... nobody knew they were in our local area until the police got involved and the police would say we have no knowledge of the child being placed in this area… I think for me it became apparent that this wasn't as joined up as it needed to be.*"[1152]

3.1264 In recent years, however, and particularly since the CATE Team took on responsibility for missing children which is often, as stated above, the first knowledge that the local agencies have of a looked after child residing in the area) I am satisfied that this potential gap in safeguarding is being addressed. The CATE Team now chair the Missing multi-agency group, held every six to eight weeks, in which the cases of those missing children deemed to be most seriously at risk are discussed. I heard from one senior local authority witness that, in the case of an OLA child where the Council is the host authority, then the Council will formally notify the placing authority who will then conduct the RHI, or may have a contract with another company/third party organisation to do so. However, as the local police also carry out these interviews, the Council is comfortable that it also gains an understanding, through this route, of which local authorities children are from and the circumstances around their case. The level of intervention needed by the Council itself is assessed on a case by case basis, with the CATE Team involving the service delivery manager where appropriate.[1153]

1149 [redacted] pg 22
1150 [redacted] pg 40
1151 [redacted] pg 41
1152 [redacted] pgs 10-11
1153 [redacted] pg 107

3.1265 This evidence was further supported by a member of the CATE Team, who told the Inquiry that there are national information sharing procedures in place for looked after children who are placed in another authority or indeed OLA children who are placed within Telford. The Inquiry also heard:

"*I think mostly we are alerted and similarly if we place the young person out of the area, we alert them.*"[1154]

3.1266 When asked about ongoing support to the child, the Inquiry understands that if that person is open to CATE, the CATE Team would maintain the relationship and continue the support, and also that:

"*… if a young person is not open to CATE, then the social worker can refer them into CATE and it will be explored…. if the concern is exploitation in that area it might be that they need to be moved, rather than referred into CATE, so it is explored at a safeguarding level.*"[1155]

3.1267 The issue of missing children, including OLA children, and the question around responsibility for RHIs is something I also discuss in detail in Chapter 5: The Policing of CSE in Telford.

CATE Team - 2016 to date

3.1268 The relationship between CATE and Safeguarding/Cohesion was explored in an email dated 27 January 2016 from a high level officer in Safeguarding to the then DCS:

"*What is the timeframe for restructure* [of Cohesion]. *Currently CATE sits in* [t]*his service although they are managed very recently by* [Safeguarding] *– I am looking to have a child exploitation team that will cover CSE, Missing, FGM, Forced Marriage. Currently there are 4 workers for CATE – if the restructure includes CATE it will provide us with an opportunity to red box the team and recruit suitable people – if we could have two additional posts? Although not thinking this would be possible as it would impact on savings but would mean we could properly meet the needs of this group of children it would be in line with all the components of the Exploitation Action Plan.*"[1156]

3.1269 Cohesion's role with CATE came to an end with another restructure known as '*Being the Change'*, which led to the end of Cohesion and CATE's move back to Safeguarding.[1157] I read evidence from one witness who said:

"*I never felt in all of the time I was there that the CATE resources were adequate.*"[1158]

3.1270 A senior official in Safeguarding then became Strategic Lead for Missing and CSE.[1159]

1154 [redacted] pg 114
1155 [redacted] pg 115
1156 [redacted]
1157 [redacted]
1158 [redacted] pg 32
1159 [redacted]

3.1271 It is necessary to underline the evidence the Inquiry heard that this was not a change made because of a view that CATE was wrongly placed within Cohesion, but primarily because Cohesion ceased to exist:

"… *it was also about the fact that Cohesion no longer existed so there wasn't really like a service where we could continue to develop because I don't think we would sit, it wouldn't be the right place to sit within like a family, like an early help prevention service which is where it all went to because we were a complex and above service in terms of threshold so we couldn't sit in a prevention service, we needed to sit in a complex and above service which would be Safeguarding which would be with the social workers and it gave us then chance to develop that relationship with social care directly*."[1160]

3.1272 The Inquiry has heard a number of witnesses express the view that Cohesion had been a bad fit for CATE:

"*Upon hindsight, absolutely it should have sat somewhere else and it should have had different people managing it and managing the risk, just simply because of the understanding that's required... You needed to have a really experienced service delivery manager that was a social worker. I don't think we gave it the priority that it needed.*"[1161]

"*I think of the end of the day it's child protection business, what they're doing is child protection. What they're skilled at is being able to reach young people that are very difficult to reach, really reach, very, very difficult. What they're also very good at is they form relationships, they assist the young person to gain access to people, other professionals that will be supportive to them, whether that's housing, whether that's police and whether that's social workers. So all of that skill and those engagement skills comes with managing a lot of risk because alongside that you've got young people that are being abused, on the fringes of being abused or are vulnerable. You need the social work element of it… They wouldn't have that in Cohesion.*"[1162]

"[CATE] *came back in 2015/16 because that's where it should sit. It probably should always have sat there. I would not have put CATE into Cohesion if I was in a position to influence anything.*"[1163]

3.1273 There was a reported drop in CATE caseload on 1 August 2016,[1164] (from 61 at the end of December 2015 to 45 at the end of March 2016) thought to be due to a change in direct management of CATE practitioners; analysis of the caseload; and a review of open cases. Notwithstanding this change in approach, numbers were rising again.

3.1274 At the LSCB on 13 January 2016,[1165] it was noted the caseload of CATE was still increasing. Referrals from health were still low; it appeared sexual health professionals were not used to passing on information. The RHIs completed within timescale remained poor – only 55%

1160 [redacted] pg 21
1161 [redacted] pg 28
1162 [redacted] pg 20
1163 [redacted] pg 13
1164 [redacted]
1165 [redacted]

completed in time in November 2015;[1166] it was suggested that the problem lay with "*recording*" issues. It is unclear what those recording issues might have been or what was proposed to address them.

3.1275 It was noted that a senior safeguarding officer was taking more responsibility for the CATE Team and CSE; while another manager was expressing concern that:

"*… we are pushing safeguarding responsibilities onto CATE workers.*"[1167]

3.1276 On 8 December 2016, CATE staffing was discussed again; it was noted that CATE practitioner numbers were to be increased by a further senior social worker and two more CSE practitioners.[1168]

3.1277 In November 2016, an analysis showed only 50% of RHIs were being completed within timescale and there was an issue with RHIs not being sent to Family Connect or WMP's HAU[1169]. There was also "*a lack of communication between social workers and agencies regarding the information that is provided on missing children*".[1170]

3.1278 So far as RHIs were concerned, the evidence shows that it was the view of a senior member of Safeguarding that:

"*I felt very strongly that we needed the missing function with CATE because obviously missing children and exploitation are so closely aligned.*"[1171]

3.1279 By early 2018, a Missing Children Co-Ordinator had been appointed in the CATE Team.[1172] It was suggested the team was now "*comfortable*" with capacity.[1173] A Task & Finish group had been set up to examine the transition between Child and Adult Social Services.[1174] The Joint Exploitation subgroup discussed CSE and identified the following gaps in service provision:[1175]

- *"Schools;*
- *CSE education and training post;*
- *Therapeutic support to work alongside CATE team;*
- *Parent and sibling worker to work alongside CATE team;*
- *Step down to non-statutory services; and*

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1171 pg 22
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- *Perpetrator work and a perpetrator profile."*

3.1280 It was agreed to arrange further meetings to explore the "*need and evidence*" behind these ideas. On 4 June 2018 it was reported that a partnership CSE Co-ordinator post had been created as well as a CSE education and awareness post;[1176] the Joint Exploitation subgroup meeting on 7 June 2018,[1177] heard that there had been a proposal for a post of family therapist within the CATE Team. The CATE Team was now dealing with RHIs when the missing child was open to CATE or had an allocated social worker; information obtained was recorded on Protocol and shared with WMP, while missing children without CATE or social work involvement would be interviewed by members of the Strengthening Families team. Regardless of whether the interviewer was from CATE or from Strengthening Families, the officer would be expected to complete the same form and take any referral to Family Connect.[1178]

3.1281 The Council invited third sector bids for development of a therapeutic support programme for CSE victims/survivors and their families.[1179] It seems that attempts to involve the third sector was finally being embraced.

3.1282 The Joint Exploitation subgroup on 13 September 2018[1180] noted an increase in CSE amongst looked after children who were fostered. Production of a foster carer plan was proposed in cases where there had been 'multiple missing episodes', with it being noted that information sought by Family Connect would be reviewed in this regard. The subgroup stressed the "*need to review Return Home Interviews when they are completed and who is in attendance*". Again I query what action was taken to address this serious issue for children, for whom the Council had corporate parenting responsibility, and I have seen no evidence that it was shared with the Corporate Parenting board.

3.1283 A paper dated October 2018[1181] posed the question in respect of CSE: "*Which operational groups underpin this work? CSE Operational Group, CATE Risk Panel? Other multi-agency groups?*" I confess to not having found this easy to answer and so am to some extent reassured to see that others found it difficult.

3.1284 That said, it is important to recognise at this stage of the chapter; first, the expansion of the CATE Team to include team managers, practitioners and a senior social worker.[1182] Second, the conclusions of the NWG review of 1 November 2018 (with which I deal with in greater detail below):[1183]

"*Clear multi-agency work was demonstrated in the case recordings, drawing on a range of professionals to compliment the work of the CATE Team, this was particularly impressive in a number of cases audited, which were jointly worked with children's social care. The nature of this partnership was observed to be seamless by the CSE Response Unit. The review team noted the high-quality work carried out by the CATE Team, in a context of a*

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1178 pgs 17-18
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1182 pgs 61-62
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challenging climate, with significant political scrutiny and media interest. Team members are supportive of each other and clearly value the support given to them by management at all levels. The case audits revealed a high standard of support offered by the CATE Team to children who were either at risk of being exploited or who had been victims of abuse. Case recording was of an excellent standard, clearly articulating both the risk and the interventions for individual cases, as well as the outcomes of any sessions."

3.1285 The Inquiry has been told that there are 11.6 workers currently in the CATE Team, comprised of two managers, one senior practitioner; 7.6 FTE (full time equivalent) CATE practitioners; and one senior social worker. According to data provided to me by the Council in its Corporate Submission[1184], the CATE Team received the same number of referrals in 2010/2011 as it did in 2019/2020. Despite this, the size of the CATE Team was dramatically smaller in 2010/2011. This demonstrates to me the extent of historic underfunding of the CATE service.

Current Function of the CATE Team

3.1286 It is important to note that the CATE Team has developed over the years since it was introduced. I set out below my understanding of the evolution of the CATE Team together with the current position with regard to the role and current practice of the team.

Role of the Team

3.1287 According to the Council's Corporate Submission:

"[T]*he focus of the CATE team was to identify children/young people at risk of being subject*[ed] *to CSE by assessing a number of risk factors. In turn, this would help to raise awareness on the part of the child/young person, their parents and other agencies involved with the child/young person and plans put in place to mitigate those risks. Often, this would involve a period of intensive intervention on the part of a CATE member of staff to help educate the child/young person on how to stay safe whilst, at the same time, holding partners to account to ensure safeguards were implemented to support the child/young person".*[1185]

3.1288 I note that the team's remit is still to "*educate young people*" which again underlines my view that the CATE response is fundamentally a victim behaviour modification approach.

3.1289 A number of past and present CATE Team members have given evidence to the Inquiry and helped piece together the journey of the CATE function, from its effective beginning in 2007 to the present day. Upon its inception, the CATE "*project*" (as it was initially described) was staffed by two team members with youth work experience, working with children who were the victims of sexual exploitation or at risk of being sexually exploited.[1186] This involved providing a 24 hours per day, seven days per week on-call service to children finding themselves in difficult situations, even on occasion travelling to pick a child up from an

[1184] [redacted] pg 60
[1185] [redacted] pg 15
[1186] [redacted] pg 15

unfamiliar town or environment, the child having been taken there by their perpetrator.[1187] The role of a CATE practitioner was not defined and those performing it appear to have acted instinctively and often in response to emergency situations.

3.1290 Over the last 14 years, the "*project*" – subsequently, the team - has evolved into a standalone service and is led by a qualified social worker (since 2017). Formal processes and procedures are now embedded.[1188] Detailed job descriptions of a CATE practitioner[1189], a CATE senior practitioner/social worker[1190] and a CATE Team manager[1191] have been provided to the Inquiry.

3.1291 I have been told that the team is now positioned on a floor with social workers and has fortnightly meetings with WMP's designated Child Exploitation team. This enables better multi-agency working. The 2016 Ofsted inspection[1192], to which I have already referred earlier, noted that:

"[T]*he team is made up of staff from the local authority, who work closely with a police child sexual exploitation team as a 'virtual' team using a joint service pathway.*"

3.1292 Today, the number of cases each CATE practitioner manages varies, depending on the allocated risk level and complexity of each case. Some witnesses stated this number as being as few as eight[1193] and indeed in 2015, the NWG guidance for the ideal recommended number of cases requiring intensive work, per practitioner, was eight to ten.[1194]

3.1293 The Inquiry heard that, as the amount of contact varies from one individual to another, there is no 'one size fits all' approach. As such, the team is flexible and has more freedom than its counterparts in Safeguarding, in terms of frequency and timescale of support.

3.1294 In terms of supervision of cases within the current team, I understand this takes three forms:[1195]

3.1294.1 One to one meetings – between the CATE manager and the practitioner on a monthly basis to discuss an individual case, including actions taken and next steps. Protective factors are discussed, as well as risk factors and current level of risk;

3.1294.2 Peer supervision – where the team will gather to discuss challenging cases and share ideas of improved ways of working; and

3.1294.3 Systemic pods – where a Council employee from outside the CATE Team, trained in systemic practice, offers practitioners new ideas and skills around suggesting

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1188 pg 8
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1194 pg 3
1195 pg 42

ways of working with children. This is noted as being useful for looking at cases with a "*fresh pair of eyes*".

The Evolution of the CATE Pathway

3.1295 My impression from the evidence is that the development and evolution of the CATE Pathway was founded on three tenets:

3.1295.1 First, CSE cases did not automatically qualify for section 47 procedures;

3.1295.2 Secondly, the statutory approach was not necessarily helpful in CSE cases, particularly those victims/survivors with supportive families; and

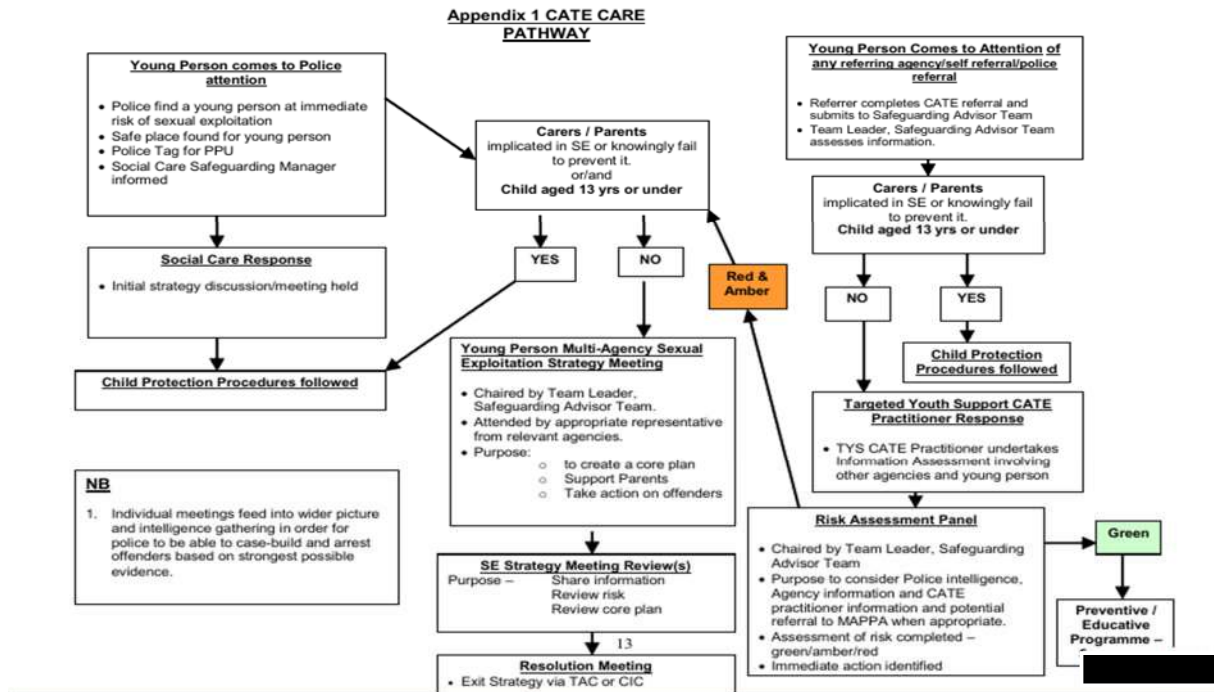
3.1295.3 Thirdly, that the CATE project intervention needed to be a structured response, with regulated structure, rather than an ad hoc variable response.

3.1296 In 2012 there was a reiteration of the CATE Pathway for Responding to Children Abused through Sexual Exploitation (the "CSE Care & Support Pathway") and the professional roles and responsibilities. These remained largely unchanged from the guidance produced in 2008 and this was likely reissued in 2012 to comply with the 2009 supplementary guidance to Working Together 2006. It is not clear to me why it took until 2012 for the document to be updated to reflect the 2009 Sexual Exploitation Guidance, however.

3.1297 As illustration of the continued separation of the CATE response from the statutory framework, the CATE Pathway was not compliant with the 2009 Sexual Exploitation, which contemplated children subject to or at risk of harm being holistically assessed using the Assessment Framework. It is important to note that today's entry point is a CAF assessment and that modern procedures comply.

3.1298 An early version of the Pathway, dated 2012, is reproduced here:

Figure 3C:[1196]



3.1299 This was a similar approach to the 2008 model. What is unclear is whether there were any discussions or reflection about how well this system was working and there appears to be no review of what was still, at that time, a new approach.

3.1300 According to the Council's '*Procedure for Safeguarding Children Abused Through Sexual Exploitation*'[1197] the key principles underpinning the multi-agency response (CATE Pathway) to the sexual exploitation of children included:

"[The] *identification and risk assessment of young people should be indicator based and not be reliant on evidence… children involved in any form of sexual exploitation should be treated as the victims of abuse and their needs carefully assessed. The aim should be to protect them from further harm and they should not be treated as criminals…. Parents and carers have an important part in recognising sexual exploitation and keeping young people safe, so every effort will be made to offer support and advice and to refer on to appropriate services if necessary.*"

3.1301 As I have been reminded by the Inquiry's expert, there was no holistic assessment process included in CATE – just a simplified self-report schedule. The reference here to the fact that the response should not be reliant on evidence is interesting and a welcome reaction, as a number of witnesses have told me that their response to CSE improved once they realised

1196 pg 13
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that they were able to rely on indicators rather than hard evidence (which is rarely available).[1198]

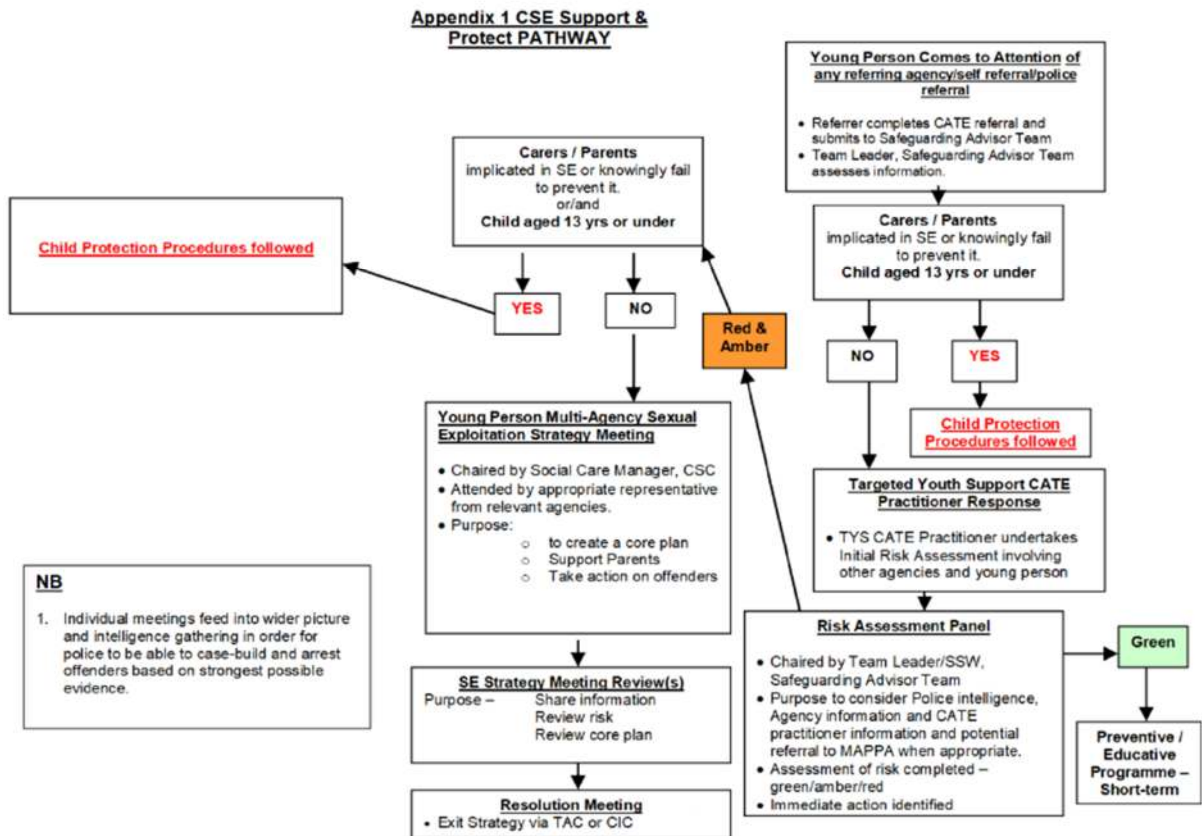
3.1302 In its Corporate Submission, the Council told the Inquiry that in 2015, the CSE Care & Support Pathway was reviewed:

"The driver for this was the recognition that there had been much learning activity relating to CSE both locally and nationally. Equally, many public sector partners had undergone restructure or reconfigurations. This work was led by a multi-agency review group reporting to the Child Exploitation operations group. A key change at this stage was the adoption of the NWG assessment tool because it was a nationally recognised tool and therefore useful in terms of consistency if information needed to be shared with other local authorities or safeguarding organisations."[1199]

3.1303 The Council provided the Inquiry with the 2015 version of the CATE Pathway, now called the CSE Support & Protect Pathway, but there is no notable change from the 2012 version:

1198 [redacted] pg 20
1199 [redacted] pg 20

Figure 3D:[1200]



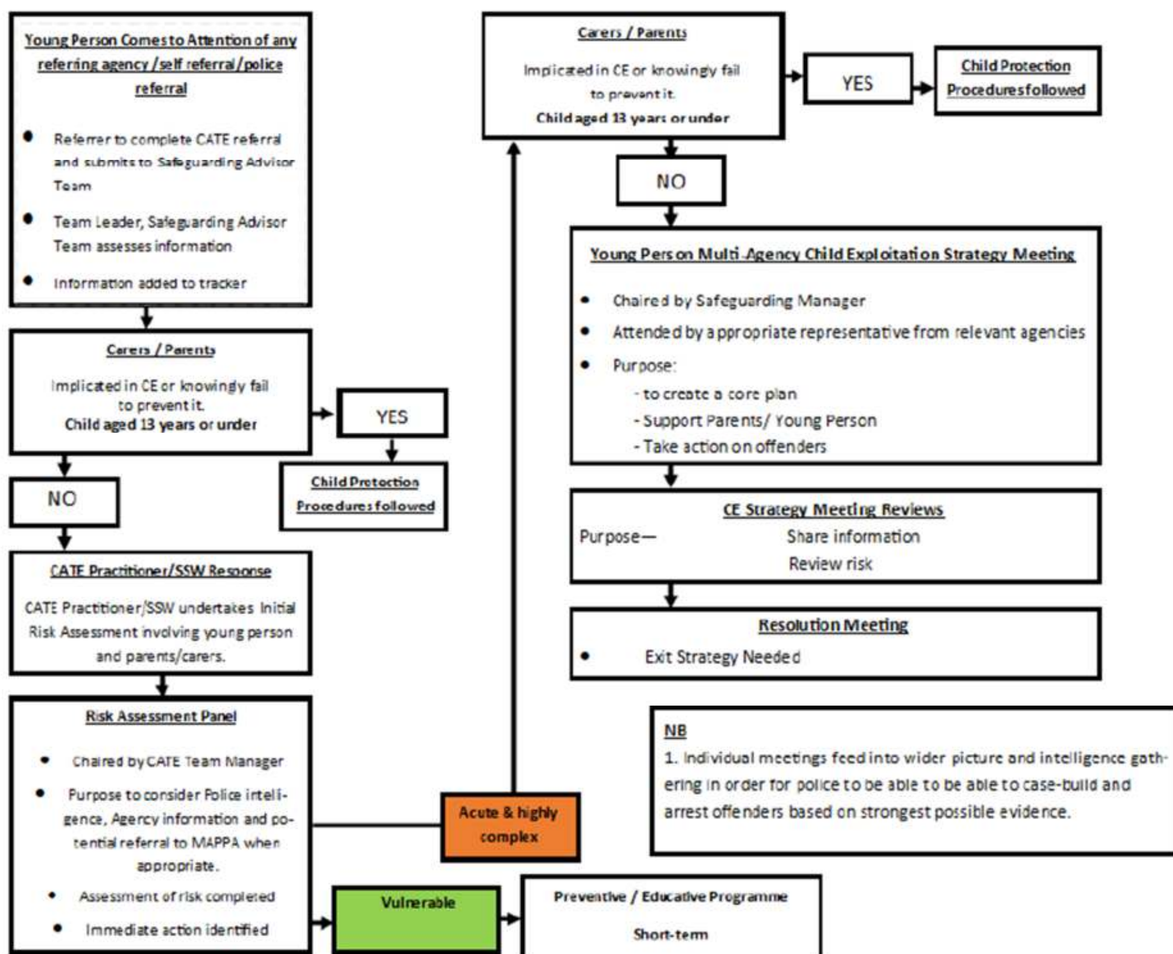
1200 [redacted] pg 21

The CATE Pathway today

3.1304 According to the Council's Corporate Submission, the CATE Pathway was adjusted in 2019 to accommodate criminal exploitation and was signed off in 2020:

Figure 3E:[1201]

Appendix 1 Child Exploitation Care & Support Pathway



3.1305 Whilst there were subtle, perhaps almost imperceptible differences - for example, the risk assessed by reference to it being highly complex, acute or vulnerable, rather than red, amber or green - the Pathway remained largely unchanged.

[1201] pg 11

3.1306 As can be seen from these documents, if a child is treated via the CATE Pathway following a referral, an initial risk assessment is carried out by the CATE practitioner before a multi-agency risk panel, also known as a Risk Assessment Panel is convened, to determine the level of risk for the child. This most recent diagram contains no recognition that many children subject to CSE were subject to child in need and safeguarding processes. I have seen evidence describing the Pathway as being "*fluid*":

"… *basically it's around what level of response and need that that young person needs at that particular time… One of the things around CATE intervention as opposed to statutory intervention is your assessments are fluid and they move with the needs of the young person. Statutory child and family assessment, you do that, and then you have to make a decision at the end of it whether it's Child in Need, Child Protection or no further action. We don't have to do that and that's one of the beauties of not having that in that statutory arena with the deadlines and the outcomes that you've got, you've only got limited choices. You have far more choices around how we manage after the initial assessment and obviously we don't just do one assessment. Our assessments are ongoing and with the young person".*[1202]

3.1307 Other witnesses have provided similar evidence about the benefits of the Pathway in not being constrained to a statutory framework.[1203]

3.1308 In its Maxwellisation response the Council further addressed the question of fluidity or flexibility of response in CSE cases. It suggested that a child's age or a parental failure to protect were not the only indicators that Safeguarding, as well as CATE, response was required, but that:

"… *there are a much wider set of considerations in order to determine the right response and therefore the right pathway for children which cannot easily be depicted within a pathway process map.*"[1204]

3.1309 I pause to note that there is no indication of such fluidity or flexibility in the 2020 process map above.

3.1310 Furthermore, an enduring feature of the Pathway has gone unchanged: namely, it focuses on the <u>risks</u> of child sexual exploitation and does not talk about children who have already been sexually exploited and the <u>harm</u> they have experienced. This impacts on the language used across the whole document which is about future risk, rather than actual past and present harm and the needs of children arising from that harm. I have seen expert analysis which suggests that this approach has the potential to influence the various operational processes, and where professional attention is directed.

3.1311 I should further remark on what I regard as instances of regrettable phraseology within the 2020 iteration of the Pathway: at two points, the document refers to "*children <u>involved in</u>… exploitation*" (my emphasis). Recent work by the Children's Society[1205] has highlighted the

[1202] [redacted] pg 29
[1203] [redacted]
[1204] [redacted]
[1205] https://tce.researchinpractice.org.uk/wp-content/uploads/2020/02/Appropriate-language-Child-sexual-andor-criminal-exploitation-guidance-for-professionals.pdf

need for use of appropriate language when discussing exploitation; the language used needs to reflect the presence of coercion and the lack of control children have. "*Involved in*" implies a choice.

3.1312 The CATE risk assessments are not an assessment of needs as required under the Assessment Framework (2000) and outlined in *Working Together*, and should not be confused with them. Similarly, the CATE Pathway strategy meetings do not meet the requirements of a child protection strategy meeting, as clearly defined in Working Together 2006 and all subsequent iterations of that document. As I have previously noted, I do consider that this dual use of the term "*strategy meeting*" has the potential to confuse and mislead, and to suggest that statutory safeguarding procedures are being undertaken when they are not. Although the Council in its Maxwellisation response indicated that the term 'strategy meeting' has been replaced by 'exploitation meeting' – and I welcome that - the chart above shows that this must have been a very recent change.

The relationship between the CATE Pathway and child protection enquiries under section 17 and section 47 enquiries

3.1313 It is important to note at the outset that the CATE Pathway was never a child safeguarding pathway and should not be regarded as such.

3.1314 The Council's Procedure for Safeguarding Children Abused Through Sexual Exploitation[1206] claimed that:

"[T]*his procedure will provide a consistent and agreed multi agency response for use when responding to concerns relating to child sexual exploitation. It offers a Care Pathway known as the* CATE… *Care Pathway that is proactive and integrated in its approach, enabling agencies to work together to:*

- *Implement local preventative strategies;*
- *Identify those children and young people at risk of sexual exploitation;*
- *Take action to safeguard and promote the welfare of particular children and young people who may be sexually exploited;* [and]
- *To jointly take action against those intent on abusing and exploiting children and young people in this way.*"

3.1315 The document notes that:

"… *young people aged 14 years – 17 years are eligible for the CATE Care Pathway…. Children aged 13 years and under will automatically initiate child protection enquiries to be undertaken as set out in the Children Act 1989 (Section 47).*"[1207]

1206 [redacted] pg 3
1207 [redacted] pg 4

3.1316 The Council's Safeguarding Children Abused Through Exploitation procedure dated May 2013 sets out the threshold for section 47 enquiries where there is a suspicion of CSE. I understand from this that any of the following should trigger a section 47 referral[1208]:

- *"The child is aged 13 or younger.*
- *Concern that abuse through sexual exploitation is being actively encouraged by a parent/carer.*
- *Concern that abuse through sexual exploitation is facilitated by the parent/carer failing to protect the child.*
- *Concern that a related or unrelated adult, in a position of trust or responsibility to the child, is organising or encouraging abuse through sexual exploitation."*

3.1317 We see repeated, here, the insistence that in exploitation cases age and parental behaviour were crucial to whether a safeguarding response was regarded as merited. The entry points for the two services had not changed since CATE – and the Pathway – were first created.

3.1318 This document reinforces that the section 47 child protection procedures and the "CATE Care Pathway" (as set out in the document itself) were mutually exclusive. Moreover, the Inquiry has heard witness evidence that suggests that when the CATE Team was sitting within Cohesion, they were only working with children aged 14 years old and over.[1209]

3.1319 I cannot understand the rationale for this practice, as the Inquiry has plentiful evidence that those younger than 14 years old were being exploited in Telford and may have benefitted from the support of the CATE Team – regardless of whether they were subject to statutory safeguarding procedures.

3.1320 The Inquiry has seen evidence which shows that the relationship between the CATE Pathway and section 47 enquiries has not always been clear to practitioners. In an internal Council communication dated October 2013,[1210] concerns were raised about one particular case. The child concerned was on a Child Protection Plan. The person raising the concern, who worked in this area, was of the opinion that the needs of the child would be better met under the CATE Pathway, rather than a Child Protection Plan (which again suggests that both did not operate in parallel). The concern was shared with Safeguarding managers who recognised that: "…*this can get tricky* [when you have] *two processes going simultaneously - a CATE Strategy & a CP* [(Child Protection)] *Core Group activity*".[1211]

3.1321 Another commented that:

"… *things aren't working as smoothly as they need to be for the CATE/CP cases as I am aware the CATE aspects haven't been properly integrated by SWs* [(social workers)] *or*

1208 [redacted] pg 8
1209 [redacted] pg 67
1210 [redacted]
1211 [redacted]

indeed the police in CP conference and core group processes. [A manager] *was working to resolve this – clearly still more to do.*"[1212]

3.1322 This illustrates the concerns that I have expressed that those diverted exclusively through the child protection processes did not have access to specialist CATE support, and so presumably missed out on the CSE intervention in place, regardless of whether they needed them.

3.1323 Equally, the response to CSE outlined within the CATE Pathway means, on its face, that children who met the criteria for a CATE response missed out on social work led routine child protection processes such as holistic assessments; section 47 enquiries; child protection registration; and core group processes - regardless of whether it was deemed necessary. There was no reflection on whether the alternative CATE processes met the same functions of keeping children safe and understanding their needs.

3.1324 Nor is it easy to determine what was the method of CATE intervention. The CATE Pathway was a map of approach, not method. It provided information about decision making, risk assessment and planning, but did not outline the specialist CSE interventions and support on offer. While this has now changed with the current process being described as a '*Pathway for Responding to Children at risk of CSE: The CSE Care & Support Pathway'*, the current pathway still does not provide information about what interventions will be provided. It is no surprise, in my judgment, that historically "*families, frontline staff and organisations*" (as identified by the Scrutiny Committee) were not fully aware of the range of support available and it seems to me that is still a risk.

3.1325 Those who were working in Safeguarding at the time have told the Inquiry that there may have been misunderstanding between the CATE and Safeguarding roles, but also told the Inquiry that the position today is far improved.[1213] Their evidence suggests that the current practice is that a child is now not precluded from referral to the CATE Team whether 13 years old or under; and that the child protection procedure and the CATE Care Pathway can operate in parallel. The fact that a child is 13 years old or under simply dictates that there must be safeguarding involvement. However, it is still possible for that child to work with a CATE practitioner under the CATE Care Pathway, though it is not clear on the evidence how roles and responsibilities are negotiated and tasks allocated.[1214]

3.1326 In its Maxwellisation response, the Council indicated that:

"[A]*t any time throughout involvement with CATE, the practitioner or Team Manager can ask for a review either via a return to panel for consideration regarding the suitability of continued progression on the CATE Pathway or through case discussion between the practitioner and their manager. In the event that it is decided the child*['s] *needs require assessment and consideration via the statutory procedure, a referral is made to Family Connect… Statutory safeguarding procedures can then operate in parallel with continuing support and intervention from the CATE team.*"[1215]

1212 [redacted]
1213 [redacted] pg 65
1214 [redacted] pg 15, [redacted] pg 30
1215 [redacted]

3.1327 This approach is to be welcomed; and while I accept that flexibility means that it is difficult to set out a 'pathway process map' as the Council has told the Inquiry, the difficulty is that the current CATE Pathway does not hint at this: it has kept the same criteria for whether a child will be supported through the CATE service or through child protection processes. It seems to me that while to attempt a joined pathway may well be an impossible task, and result in an unhelpful lack of flexibility or certainty, it is not helpful either to maintain that the CATE Pathway as drafted is accurate – the written document should reflect the discretion available to institute a safeguarding response.

Data provided to the Inquiry

3.1328 From information provided to the Inquiry by the Council, specifically a progress report produced by the Scrutiny Committee's review of Multi-agency Working Against CSE (the "Scrutiny Review"),[1216] I have been able to establish that, over a 12 month period in 2016-2017, the Council received 337 contacts about concerns regarding CSE. These amounted to 2.7% of total child welfare contacts to the front door service and related to 224 children.

3.1329 It is interesting to note that, at this point, over 50% of those subject to CSE were going through the child protection pathway, and less than 50% to CATE, the specialist service. There was no discussion over time regarding this. The whole point of the CATE Pathway was, as I understand it, that it provided a more approachable workforce, where children could feel able to talk about their experiences and it is presumed that, over time, expertise of addressing CSE had built up.

3.1330 There is little evidence of what specific interventions were in place; for many children, notwithstanding the new flexibility, it is unclear if they were provided with a CATE practitioner as well as a social worker.

3.1331 In 2013/2014 there were more referrals to CATE for children subject to CSE than the child protection route (36 to CATE:30 to child protection). In 2014/2015 this ratio was still more weighted towards CATE (53:35). This changed in 2015/2016 where the balance was greater to child protection, being 62:91 and in 2016/2017 the number in child protection was nearly double, at 68:112. In 2017/2018 the CATE/child protection ratio was 39:64. In 2018/2019 there were marginally more children going through CATE (86:74) and in 2019 the ratio was down again 43:51. I have not been provided with an analysis of the reasons for allocations of cases to these pathways – presumably those reasons may have been different in 2014, when CATE was under Cohesion, than in 2018, under Safeguarding. Nor is it clear what the differences meant for those children involved.

CATE involvement with a Child

Receiving the Referral

3.1332 I was told by a number of Council witnesses that, since 2012, the referral process has been managed by Family Connect.[1217] The child's consent to the referral, and that of their

[1216] [redacted] pg 1
[1217] [redacted] pg 58

parent(s)/carer(s), will already have been gained by the time the referral is passed to the CATE Team.[1218] The Inquiry was told by one parent witness that her son's lack of consent prevented him receiving CATE support.[1219] Of course consent is not required for safeguarding procedures when a child is thought to be at risk of serious harm: it is not clear to me whether refusal of parental consent to CATE would impact upon this assessment, but the process should be clearly articulated.

3.1333 So far as procedure is concerned, I understand the position to be as follows:

3.1333.1 Upon receipt of a referral, the CATE Team manager will look at caseloads and allocate the case accordingly, in consultation with the practitioners. If the child is aged 13 years old or younger, there is mandatory social worker involvement in addition to CATE support. Cases are not allocated to a practitioner where that member of the team is already the nominated CATE contact for a known friend of that child.[1220]

3.1333.2 Once allocated, contact should be made within 72 hours (and within five days of the initial referral being made).[1221] 'Risk indicators and details of CSE' are detailed on the referral form.[1222]

3.1333.3 Following allocation, the CATE practitioner will organise an initial meeting with the child. This is an informal meeting, by way of introduction to the child and also to the parent(s)/carers(s), if required.[1223] The CATE practitioner will be open and transparent about the reason for the referral, advising of the concerns raised and giving the child the opportunity to refute or explain these, or indeed discuss any worries they may have.

3.1333.4 Further meetings will then be scheduled between the child and CATE practitioner, but at a date/time and place of the child's choosing.

3.1333.5 The CATE practitioner will explain their role, that of a 'befriender', in more detail, and will also take a range of resources, for example a pack explaining what a good relationship looks like, or an explanation of what CSE is, with information being tailored specifically for children, parents/carers and other professionals. These will be used as and when required, to help identify to the child that what they believe to be normal experiences, may in fact not be. The lack of strict timescales mean that the CATE practitioners can go at a child's speed, the preferred course of action being to not to push or challenge the child, but rather wait for the child to come to the conclusion on their own.[1224]

3.1333.6 The CATE practitioner will have received initial paperwork about the individual case when the referral was made. This identifies not only the reason for the

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1218 [redacted] pg 13; [redacted] pg 28, [redacted] pgs 8-9
1219 [redacted] pg 8
1220 [redacted]
1221 [redacted]
1222 [redacted]
1223 [redacted] pg 25
1224 [redacted] pg 11

referral and family background or past social care assessments, but also any information already held by the Council about the child, such as any notification of missing episodes which the authority has been advised of by WMP. Knowledge about the child is further built from information sourced during the visits with the child and also from other organisations with involvement in the child's life. This is directly requested from the relevant organisations by Business Support Officers who support the CATE Team, and might include missing from care episodes, mental health concerns, anti-social behaviour incidents or police reports, for example.[1225] Positive aspects, for example interests and hobbies, which could act as protective factors, are also recorded.

3.1333.7 At any point in this early process, if there are immediate concerns about the child, the CATE practitioners would liaise with the CATE Team manager and also the Child Exploitation team within WMP to agree any emergency action which needs to be taken.[1226]

3.1333.8 At this stage, other agencies can choose not to share information about a certain child, but may instead opt to share the information at the risk panel meeting, scheduled to take place six weeks after the initial referral is made. This may be because the information is part of an ongoing investigation or because there are concerns about sending the information by email.[1227]

3.1333.9 The CATE practitioner will meet with the child at least weekly for first six weeks, prior to the risk panel meeting.

3.1334 I understand from the evidence that a CATE practitioner's work is often about building a relationship with the child, to seek to identify the 'push and pull' factors and vulnerabilities. The practitioner will identify what needs to be put in place to help reduce the risk. Their role includes preventative work and they have access to a number of resources and tools developed over the year.[1228] The '*How Safe Am I*' self-assessment of risk form is a useful tool for early visits. This is completed by the child and then used as the basis for discussions exploring how happy that child is in school, for example, how well they get on with their parents and their level of internet use. Various multi-media aids may also be used, on subjects such as, '*What is Consent?*' or '*What is Grooming?'*.[1229]

3.1335 I further understand from the evidence that whilst CATE practitioners have access to a number of tools and resources, the work carried out with children is often informal, designed to build a trusting relationship. One example included driving the child to a local fast food establishment or just sitting with a child and conversing about reality television. The aim here is to a build a trusting relationship between the CATE practitioner and the child.[1230]

3.1336 I have heard that the CATE practitioners' work was initially focused on the child. There was fear that engaging with the wider family at the same time might cause a conflict of interest.

1225 [redacted] pg 27
1226 [redacted]
1227 [redacted]
1228 [redacted]
1229 [redacted] pg 26
1230 [redacted]

The role of the CATE practitioners has moved forward and now incorporates the wider family as well.[1231]

3.1337 The focus of the CATE work on building awareness, discussing good relationships, identifying 'push and pull' factors and allowing children to come to their own conclusions, placed the emphasis - and arguably the responsibility - on the children. I have heard the opinion that such an approach can be thought to give the impression that if young people were better at recognising what was happening to them, they would not be exploited. The Council refutes that interpretation and makes the point "*if we do not educate our children and young people on how to keep themselves safe, then we are letting them down*".[1232] It seems to me there is a careful balance to be struck here to ensure that no child feels the intervention is blaming them for their exploitation.

Categories of Risk

3.1338 The Inquiry heard that once the information has been gathered, as detailed above, the child is graded into a risk category. The lowest risk category, *'Universal'*, is not relevant for the purposes of the CATE Team, as the referral itself elevates the risk level to at least that of '*Vulnerable'*.

3.1339 In terms of assessing the level of risk, the CATE practitioner will use their own judgment, also liaising with the CATE manager using the CE Care Pathway '*Windscreen'* tool,[1233] '*CE Risk Threshold Indicator'*[1234] and other guidance documents.[1235] There is a pre-panel discussion between practitioner and manager to agree the proposed level of risk, with the supporting information taken to the risk panel meeting, at which the attendees will confirm or amend the risk rating for that particular child.[1236]

3.1340 Following the CATE Care Pathway, the case then progresses to a risk panel meeting.

Risk Assessment Panel, or Risk Panel, Meeting

3.1341 The risk assessment should be completed within 30 working days[1237] and a risk panel meeting convened within six weeks after the date of the initial referral.[1238] By this time, information from the relevant authorities will have been collated and a decision taken as to the proposed risk category of the child.

3.1342 Risk panels are held fortnightly (although not every child is considered at each one) and are attended by standing members[1239] and also any agency specifically involved with the particular child. Meetings are chaired by a qualified social work manager[1240] or the CATE manager (as a qualified social worker). Witnesses giving evidence to the Inquiry report

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1232
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1235 pgs 12-13
1236
1237 pg 10
1238 pg 28
1239 pg 11
1240 pg 63

good attendance at these meetings, with standing members always attending or else sending a representative in their place.

3.1343 The purpose of the risk panel is to consider:[1241]

3.1343.1 The risk assessment information provided by the CATE practitioner;

3.1343.2 Any police intelligence;

3.1343.3 Any other agency information;

3.1343.4 As a panel to complete a multi-agency assessment of risk – identifying and agreeing the level of risk to the child;

3.1343.5 Any immediate action that is required to be taken; and

3.1343.6 The wider needs of the child and to instigate access to appropriate resources for the child.

3.1344 Information in the risk assessment is discussed, with each participant giving feedback about this child. Feedback may raise further concerns, for example new recent friendships, which is taken into account when reviewing the proposed risk rating.

3.1345 In terms of deciding next steps, this is dependent on the category of risk determined for the child. For *'acute'* and *'complex'* cases this is usually six weeks, but could also be four or eight, to fit in with other professionals' meetings in relation to this child.[1242]

3.1346 For these cases, consideration is given once again as to whether the CE Care Pathway remains appropriate. If it is considered not appropriate, then child protection procedures will be instigated at this point. If it is appropriate to continue with the CE Care Pathway, a multi-agency high risk strategy meeting will be convened (this would be done immediately for an *'acute'* risk rating'). Following the risk panel meeting, and regardless of the risk rating, a CSE safety plan would also be put in place for the child, detailing actions and next steps.[1243]

3.1347 In terms of the ongoing contact with the CATE practitioner, if the case is deemed to be *'complex'* or *'acute'*, contact would continue weekly. If the child was deemed to be *'vulnerable'*, the CATE practitioner would continue to meet with them regularly, but this would be decided on a more bespoke basis, in discussion with the CATE manager.[1244] In addition, another risk panel meeting would not be required for that child unless exploitation concerns increase, necessitating a proposed change to the risk rating, or until closure is being considered.

1241 [redacted] pg 11
1242 [redacted] pg 41
1243 [redacted] pg 14
1244 [redacted] pg 18

Child Exploitation or High Risk Strategy meeting (now known as a Contextual Safeguarding meeting)[1245]

3.1348 If, at any point during the assessment period, there is any indication of a high level of risk to the child then, following discussion with the CATE Team manager, a high risk strategy meeting is convened to ensure that the child's immediate safeguarding needs are considered and responded to, from a planned multi-agency perspective, without delay.[1246]

3.1349 Strategy meetings, as part of the CATE Pathway, commenced in 2010. Prior to the introduction of the Pathway, section 47 strategy meetings were undertaken, though these were not the strategy meetings referred to in Working Together 2010. The key difference is that the parents/carers and child are a core part of these later meetings.[1247] This meeting is chaired by the manager of Family Connect and anyone directly involved with that child, including the parent/carer, the child themselves and any professionals will gather to discuss the areas of concern. The purpose of this is to ensure that the child is part of their own plan around what is needed and how CATE can help.

3.1350 The meeting is designed to be an open and transparent process and attendees will gather at six weekly intervals, the purpose being to create a core plan, support parents and the child and take action to tackle offenders.[1248] At any point in the process, if information is shared that the threshold for a section 47 enquiry is met, the case will be managed through statutory safeguarding procedures.

3.1351 In terms of attendees at these meetings, there are standing members, but this meeting is more targeted in terms of who attends, for example the allocated WMP officer to the child's case would attend, as opposed to a Co-ordinator and a Detective Constable at a risk panel meeting.

3.1352 Following this meeting, the support plan is implemented as agreed at the meeting. The support plan will be reviewed at future meetings, which will also review the current risk rating in place for the child.

3.1353 These meetings continue until the level of assessed risk to the child has been reduced to '*low-level complex'/'vulnerable'*. To go from being labelled *'complex'* to '*vulnerable*', a considerable amount of time would have to have passed with no concerning information received from all parties. The goal is that the child would be stepped down through the risk categories and eventually closed, with consent, although noting that it would be easy to be pulled back in if there was, for example, a change of circumstances or a trigger point, which meant the risk could escalate again.

Continued visits

3.1354 In cases of children with a '*vulnerable*' or '*low-level complex'* risk rating, ongoing contact takes the form of preventative education and support.

[1245] [redacted] pg 30
[1246] [redacted] pg 9
[1247] [redacted] pg 19
[1248] [redacted] pg 12

3.1355 Cases are kept open as long as it is deemed necessary and with support given as required, for example in the event of a family breakdown, a practitioner could be speaking with a child on an almost daily basis.[1249] Practical, as well as emotional, support is offered, for example taking a child to a sexual health clinic.[1250]

3.1356 The CATE Team is authorised to continue working with a child past the age of 18 and will close a case by consent only. In order for a child to be closed to CATE, all actions need to have been carried out and the case taken to a risk panel meeting again, with a recommendation to close, and the risk panel agreeing to this. After the case has been officially closed to the service, it is then closed on the system.

Recording of information

3.1357 In summary, the Inquiry was told that:

3.1357.1 In the earliest days, CATE records were made on password-protected Word documents[1251] and stored on the '*Z drive*',[1252] a drive accessible only to the team. The team did not have access to social worker case notes on children, even if open to the CATE service.[1253] Information which needed to be shared with other professionals was done either verbally or by email. In 2017, a workspace was created on Protocol, the case management system of the authority, for CATE practitioners. This meant that CATE practitioners could now see all information recorded on Protocol for a child[1254] and in time they could also input information; although reciprocal access was not granted to social workers until 2020.[1255] At the same time, the CATE Team moved to the same floor as Safeguarding[1256] which was seen as a positive move by the CATE witnesses who gave evidence to the Inquiry.

3.1357.2 All information on cases is logged on Protocol and this is updated with case notes after each contact. If there is an allocated social worker for the child, Protocol will automatically send the social worker a notification, to alert them to recent contact in respect of that child.[1257]

Referrals to other sources of support

3.1358 The Inquiry was told that the CATE service is seen as a holistic process which helps reduce the child's vulnerabilities, so the CATE Team are able to refer onto other organisations for support and guidance. Indeed part of the role of a CATE practitioner is to help children

1249 [redacted] pg 30
1250 [redacted] pg 25
1251 [redacted] pg 68
1252 [redacted] pg 68
1253 [redacted] pg 24
1254 [redacted] pg 51
1255 [redacted] pg 98
1256 [redacted] pg 27
1257 [redacted] pg 41

accept the help of other professionals.[1258] Organisations which are used by the CATE Team to provide additional support for the children include:

3.1358.1 CAMHS;

3.1358.2 Axis Counselling;

3.1358.3 Relateen;

3.1358.4 STARS - a substance misuse service;

3.1358.5 ISVA service;

3.1358.6 BEAM (Be You Emotional Wellbeing) - a drop in service run by The Children's Society;

3.1358.7 National Referral Mechanism ("NRM") if trafficking issues are suspected (via WMP);

3.1358.8 The Holly Project, a victim/survivor support service; and

3.1358.9 PACE, formerly CROP – a support service for parents/carers.

Missing Persons

3.1359 The Inquiry heard that:

3.1359.1 The CATE Team took over responsibility for 'Missing' in 2018[1259] and, since then, RHIs are completed by the CATE Team, where the child is open to CATE or has an allocated social worker. If no social worker is allocated, the RHI will be completed by Early Help practitioners in the Strengthening Families team.[1260]

3.1359.2 A CATE practitioner is nominated on a duty basis to complete the RHIs, although sometimes it is decided that this would be better completed by the nominated CATE practitioner for that specific case. In either event, the RHI should be completed within 72 hours.[1261]

3.1359.3 By way of follow up, the completed RHI is sent to the CATE manager as well as any professionals who have been allocated follow up actions, for example Family Connect or the nominated social worker for that child. The risk rating may be adjusted as a result of the RHI findings. The CATE Team also receive 'missing' and 'found' notifications of all MISPERS from WMP.

3.1359.4 Protocol will flag when a child has reached three missing incidences in 90 days, which will trigger a Missing Intervention meeting, chaired by CATE with the

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[1258] [redacted] pg 59
[1259] [redacted] pgs 4-5
[1260] [redacted] pg 14
[1261] [redacted] pg 107

Missing WMP representative also in attendance. The CATE Team will work with WMP and the child to see how they help support in reducing the missing episodes.[1262] Where missing episodes are fewer than this, they are discussed at multi-agency Missing operations meetings, which are held on a monthly basis.

3.1359.5 If the child refuses to engage after three attempts are made, following a Missing episode, and the CATE Team fails to complete the RHI as a result, this will be logged on Protocol as a refusal, although I was told that every effort is made to encourage cooperation.[1263]

Research and training

3.1360 The Inquiry further heard that:

3.1360.1 In addition to the ongoing relationships and support to the children on their case files, which includes any actions arising out of risk panel meetings, the CATE Team undertake ongoing training to ensure their own knowledge remains up to date, for example the Council's OLLIE training, as well as attending sessions run by Barnardo's and the NSPCC.

3.1360.2 A Council shared drive, 'SharePoint', is accessible to CATE practitioners and this contains up to date CSE, and latterly CE, research and documentation.[1264] Practitioners are also involved with conducting additional research into areas which risk panels may have highlighted as a broad area of concern.[1265]

3.1360.3 In addition, members of the CATE Team attend practitioner forums, in order to share best practice with other authorities. They deliver awareness raising sessions to schools and support the police in contributing to the 'mapping' process, based on the 'gangs matrix' devised a number of years ago.[1266] This assists in building a picture of children who are known to each other, or locations of concern.

3.1360.4 Witnesses were generally very positive about the overall function of the CATE Team currently. In terms of caseloads, I was told:

"*It's fair to say I feel comfortable with the number of cases that I've got at the moment … if I felt like I was running ragged and I couldn't actually offer the service that I need, I would speak up. That hasn't actually happened as yet if I'm completely honest since I've been in post.*"[1267]

3.1361 Information sharing and multi-agency working is also reportedly much improved. Evidence I read indicated that:

1262 [redacted] pg 60
1263 [redacted] pg 14
1264 [redacted] pg 28
1265 [redacted] pg 43
1266 [redacted] pg 31
1267 [redacted] pg 20

"*The relationship between the CATE team and the Assessment team, and I'm not just saying this, I truly mean it, we are, it is one team and how we sort of work and talk to each other.*"[1268]

"*We link very closely with the social workers within the duty and assessment team, we link in very closely with the managers in that team, and our manager of the CATE team would be linking in with those social workers and those social work managers.*"[1269]

"*I think we're really fortunate and I think we're in a really fortunate position of strong partnership working and communication and buy in to action plans and continue to tackle the ongoing problem that we have.*"[1270]

"*We need to continue the work that we do. We have just had the team expanded and taken on criminal exploitation as well … it's early days and it's embedding that partnership working in the same way as we have done with the CSE. They've got the dedicated police team; we've got the buy in from police. We are really lucky.*"[1271]

3.1362 Furthermore, working practices and processes are more formalised, with improved oversight. Notable comments included:

"… *It is unrecognisable because we have the structures now, we've got the pathway, we've got the referral, we've got the risk assessment. When I started and had my very first case, there was none of that really.*"[1272]

"… *We've got a proper structure. Our team has gone from just* [one practitioner] *who was like fighting for CSE, we've got 13 staff now.*"[1273]

"*Throughout my time in the CATE team, the support and oversight from management has been really supportive.*"[1274]

"*Having* [Name] *as that team manager within the team, having that qualified social worker, especially when we were working with young people that don't have an allocated social worker, is really a good aspect of the team to have, really, in terms of holding that and working with those young people.*"[1275]

"*I'm lucky in some ways to have the management that I've got … they want us to be at the front end of knowledge as opposed to carrying on behind them.*"[1276]

[1268] pg 50
[1269] pg 37
[1270] pg 46
[1271] pg 46
[1272] pg 7
[1273] pg 8
[1274] pg 46
[1275] pg 5
[1276] pg 73

3.1363 Recent developments of the team being responsible for dealing with the wider issue of criminal exploitation more generally seem to have been successfully incorporated and, in my view, are a sensible next step.

"*We made it very clear that we couldn't take criminal exploitation into the team unless there was an extension to the team, because we couldn't dilute the way that we worked in that way, and that was taken seriously.*"[1277]

"*There are a lot of resources put into working with young people and identifying exploitation but, not only that, but we work wider than that around tackling exploitation at a wider level.*"[1278]

3.1364 In summary, while most would agree that "t*he journey has just been massive*"[1279], my overall sense is that the team is now established and properly resourced, and that its workforce is able to focus on their core concern – the children needing support. I accept the practitioners' motivation and dedication. One example from the evidence was :

"*Everybody that you would talk to has loved being part of the CATE team and really care about the young people and their welfare and want them to be safe.*"[1280]

Analysis of selected risk assessments and strategy meetings

3.1365 Having dealt with the genesis of the CATE pathway I turn to consider the working of the current processes. This has involved a review of the current Pathway and a small sample of risk assessments completed between 2018 and 2020, and a reflection on the evidence in light of what I understand to be best practice.

3.1366 Under the Pathway, the risk assessment will be reviewed at the child exploitation risk panel and where it is considered that the level of assessed risk is highly complex or acute. The purpose is said to be to:

- Share information;
- Discuss the level of risk;
- Explore the reasons for this level of concern for the child;
- Develop a CE support plan to reduce risk for the child;
- To support parents/carers; and
- To take action on offenders.

[1277] [redacted] pg 38
[1278] [redacted] pg 45
[1279] [redacted] pg 9
[1280] [redacted] pg 41

3.1367 The child and their parents will be encouraged to attend the strategy meeting as they are considered to be central to the success of the discussion and development of the support plan.

3.1368 In the first documents I reviewed, which were all completed before mid-2019 and completed by the same CATE practitioner, the risk recording format starts with a section on 'Background Information'. There is, however, no dedicated section regarding either who is sexually exploiting the child or posing a risk to them. The Background Information section appears to have been infrequently used to describe the sexual exploitation experienced by the child or to describe the perpetrator: indeed, in the view of the Inquiry's social care expert, in none of the first five risk assessments reviewed were these points properly addressed. It is hard to see how this was an effective risk assessment process without a focus on the actual or likely perpetrators, and further this approach has the potential to force thinking about solutions involving changing the child's behaviour rather than disruption.

3.1369 In its Maxwellisation response, the Council offered what it suggested was a 'hypothetical' explanation for this approach:

"*… this may be because we only have partial information or no information has been disclosed to us…* [such information is] *included where this information is known."*[1281]

3.1370 It is right to note that the Inquiry has seen file notes relating to these cases which deal with perpetrator detail.[1282]

3.1371 Further, as to the format of the assessment, there is no section of whether actual or potential perpetrators/sexual exploiters pose a risk to the child or their family because of threats to person or property; nor indeed about ongoing police enquiries or how such enquiries may impact the child or their family or disrupt exploitation; these are obvious omissions. Indeed the NWG report, with which I deal below, makes specific reference to the failure to record disruption activity.

3.1372 It is important to note that there was a format change in 2019 with an appropriate focus on harm; this seems to me to be another positive outcome of the Safeguarding influence over CATE.

3.1373 I have heard expert evidence and accept that there has been national concern about the use of certain risk assessment tools for several reasons. They can lack consistency, and focus on the behaviour and circumstances of the child rather than coercion and control by those who would seek to exploit; and overall they imply that for the sexual exploitation to be either stopped or mitigated, the main task is to change, and often limit, the behaviour of children. These are all important areas to understand, but they indicate levels of harm and need, rather than risk.

3.1374 One of the risk assessments I have reviewed illustrates the point. While it related to a child who had been sexually exploited, no detail was given of the exploitation, so it is difficult to

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1281 [redacted]
1282 [redacted]

understand the nature, extent and quantity of the harm. The background material refers to drug use, negative friends/associates, and going missing, and while these are clearly examples of the impact of CSE, one of the consequences of not outlining and naming the harm, is that these factors become the problem of (and resolvable by) the child, rather than needing to be understood as having been caused by exploitation. After all, if a child has been sexually exploited it is not surprising that they will exhibit distressed behaviour. The characterisation of distressed behaviour as a risk factor lacks a trauma-informed approach and reinforces the suggestion that if victim behaviour changes, exploitation will stop. I am fortified in that view by wording of the conclusion of the risk assessment that "*there has been 2 weeks of no concerning behaviour from the young person, so the risk is reduced to "complex" from "acute*"."

3.1375 The next stage under the CATE process was a "*strategy meeting*". A fundamental issue in the documents I reviewed is the use of this term. I have dealt with this above, but there is a danger that this will be confused with strategy meetings as outlined within *Working Together*. The two are quite different: a statutory strategy meeting seeks to understand harm, plan child protection inquiries, seek evidence of harm, organise medical assessments and put in place protective measures; while the sexual exploitation strategy meeting seeks to evaluate risks and put a plan in place – no guidance is given about understanding the exploitation suffered. I consider that the use of the same term could have led to confusion – if not within Telford, then in the case of a child who moves authorities subsequently – and I was reassured to learn from the Council's Maxwellisation responses that such a meeting is now termed an 'exploitation meeting', as indicated above; but in my view the change was long overdue and was not flagged up until very late in the Inquiry's work.

3.1376 I have noted that before mid-2019 there was no agreed format for the strategy/ exploitation meeting documents. Of the five I have reviewed from that time period[1283], four lacked any structure or framework – for example, the strategy meeting documents did not include the child's date of birth, family details or the reason for the meeting. Nor was there a uniform approach to recording data: adults were described using a single name; ages were not always recorded; and although there was acknowledgement that many of these adults knew each other, and were harming other children, there was no action recorded regarding either a mapping exercise or use of the complex strategy procedures.

3.1377 It may be that some lack of recorded detail about the nature of the exploitation was related to the presence of the child and their parents at the meeting; though – I saw evidence that in those meetings when exploitation was discussed that insufficient care was taken with children's privacy – parents were often present. In my judgement this underlines the twin points that great care is needed in discussing issues that are private to a child and that it is better to discuss the nature of the exploitation, if necessary, in the absence of the child's parents or guardians, or even the child, than not discuss it at all.

3.1378 Further, in those meetings where exploitation was discussed I saw examples of unfortunate language being used: children described as "*being too trusting*" and "*sneaking off to have sex*", neither of which recognise coercion or a situational risk.[1284] A particularly unfortunate example from a meeting dated 2019 regarding conversations about a child was "*around her*

1283 [redacted]
1284 [redacted]

relationships and how they have been unhealthy. [She has been given] *advice on what the risk factors are, however can't implement these in her own life*".[1285]

3.1379 The expert evidence I have seen suggested that these meetings focused on victim behaviour in a way that was not useful, and which tended to suggest the child was responsible for their own safety and, by implication, their exploitation – professionals were concerned "*that the risk to* [the child would] *not reduce unless* [the child] *works on her trust element with people she does not know*".[1286] This ignores the fact that a child changing their behaviour does not stop others seeking to sexually exploit them using coercive control, threats, violence and grooming. Further expert evidence suggested that a similar approach was shown in the support plans which seemed on occasion to be "*punitive*" by including provisions such as curfews, confiscation of phones and anger management work.

3.1380 The Council has responded to this in its Maxwellisation response, refuting an undue emphasis on victim behaviour modification and asserting "*awareness raising around CSE, internet safety, positive relationships is about behaviour change and does bring about change*".[1287]

3.1381 It seems to me that there is a balance to be struck here; there are a number of features to be noted:

3.1381.1 First, five of the assessments considered by the Inquiry were pre-2019.

3.1381.2 The 2019 format change, to which I have referred in the context of harm, brought an agreed format to recording of strategy meetings: an overdue change but an entirely positive one, more focused on effective recording of risk including contextual risk.

3.1381.3 Second, having made that change, it is important that the Council ensures that those who operated under the 'old' CATE system appreciate the fundamental purpose of these meetings - to understand and reduce <u>all</u> risk including <u>external risk</u> - and to appreciate the importance of rigorous recording of information to that end. Without detailing exploitation and naming exploiters, without considering contextual factors, then mapping – and with it, disruption and protection – become more difficult.

3.1381.4 Third, that it is also important that CATE practitioners fully appreciate that risk assessment is about more than a child's actions and that its child protection response is about more than victim behaviour modification. That it may have been otherwise – and some of the cases I have reviewed tend to suggest it was - is not a criticism but a recognition of the CATE Team's history and development.

3.1382 CATE was never a safeguarding service. It was an ad-hoc project run by youth workers who had never been trained in safeguarding or its philosophical underpinning. They saw CSE was not being dealt with by Safeguarding and so addressed it as they could. They used their own skills and made their own processes according to the techniques they knew –

1285 [redacted]
1286 [redacted]
1287 [redacted]

which were those of the youth service, the remit of which was about instilling behaviours rather than addressing risk. The team's processes received the approval of the Council through the Pathway Group and those processes remained essentially unchanged from 2008 onwards; further CATE remained a youth work service with youth work methods until 2016.

3.1383 The CATE Team's move from Cohesion to Safeguarding has brought welcome changes in approach including a broader focus on contextual risks as well as victim behaviour.

National Working Group

Background to the review

3.1384 In 2018, the Council commissioned NWG to undertake an independent review into the Council's response to CSE and prepare a report of its findings and recommendations (the "NWG Report"). The Government's CSE Response Unit has been within the remit of the NWG since 2016, and the work of this unit includes conducting strategic reviews, assisting with inquiries into CSE, and assisting professionals and agencies to develop understanding and approach to CSE.

3.1385 Six members of the NWG undertook the review from 6 November to 29 November 2018, which included five site visits. The terms of reference for the review were agreed between the NWG and the Council as:

"*To provide independent specialist opinion into current practice in regard of child sexual exploitation within Telford and Wrekin, to review and audit Telford & Wrekin's current pathway for child sexual exploitation.*

To consider current thresholds for child sexual exploitation cases in Telford & Wrekin, and the implications for children and young people in terms of support."[1288]

3.1386 The review focused only on cases from 2016 to November 2018 as the remit was limited to current practice (at that time). The NWG review included:

3.1386.1 Reviewing documents agreed by the Council and NWG;

3.1386.2 Conducting five site visits at the Council;

3.1386.3 Auditing 20 CATE Team cases selected at random;

3.1386.4 Observing operational meetings relevant to the Council's response to CSE;

3.1386.5 Facilitating three meetings with a range of professionals involved in the Council's CSE Pathway; and

3.1386.6 Speaking with children and parents that had been supported by the CATE Team.

[1288] [redacted] pg 4

3.1387 In terms of the approach of professionals at the Council to the review, the NWG commented:

"*We would particularly commend the open approach professionals took to the review, despite the current additional pressures facing professionals working in the field of CSE in Telford & Wrekin…*

The CSE Response Unit welcomed the level of openness and honesty from all professionals whilst conducting the review. The CSE Response Unit observed a culture of openness to challenge and learning in Telford & Wrekin."[1289]

Findings

3.1388 The NWG Report made the following observations, and outlined areas of good practice:[1290]

The CATE Team

3.1388.1 Members of the CATE Team were described as "*an asset to Telford & Wrekin*" and the NWG found the CATE Team had "*a unique blend of professional backgrounds, which ensures the team is able to meet the diverse needs of children identified as victims of CSE*". The CATE Team was also found to be knowledgeable, with a broad skill set.

3.1388.2 The relationship between the CATE Team and Safeguarding was *"seamless".*

3.1388.3 The work undertaken by the CATE Team was of high quality "*in a context of challenging climate, with significant political scrutiny and media interest*".

3.1388.4 The CATE Team were supportive of each other and valued support from management.

3.1388.5 The management team understood the complexities of CSE and allowed staff time to develop relationships with children. Parents told the NWG they valued the time the CATE Team took to build relationships with the family.

3.1388.6 The CATE Team provided a high standard of support to children. The high level of support was observed regardless of ethnicity, gender, or age.

3.1388.7 Both the CATE Team and police CSE team had an excellent understanding of the local nature of CSE and changes that had occurred, for example, in 2018 peer on peer exploitation was a significant current concern.

3.1388.8 The CATE Team could access appropriate resources to support their work.

3.1388.9 Systemic practice pods had been introduced to allow reflective practice. The CATE Team spoke positively of these pods.

[1289] [redacted] pgs 6-7
[1290] [redacted] pgs 7-11

Case recordings and assessments

3.1388.10 Case recordings demonstrated clear multi-agency work and were "*of an excellent standard, clearly articulating both the risk and the interventions for individual cases, as well as the outcomes of any sessions*".

3.1388.11 The case recordings showed pathways and protocols were clearly followed.

3.1388.12 The voices of the child and their parents/carers were evident in the case recordings. This demonstrated the CATE Team's engagement with children and their families.

3.1388.13 In the cases audited by the NWG, assessments were carried out in a timely and holistic manner, within agreed timescales, and recorded appropriately. The assessments contained information from the multiple agencies. It is not apparent whether these assessments were carried out under the Assessment Framework.

3.1388.14 There was regular management oversight of those assessments, which was recorded on the Council's systems, and which demonstrated management of risk.

Engagement with children

3.1388.15 Children described a good relationship with their CATE practitioner; they felt listened to and valued. They appreciated the non-judgmental approach of the CATE Team.

3.1388.16 The CATE Team gave a clear explanation of confidentiality and safeguarding procedures to the children they were supporting.

3.1388.17 The CATE Team adopted a flexible approach to engagement with children.

3.1388.18 Parents spoke positively of the support their children received from the CATE Team. They felt listened to, valued and supported; they were pleased the CATE practitioner was a single point of contact. In particular, they valued the CATE practitioners' independence and lack of judgment.

The CSE Pathway

3.1388.19 The CSE Pathway was well embedded, well established and well understood by operational and strategic staff.

3.1388.20 The CSE Pathway was clearly laid out in strategic documents, including through the use of a simple flow chart, which led to the pathway being well implemented.

3.1388.21 The 'continuum of need' chart provided a clear outline of the thresholds for staff to follow.

3.1388.22 There was clear ownership of the CSE Pathway by both the CATE Team and the wider children's workforce.

3.1388.23 "*Risks are swiftly identified, and children safeguarded by the consistent application of thresholds, leading to appropriate support and safeguarding for children*." This consistent approach was identified by the NWG in case audits and observed at the multi-agency risk panel meeting.

Closure of Cases

3.1388.24 There was a lack of pressure to close CATE cases and there was reassuring oversight by the multi-agency risk panel, prior to the closure of cases.

3.1388.25 This lack of pressure ensured there was "*no "drop off" of service for children aged 16 and over*" and "*support was also still offered to those turning 18 and beyond*".

Multi-agency Meetings

3.1388.26 Multi-agency meetings, which formed part of the Council's CSE Pathway and protocol, added value to the Council's response to CSE. This included the multi-agency risk panel, which considered up to date information and provided case holders with appropriate guidance and support. The resulting actions from the panel were recorded on children's records.

3.1388.27 There was clear ownership of CSE as an issue. CSE was not seen solely as the CATE Team's responsibility.

Awareness of CSE

3.1388.28 The CSE team identified incidents involving businesses or locations and used this as an opportunity to engage with those businesses. They involved other organisations, including licensing enforcement, to support them with this work.

3.1388.29 The review stated:

"There was clear evidence of the work taking place locally to engage with the business community, and licensed trades… it was impressive to see the range of professions, including post office staff, who were being engaged with, which should lead to improved reporting of concerns to the police."

3.1388.30 Knowledge and awareness of CSE had been disseminated effectively by the CATE Team, and others, to a wide range of professionals.

Police

3.1388.31 There was evidence in WMP records that activity to disrupt CSE was taking place.

3.1388.32 The NWG identified the following areas of concern:

3.1388.32.1 The CATE Team and WMP did not consistently use the NRM where trafficking was suspected.

3.1388.32.2 It was not clear whether actions from multi-agency risk panel meetings, which did not relate to specific cases, were monitored. As a "*point for consideration*", the NWG suggested developing a generic action log which monitored the generic actions following the risk panel meetings.

3.1388.32.3 The Council did not record police disruption activity on their files. This was identified by the NWG as a point for consideration. They suggested making a record of disruption activity on the Council system, without disclosing the police operational tactics, and highlighting that full details were held by WMP.

3.1388.32.4 The multi-agency focus group held by the NWG identified two development needs for professionals; improved trauma-informed practice and better awareness and knowledge of criminal exploitation.

3.1389 In light of the above observations, the NWG suggested the following points for consideration by the Council:[1291]

3.1389.1 To include training in relation to trauma-informed practice, Adverse Childhood Experiences and use of the NRM for the CATE Team;

3.1389.2 To include training in relation to understanding the specific needs of children with learning disabilities and additional needs;

3.1389.3 To review the impact of the systemic practice pods in six months to ensure it was meeting the needs of the CATE Team;

3.1389.4 To improve engagement of the Youth Offending Service and Emotional Health Wellbeing Service in the CSE Pathway, considering whether practitioners from those services should be directly involved in the multi-agency risk panel meetings;

3.1389.5 To complete the NWG's '*parents as safeguarding partners*' benchmarking tool;

3.1389.6 To repeat the parental consultation process to establish whether parents would find a parent support group helpful; and

3.1389.7 To consult with partner agencies in relation to developing a CSE practitioner network.

[1291] [redacted] pgs 12-13

Analysis

3.1390 I have spoken with a number of witnesses in relation to their experiences of the review undertaken by the NWG, and their views on the NWG's findings and recommendations. I have heard evidence from a number of Council witnesses that the review itself was prompted by the media interest in CSE, and the increased scrutiny and criticism of the Council in 2018. There was a desire to commission the NWG Report to assess and audit the CSE Pathway in order to alleviate concerns about the Council's response to CSE.[1292] Council witnesses expressed that they were supportive of the NWG being commissioned and reviewing the CSE Pathway.[1293] One Council witness considered it a positive experience, as the NWG were good at listening and talking through the CSE cases, and the outcome of the review reinforced that the CATE Team were doing everything they were able to do to support the children open to them.[1294]

3.1391 However, it is clear that there was nervousness around the NWG Report. Despite the intention of the NWG review to audit 20 CATE Team cases selected at random, the cases do not appear to have been selected at random and I have seen documents which show the files were carefully selected with any issues resolved and tidied up before they were shared with the NWG team.[1295] The evidence also shows that it was predominantly the managers that engaged with the NWG team. I have queried this with witnesses who have provided evidence to the Inquiry and have no reason to believe that the files considered by NWG were interfered with or not illustrative of practice at the time, even if they were carefully audited before being shared with the review team. However, this does lead me to doubt the Council's commitment to the spirit of the learning review, as the NWG were simply not provided with a full picture. I have also seen that some Council witnesses were unhappy with the conclusions reached in the NWG Report, and the way that the NWG Report had been written. There were concerns regarding the scope of the NWG Report, and that there had been "*scope creep*" outside its agreed strict remit.[1296] There was some discussion around amendments to the NWG Report, in particular around how it was written before it was finally published.[1297] I have made a recommendation with regard to further training in respect of the NRM.

Ofsted Inspection – 2020

3.1392 Ofsted conducted an inspection of Children's Social Care at the Council between 20 January 2020 and 31 January 2020.[1298] This was an inspection of services conducted in accordance with Ofsted's 'Inspection of Local Authority Children's Services' ("ILACS") protocol. The Inquiry heard that ILACS was introduced in January 2018 to:

1292 [redacted] pg 34, [redacted] pg 24, [redacted] pg 46
1293 [redacted] pg 47; [redacted] pg 17; [redacted] pg 25
1294 [redacted] pgs 17-18
1295 [redacted]
1296 [redacted] pg 35
1297 [redacted] pg 25
1298 [redacted]

"… *ensure* [..] *that local authority responses to child sexual exploitation, and indeed any form of exploitation, are examined and appropriately evaluated in the context of their holistic response to the many issues that impact upon children.*"

Findings

3.1393 This inspection showed very marked improvement since 2016; the inspection report opens *"[C]hildren's Services in Telford and Wrekin are outstanding"* and continues:

"[S]*ocial workers and other staff who support children are very committed, and they are exceptionally well trained… Children are listened to and their experiences are well understood and inform planning to improve their lives."*[1299]

3.1394 The inspectors further noted the following:

3.1394.1 Workforce development, recruitment and retention are particularly strong;

3.1394.2 Staff at all levels are valued and very well supported;

3.1394.3 Children and families are offered highly effective early help and support when their needs are first identified;

3.1394.4 Strong multi agency information sharing supports effective decision making;

3.1394.5 Parents spoken to were extremely positive about the non-judgmental and helpful support they receive;

3.1394.6 Family Connect benefits from experienced social workers who are skilled at ascertaining information to identify risk and need;

3.1394.7 Children's needs are identified and decisions about next steps are made in a timely way by suitably qualified and experienced social workers;

3.1394.8 Where needed, children and families are diverted to the appropriate service commensurate with their level of risk and need;

3.1394.9 Case summaries on children's records are a particular strength and provide and immediate and up to date overview of children's circumstances; and

3.1394.10 Child protection work is highly effective.

3.1395 In particular, so far as the CATE response was concerned the inspection noted that the response to children facing risks outside the family is very strong; consultations offered by CATE practitioners add value and support social workers working with children and families; effective multi agency information sharing and decision making takes place though risk panel meetings.

[1299] [redacted] pg 1

3.1396 The report did sound some cautionary notes; its assessment of the *experiences* of children who need help and protection was merely "*good*", rather than "outstanding" – though I should underline this was an improvement on the 2016 report. It was suggested that assessments could be further strengthened by better use of research to anticipate likely future harm.

Overall

3.1397 This was plainly a very positive report. It shows that the Council had addressed some longstanding issues, including:

3.1397.1 The Safeguarding workforce was now stable with strong recruitment and retention and staff feeling supported. The contrast with the 2004-2012 era, when recruitment was difficult and Safeguarding was an isolated operation reluctant to take on CSE could not be more stark.

3.1397.2 Social workers and staff were said to benefit from a very strong learning culture with reflective group supervision and learning from external sources. This too is a significant difference from the early days when the Safeguarding approach was in my judgment – and, as I have shown, in the views of its own practitioners and others - closed-minded and dismissive.

3.1397.3 The sexual exploitation response appears now to be primarily seen as a Safeguarding one:

> "*Additional capacity has been created within the child sexual exploitation team to develop it into a children abused through exploitation team (CATE). Consultations offered by CATE workers add value to support social workers….*"[1300]

3.1397.4 Putting aside the dubious historical accuracy of the suggestion of a pre-existing sexual exploitation team (by implication a Safeguarding response) being transformed by addition of CATE practitioners (the opposite, as I have shown, being the case), the expectation of early engagement of social workers in CSE cases is much to be welcomed.

Complaints

3.1398 My Terms of Reference require me to consider how complaints relating to CSE were dealt with, including the handling of whistleblowers.

Request for information from the Inquiry

3.1399 As part of its disclosure to the Inquiry, the Council was specifically asked to provide the Inquiry with any complaints relating to safeguarding which refer to or are linked to CSE. In a further request for information, it was asked to provide:

1300 [redacted] pg 4

"… *any information and relevant documentation concerning complaints made in connection with Social Services by parents or carers with children on the CATE pathway or who had been referred to CATE* [including] *the complaint itself, any discussions concerning the complaint and any outcome. Relevant documents might include emails, notes, reports prepared and minutes of meetings*".

3.1400 In preparing its Corporate Submission, the Council was also invited to deal specifically with the issue of complaints and I asked the Council:

"[To] *list any complaints or concerns about how the Council's investigations of CSE have been handled, including how victims and survivors are supported. Please indicate the complainants involved, the nature of the complaints or concerns, how these have been dealt with and the outcomes. This would include complaints about the acts or omissions of any individuals within the Council.*"

3.1401 Acknowledging the role of Shropshire Council, formerly Shropshire County Council, during the early period of my Terms of Reference, the Inquiry also asked Shropshire Council to provide:

"… *any information concerning complaints made in connection with CSE issues from 1989 to 1998. These might be external or internal complaints, and relevant documentation would include the complaint itself, any discussions concerning the complaint and any outcome. Relevant documents might include emails, notes, reports prepared and minutes of meetings.*"

The information disclosed to the Inquiry

3.1402 The volume of documentation and information relevant to this particular Term of Reference has been limited and extremely disappointing.

3.1403 Dealing firstly with Shropshire Council. It informed the Inquiry on 14 March 2021 that it did not hold any documents relevant to the Inquiry's request. It later clarified that it believed such documents no longer exist. I was not surprised by this response given the passage of time and the retention period for such documents.

3.1404 The Council provided some disclosure relevant to this issue of complaints to the Inquiry but acknowledged in its Corporate Submission that this element of disclosure had not been substantial. Work continued to identify any additional information, but it confirmed on 18 June 2021 that it had been unable to locate any further information. No information was provided in response to the question I had raised.

3.1405 The lack of disclosure from the Council, although disappointing, is enlightening in so far as it demonstrates to me, for reasons that I will set out below, that the Council does not have a suitable process for recognising CSE specific complaints and does not have a repository for such complaints.

Policies and procedures

3.1406 I have not seen a complaints procedure that is specific to cases of CSE. However, I have seen two copies of a '*Complaints Procedure for Children and Young People*'.[1301] Both are undated and whilst there are subtle differences in the documents, the complaints process outlined is the same. The Council's complaints system comprises three stages:

3.1406.1 The first stage of the process is referred to as 'informal resolution' – attempts are made to resolve the complaint promptly. A business manager responsible for the service will contact the individual concerned to discuss the concerns and a written response will be provided within between ten and 20 working days.

3.1406.2 The second stage of the process, if a complaint is not resolved at Stage 1, offers the complainant the opportunity to request a 'formal investigation'. As part of this process an Independent Investigator and Independent Person will be appointed and the Investigator has between 25-65 working days to complete the investigation and submit a formal report.

3.1406.3 Where the individual is dissatisfied with Stage 2, a request can be made to have the investigation reviewed and a 'review panel' should take place within 30 days of the request. The Director of Children & Young People will make a formal response within 15 working days.

3.1407 I have seen no evidence of how this information about the Council's complaints procedure has been shared with children and their families which suggests to me that there is no process for ensuring that the Council's complaints procedure is adequately communicated to the service users. However, I was informed by the Council in its response to Maxwellisation that its corporate complaints procedure is widely publicised, including via the Council's website. I understand that this leads to the Council receiving several hundred complaints each year.

3.1408 By way of example:

3.1408.1 In 2020/2021, the Council received 409 complaints: 39 of these complaints related to Children's Safeguarding & Family Services.

3.1408.2 In 2021 to the end of January 2022, the Council received 587 complaints: 46 of these related to Children's Safeguarding & Family Services.

3.1409 The Council also informed the Inquiry that there is a separate process for Children's Social Services.[1302] Despite this, the Council acknowledged in its Corporate Submission that it was not able to provide the Inquiry with full disclosure and a comprehensive response in relation to the queries raised about its complaints processes and data.

1301 [redacted]
1302 [redacted]

3.1410 I have also not seen any protocols or guidance to staff on how to deal with complaints under this procedure.

Evidence of individual complaints

3.1411 Despite the lack of documents disclosed to the Inquiry, the witness evidence I have heard, and some of the documents I have seen, show that the Council has received complaints relating to CSE:

3.1411.1 I have seen evidence relating to a victim/survivor of CSE who was groomed and raped by a number of men in Telford, and was placed in the care of the Council. I am aware that they wrote a significant number of complaint letters to senior members of various organisations *"about* [their] *treatment at the hands of the authorities"*. This includes Head of Social Services at the Council, CEO of Children in Care, the manager of the Children's home and various CATE Team members. The Inquiry understands that:

"… *despite asking for answers and demanding* [their] *allegations be investigated,* [they] *received no satisfactory responses to* [their] *letters. In some cases,* [they] *received an apology or an answer which failed to address the points* [they] *had made. In many cases,* [they] *received no response at all."*[1303]

3.1411.2 I have not seen a complete complaint file for this individual. Although I have seen some correspondence relating to the complaints, the documents I have seen are sparse. For example, I have seen that the matter was escalated to a Service Delivery Manager as the individual had not received a response and the complaint was "*now well outside of complaint timescales*".[1304] I have not seen any documents to evidence what the outcome of this complaint was.

3.1411.3 I have seen another example of a complaint relating to CSE in a letter written by a family member of a victim/survivor of CSE.[1305] The family member raised concerns about the child who had been missing for a number of days and had absconded and slept rough. This was despite the fact that the child had been placed in care because of being targeted for CSE. I have seen a number of documents relating to this child, as well as other complaints raised about a matter not related to CSE. However, I have not been able trace a response to this particular complaint.

3.1411.4 Another complaint was raised by the parents of a child who had been placed in a children's home given that they were at risk of CSE.[1306] Concerns were raised that they were placed in a room next to children of the opposite gender from whom they had previously been subject to sexual abuse.

3.1411.5 I have seen some documents relating to this complaint. For example, I have seen a Stage 2 report by an Independent Person which confirms that the

1303 [redacted] pg 16
1304 [redacted]
1305 [redacted]
1306 [redacted]

complaint was upheld.[1307] However, I have been unable to locate the report of the Independent Investigator. I would have expected to see a Stage 1 response, together with a Stage 2 complaint and documents relating to the Stage 2 investigation.

3.1411.6 The child concerned also appears to have made a complaint as I have seen a letter from the Council to the individual concerned notifying them that their Stage 3 complaint was not upheld.[1308] No reasons for this decision are provided in the letter. Reference is made to the report of an Independent Chair, but I have not been able to locate this, neither have I been able to locate the Stage 1 complaint by the individual or documents relevant to Stage 2.

3.1411.7 The individual was dissatisfied with the outcome and escalated the matter to the Local Government Ombudsman.[1309]

3.1411.8 I have only seen a draft decision by the Local Government Ombudsman[1310] which states:

"*The investigator decided the Council had not managed the risks to* [the individual] *properly and had failed to keep* [them] *protected from harm. Having considered the evidence I agree with these conclusions. The Council's failure to keep* [the individual] *safe in care was fault*."

Whistleblowers

3.1412 I have not heard or seen any evidence to suggest that there have been instances of whistle blowing in the Council in relation to CSE, and in September 2019, the Council formally indicated that it had received no whistleblowing complaints.

3.1413 As has been demonstrated by a number of previous inquiries, whistleblowers are a potentially valuable source of information that can bring mishandling of CSE allegations to light and spot patterns of failure. It is therefore important that the Council have clear whistleblowing guidance for all employees, which clearly sets out the whistleblowing process and the support systems in place. The Council has during the Maxwellisation process disclosed its Speak Up (Whistleblowing) Policy (the "Whistleblowing Policy"), which was created in early 2020 and appears to fulfil these necessary requirements for such a policy; it is not clear to me whether a policy existed before the Inquiry's 2019 request for whistleblowing information.[1311] Furthermore, the Whistleblowing Policy makes reference to "*other specific 'Whistleblowing' investigation procedures developed for example in Child Protection*"[1312]; the Inquiry has not been provided with material relating to those other policies.

1307 [redacted]
1308 [redacted]
1309 [redacted]
1310 [redacted]
1311 [redacted] pg 7
1312 [redacted] pg 1

3.1414 One of the recommendations made by the Scrutiny Review in 2016 was that a whistleblowing hotline be established to enable people who have information but may want to provide this anonymously to raise concerns about CSE.[1313]

3.1415 There was some reluctance, or perhaps lack of understanding on the part of Council employees, about this. I have seen an email dated May 2015 exchanged between two senior Council officers where concerns were raised about the costs associated with implementing the recommendations likely to be made by the Scrutiny Committee. It states:

"… *my biggest concern without seeing what they come up with would relate to being able to meet increased demands on the service. For example from setting up a whistleblowing hotline. We have no plans to cut the CATE team size, but may need to add an additional social worker to the team.*"[1314]

3.1416 Further, I have seen a '*Scrutiny CSE Response Template'* document[1315] which notes the following response to the recommendation:

"*Not sure why 'whistleblowing hotline'. Members of public are already able to contact Family Connect and refer anonymously* – [the Children's Act 2004] *makes provision for this. CA 2004 places duty on all professionals to report any concern for a child's welfare. Concern that a 'hotline' confuses as more than one point of contact – should always be Family Connect*."

3.1417 This suggests to me that the author of this response had misunderstood the fundamental difference between a referral for CSE and a whistleblowing concern. It would clearly not be appropriate, in my opinion, for whistleblowers to raise their concerns via the Family Connect route. Indeed, such a process risks deterring a whistleblower from raising a concern.

3.1418 Council witnesses who have provided evidence to the Inquiry have told me that all 38 recommendations made by the Scrutiny Committee were implemented in full. The Whistleblowing Policy sets out that complaints can be made via an online form, noting "*this request can be made anonymously*" or by a "*confidential*" reporting line where "*it is up to you if you wish to leave contact details or not*". There are, of course, differences between a complaint being kept confidential and it being made anonymously, and differences between making a complaint anonymously and choosing whether or not to leave contact details; and these differences seem to me to be underlined by the fact that the Whistleblowing Policy only makes reference to anonymity in describing the online form. It would be better, in my judgment, if the policy made clear that whistleblowing complaints can be made anonymously through any of the reporting channels, and I have made a recommendation to this effect.

1313 [redacted]
1314 [redacted]
1315 [redacted]

Conclusions

LSCB

3.1419 The story of the LSCB from 2012 until its eventual end in 2018 was one of enthusiastic embrace of the worst excesses of bureaucracy. The tone was set by the adoption of the "*strategic business cycle*"[1316] in 2013, envisaging – and by envisaging, I take to mean demanding – a revision of "*strategic priorities*"[1317] every year.

3.1420 The Inquiry heard from witnesses and from the Council[1318] that the business cycle, along with annual reviews of performance and objectives, is envisaged to be a component of the process by which the LSCB conforms to the statutory requirement to publish an annual report and annual strategy. An alternative view and one, having reviewed the evidence, I prefer, is that the business cycle was designed to give the appearance of scrutiny and activity, and that actually it was largely unnecessary, and created change for changes sake. The difficulty is that, however much it is stressed that an area of interest is being stood down as a "*key area for development*" (or "*strategic priority*") but not as "*a*" priority, words matter.

3.1421 Accordingly, I consider that in respect of the stand down of the CSE group and the missing groups:

3.1421.1 First, as to CSE: CATE was then a one-person team struggling with workload and training demands. To suggest the CATE approach was "*embedded practice*" was simply to accept the hopes of the 2012 restructure and ignore the reality. As to Missing: there were no clear lines of responsibility for RHIs; completion of those interviews was patchy, and there was no established system of reporting the information returned.

3.1421.2 Second, the key message from the stand down was not that the LSCB was looking forward to new priorities under the guidance of a new broom, but that that CSE – and, later, Missing - were no longer its focus. That conclusion is amply supported by the accounts of those who were close to Safeguarding, CATE and Cohesion.

3.1422 In considering the effectiveness of the LSCB, I have reminded myself that the function of the LSCB is, by statute, to:

"*… co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established…* [and] *to ensure the effectiveness of what is done by each such person or body for those purposes.*"[1319]

1316 [redacted] pg 1
1317 [redacted] pg 6
1318 [redacted]
1319 [redacted] pg 4

3.1423 There were many different actions plans, emanating from the NewStart Review, the Principal Officer for Child Protection's CSE response report, and recent audits. These separate quality assurance processes did not have any mechanisms for assurance that tasks agreed were carried out and no oversight of all the different plans and processes. It is difficult to see what action was taken, as people were not asked to account for this. Reports – including this one - are useless unless their conclusions are carefully considered and their recommendations followed.

3.1424 I further consider that standing down the priority groups for CSE and Missing with their direct reporting to the LSCB as a whole not only made it less likely that the LSCB would be able to perform its statutory function, but that it did not perform its statutory function effectively: I have in mind the specific assertion in the LSCB Annual Report of 1 March 2013[1320], that "*the CATE service has been successfully mainstreamed*": when, in fact, the CATE Team was at that stage very short of personnel, struggling with workload and on the brink of another attempt to cancel out its senior practitioner. If that is what "*successfully mainstreamed*" was intended to mean, it is doublespeak of the highest order.

3.1425 I have previously set out a list of the various LSCB subgroups with responsibility for CSE and related matters. I am not going to list them again. The lessons are clear:

3.1425.1 There were too many groups;

3.1425.2 There was too much overlap in their areas of interest;

3.1425.3 There was excessive churn: group after group was rebranded or refreshed leading to lack of clarity about purpose, exemplified by the occasion that a group could not decide whether it should be strategic or operational;

3.1425.4 All the groups (including the LSCB itself) were too big to be effective; and

3.1425.5 Too many people were part of more than one group with the result, inevitably, that attendance was poor – because, as has been confirmed to me in both documentary and witness evidence, people have better things to do than sit in interminable repetitive meetings – and the meetings were often ineffective, for reasons detailed in the main body of this chapter.

3.1426 In my view this approach was plainly wrong and counterproductive, leading to a bureaucracy that appeared to exist for its own sake. Again and again the same issues were raised – RHIs, CATE management, Protocol access, therapeutic support; and nothing was done. I have come to this conclusion after considering not only the documents of the time, but also witness evidence of those present at the meetings and the response of the Safeguarding Partnership in Maxwellisation.[1321]

3.1427 As I have noted previously, I do not regard the positive tone of the 2016 Ofsted review of the LSCB as inconsistent with these findings. The inspectors considered a 'frozen' picture

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1320 [redacted] pg 15
1321 [redacted]

of the bureaucracy over a relatively short time period and were not called upon, as I have been, to review performance or effectiveness over the preceding four years.

3.1428 I have made recommendations that the Council review its bureaucratic structures for necessity, membership and efficiency.

The CATE Team under Cohesion

3.1429 The inescapable conclusion from the evidence I have seen is that CATE should never have been placed under Cohesion, but should have remained under Safeguarding. The reality is that the Council did not expect there to be a CATE Team after the 2012 restructure and as a result no proper thought had been given to where it sat. Its reprieve was essentially the retention of a single senior practitioner post. The manager with responsibility for CATE and Missing had no experience of either.

3.1430 At a time when demand for CATE services was increasing, and CSE was very firmly not in abeyance, the single remaining CATE practitioner was overburdened with active cases and, initially, the burden of performing risk assessments; CATE was reduced to begging for help from the (itself overstretched) TYS team and looking to step down CATE cases to other, presumably less resource intensive, services.

3.1431 Furthermore, this took place at a time when the CATE Team needed scrutiny; it needed a champion. From 2012 to 2015, there were no more than four CATE practitioners and 40 to 50 open cases. Concern was expressed that children were not being visited, risk assessments were not being updated, and tasks were not being completed from one CATE strategy meeting to the next. Practitioners were unsupervised, often upset by the work and, it was suggested, in many ways in a situation similar to that which had pertained in 2007 when the response was simply ad hoc. CATE appropriate cases were not being referred and CATE cases were being "*cut*"[1322] – i.e. dropped – even before risk assessments had taken place. In 2012 the CATE Pathways group consisted of representatives from TYS, the Public Protection Unit of WMP and Children's Safeguarding. There were operational leads from each agency providing direct support, a manager overseeing the project from each agency and a strategic lead from each agency; however it is simply not clear to me how these different layers of direct work, managerial oversight and strategic planning came together to plan or how the project team had expanded so significantly. It should be remembered that for much of 2012 this group was managing a single practitioner.

3.1432 In 2014, the Council proposed that the senior CATE practitioner post be removed; a proposal initially made during that practitioner's absence. The proposal was, upon complaint, reversed. The Council has not provided any documentation in relation to this proposal which seems to me to be a staggering one; risking losing the lynch-pin of the specialist CSE response at a time of increasing demand for what must have been a very modest cost saving, and at a time when (again) there was a training need, as the Council was considering accrediting youth workers as CSE responders. Once again, I am driven to conclude that the Council either formed the view that CSE was 'over', or that it did not merit

[1322] [redacted] pg 17

a properly funded response. The evidence I have seen suggests that at this stage there was a tendency to consider CSE vanquished.

3.1433 The CATE Team moved in 2016 to sit under Safeguarding upon the demise of Cohesion. The evidence is clear and, as I have already said, I conclude that CATE should never have been housed within Cohesion. Whilst there, it lacked resources, it lacked proper supervision, it lacked even access to recording systems that would have allowed proper information sharing with Safeguarding.

The current CATE Team

3.1434 Since 2016, the CATE Team has been transformed. It has increased staff and has proper integration with Safeguarding. It has taken on responsibility for Missing RHIs, an obvious fit that allows early identification of children who may need CATE services.

3.1435 No longer a 'project', the CATE Team now has the ability to pursue perennial problem areas. For example, the question of support for family and siblings of CSE victims/survivors had been talked about from the earliest days of the Sexual Exploitation project; in 2018, there was to be an application for central funding to cover such provision. In the words of the NWG Report, the work of the CATE Team is "*particularly impressive*"[1323]; its joint working with Safeguarding was praised.

3.1436 I agree with the NWG assessment. The Council has, since 2016, finally recognised the importance of the work done by the CATE Team and put that work on a sound financial footing. The team is properly staffed and supervised. It is an integrated part of the Council's provision for children and no longer a "*poor relation*".[1324] The current CATE Pathway makes the relationship between the CATE Pathway and the Safeguarding pathway clearer. I understand that there is, by today, more fluidity between the two processes. The service now refers to itself as a CE Care & Support Pathway and makes clear that the children who are subject to child protection procedures will still be able to access support from the specialised CATE Team alongside other services.

3.1437 I accept that after CATE was brought within Safeguarding, a much greater degree of flexibility became available in the CSE response. However, even after 2020, the published CATE Pathway remains essentially the same as it did in 2008. This had the consequence that in the Inquiry's work, I only heard evidence of this flexibility from witness testimony, rather than from reading it in any documentation (at least until the Maxwellisation response). As I have noted, while I accept that a discretionary pathway is more difficult to set out than a rigid one, it would be helpful for the document itself to set out the possibility of discretion (and divergence from the set approach) being exercised, if the public and practitioners are to have confidence in the procedure. I have made a recommendation to this effect.

3.1438 I have seen evidence that the CATE Team's risk assessments have changed so as to ensure that contextual or external risks to children are properly considered. I take the view that this is sensible; the CATE response need not, and should not, be a purely behavioural

[1323] [redacted] pg 7
[1324] [redacted] pg 19

modification response, and the Council should strive to ensure that the CATE response neither is, nor becomes seen as such, again. Furthermore, the close working that I accept currently exists between Safeguarding and CATE but should serve to underline that CATE never again becomes – as it began – a substitute for a Safeguarding response in CSE cases. I have made recommendations as to ongoing training of Safeguarding and CATE practitioners.

3.1439 Any reflection on the current state of the CATE Team must necessarily include a recognition that for most of its life, its very survival was precarious. CATE was not a top-down response to a children at risk, or a curated response by Safeguarding, but a ground level reaction from youth workers and others who would not stand to see the blatant exploitation of children go unremarked any longer. That ground level response should have been encouraged, adopted, and formalised - as it has been since 2016. Instead, from the team's earliest days (as the CATE project) until 2016 it was repeatedly ignored, starved of funds, and left to wither; on two distinct occasions real attempts were made to decapitate it. I have made detailed recommendations as to the CATE Team's continuance and future funding.

Complaints

3.1440 The fact that the documents relevant to CSE complaints have been disclosed in piecemeal and incomplete fashion lead me to conclude that the Council does not have a suitable repository for complaints relating to CSE.

3.1441 I have seen no evidence to satisfy me that the Council has an effective process for the receiving of and processing of complaints from service users or staff.

3.1442 I have also not seen any evidence to satisfy me that members of staff have received appropriate training and guidance to enable them to identify a valid complaint relating to CSE. I have seen no guidance setting out how a complaint relating to CSE should be processed.

3.1443 The absence of information has made it difficult to reach conclusions in relation to whether the complaints handling process is properly resourced and whether actions are followed up to ensure that improvements are made. However, the lack of importance placed on the complaints procedures suggests to me that this is not the case.

3.1444 The lack of disclosure and information provided in the Council's Corporate Submission suggests that dealing with complaints relating to CSE is not a priority for the Council. This is disappointing given that an effective complaints process can be a valuable tool for detecting issues within the service that requires addressing, identifying early warning signs and ensuring that appropriate standards are maintained.

3.1445 In relation to those who have made a complaint relating to CSE, I have seen no evidence of support available to the complainants. I have made recommendations as to review and reform of the complaints system and as to support for the parents of CATE children.

Selected Issues

3.1446 These selected issues contain some repetition of information discussed previously in this chapter. I have extracted that information from the main body of this chapter and have reproduced it here. For the reasons that I outline below, there is value in repeating the information and in examining the topics in isolation.

Support for Parents

3.1447 In addition to support offered to children who were subject to CSE, there appears to have been recognition by the Council of the potential impact CSE has on the wider family and for the need for support to be put in place, from a relatively early stage. This theme is further explored in Chapter 9: Attitudes and Impact of my Report. The establishment of that support was not swiftly addressed and it has been a perennial issue for the Council.

3.1448 Support for parents generally was highlighted in the Children and Young People's Plan for 2008-2010.[1325] This stated that the Council had made progress in its commitment to switch more resources to allow the continuation of prevention work, previously funded through grant, which included parental support. Despite this, the evidence shows that there were concerns about the support offered and this is a concern that victims/survivors have raised when giving evidence to the Inquiry.

3.1449 To the knowledge of the Inquiry, the lack of support for parents of victims/survivors of CSE was first raised at a CATE meeting on 26 November 2008.[1326] It was noted that providing the CATE project was not able to provide such support, "*as their time needs to be dedicated to the young people*". The attendees at the meeting considered whether support for parents could be provided via the charitable and voluntary sectors and it was noted that support could be accessed through CROP.

3.1450 At a further CATE meeting on 20 May 2009[1327], it was reported that both WMP and CATE practitioners were dealing with representatives of CROP, and that a CROP parenting worker would be attending a CATE meeting to explain their role. CROP training for working with parents had been timetabled, though there needed to be agreement on paying for a venue.

3.1451 Indeed a CROP representative attended a CATE meeting on 29 July 2009,[1328] with it being noted in the minutes that "*seeking parent support is a need for the future*".

3.1452 The Inquiry has been told by a parent concerned that her child was a CSE victim/survivor that, at the time of raising concerns about her daughter in 2009, she was not told about the CATE Team or about the support that could be offered to her.[1329]

1325 [redacted] pg 60
1326 [redacted] pg 2
1327 [redacted]
1328 [redacted] pg 1
1329 [redacted] pg 6

3.1453 At a CATE Gold meeting on 14 April 2010[1330], it was recorded in the minutes that two CATE parents had asked to be involved in a parent support group and WMP confirmed that participation in the criminal justice process was no impediment to this.

3.1454 On 27 July 2010 it was suggested that Victim Support had identified an advocacy support worker who would provide support to both victims/survivors and parents via referral from specially trained officers. A building in Wellington had been chosen as a venue for a drop-in parents' support group.[1331]

3.1455 There was a proposal for a CATE parent/carer support group to be offered by CATE in September 2010, which was proposed as a two hour weekly meeting, as well as a plan to create literature to promote the parental support available. It was noted that CATE was also working closely with partner agencies to ensure effective signposting.[1332]

3.1456 The LSCB Priorities Action Plan was updated on 6 September 2010.[1333] It noted that 25 Council staff were to receive training from CROP[1334]; in the meantime the support role in respect of families was being taken on by Victim Support and family support workers. Targets were supported by ISVAs supplied on a short-term funded basis.

3.1457 The CATE subgroup met on 12 October 2010[1335] and recorded that the ISVA service would be invited to visit potential service users at CATE premises, but that ISVAs could not work with children under 16; they could, however, work with parents of children under 16.

3.1458 The CATE subgroup met again on 13 January 2011[1336]. Parental support was raised again; it was said that officers were working to develop a model.

3.1459 Support for parents came under focus during Chalice. There was recognition within the Council of the need to support the parents of the Chalice victims/survivors. The Inquiry has seen reference in several sets of minuted discussions about the support that should be offered to parents of CATE children.[1337] CROP was commissioned for parental support work and its successor, Parents Against Child Exploitation ("PACE"), also provided a good avenue of support to parents, but the Inquiry heard that this never received the full support of the Council, and the lack of available support for parents continued to be raised as an issue.[1338]

3.1460 A CATE service update on the 7 June 2011[1339] reported that CROP and Victim Support were looking to support the immediate needs of Chalice parents and proposing to develop services long term.[1340]

1330 pg 2
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1332 pg 2
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1334 pg 2
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3.1461 CALLA, a local service set up to offer support to CSE victims/survivors and their families[1341], was considered by CATE as a potential source of support for a Chalice victim. The Inquiry heard that an offer was made by CALLA to provide "*a non-affected person… who had some understanding of the case*" to facilitate the support, but that this offer was refused by the Council.[1342]

3.1462 The Council's '*Procedure for Safeguarding Children Abused Through Exploitation*', published in May 2013, stated that parents and carers have an important part in recognising sexual exploitation and keeping children safe, "*so every effort will be made to offer support and advice and to refer on to appropriate services if necessary*".[1343]

3.1463 Further, the need for an "*effective performance framework"* was raised at a CATE Pathways meeting on 4 October 2013.[1344] It was stated that "*one of the emerging themes was around therapeutic support for young people, parents and siblings*". I consider it stretching language to describe that as an "*emerging"* theme, as the evidence shows that this was first raised in 2006 when the Director of Services for Children and Young People, wrote to the Head of Children's Social Services in these terms:[1345]

"... neither Social Care or CAMHS are resourced to provide a therapeutic service for C&YP who have been abused – yet we all recognise the big gap in our collective services...

It also raises the questions about the effectiveness of our case planning mechanisms – what are the TAC doing? A major issue seems to be behaviour in school – what have the BST done so far? They and the Ed Psychs [Educational Psychologists] *will have experience of other children with sexualised behaviour – are they engaged?"*

3.1464 The Director wrote that "*this is a service gap*" and suggested alternatives of training existing staff or extending the NSPCC relationship to cover abused children. Another witness recalls that the therapeutic needs of CSE targets who were looked after children was seen to fall between the auspices of health and social care providers, causing difficulty; the NSPCC was then the only destination for non-looked after CSE targets and some referrals were made, but services were not easy to find and had to be "*spot-purchased*".[1346] This gap in service for victims/survivors of CSE was identified again in 2010, 2013 and 2018 and did not appear to have been addressed.

3.1465 In March 2014, a CATE practitioner gave feedback to Council management about one particular case, stating that the "*parents are still unclear on the roles of individual professionals and are disheartened at the number of appointments that have been cancelled and rearranged by professionals"* and that the CATE practitioner was *"still awaiting contact from PACE - this will therefore fill the gap in relation to parent support*".[1347]

1341 [redacted] pg 11
1342 [redacted] pg 13
1343 [redacted] pg 5
1344 [redacted]
1345 [redacted]
1346 [redacted] pg 9
1347 [redacted] pg 1

3.1466 The need for support for parents and families was again recognised by the Scrutiny Committee following its review of multi-agency working against CSE in 2016. It commented that:

"*Some parents of victims and survivors told us that they had felt passed from "pillar to post" and the ISVA service explained how they should be involved early in a case. The flowchart we were shown to explain the CATE/CSE Pathway does not include the range of support available to victims, survivors and their families.*"[1348]

3.1467 Following the above review, and its recommendation that the LSCB and the Council consult with parents of victims/survivors of CSE with a view to establishing a parent support group, the LSCB committed to consult with parents of victims/survivors to establish what support they would want and then to ensure this information was shared and widely known. PACE were set to be involved in this consultation.[1349]

3.1468 A response paper drafted by the Director of Children and Adult Services on 21 July 2016 noted that there would be a financial cost to the above proposal, for example venue and facilitation.[1350]

3.1469 I was told by a Council witness that the implementation of all recommendations of the review were voted through a full Council, meaning that it became a statutory requirement of the Executive to implement them.[1351]

3.1470 Further to the recommendation in question, and the requirement to implement it, a parent survey was carried out with parents of current cases. A follow up action plan noted, in September 2017, that they "*possibly do need to look at what support needed for parents of historic cases*" and the comment was made that a local CSE Victim Support service had set up a parent support group and that "*maybe this will fill that gap*".[1352]

3.1471 I understand that parents of children who had been referred at the time to CATE were surveyed, with positive responses received from 12 parents, although it is unclear how many parents completed the survey. In a 12 month period between 2016 and 2017 there had been 68 referrals to the CATE service, suggesting it may have been less than a fifth. The results of the survey appear to show that parents were generally happy with the support they were receiving on an individual basis, and that that there was not an appetite for a support group format.

3.1472 It was noted that:

"*PACE had taken an innovative approach to parental support, setting up relational safeguarding and together with individual packages, the support was joined up and the offering was good. TWC had invested in a senior social worker, to work with families. IMPACT was also used as a counselling service*".

1348 [redacted] pg 45
1349 [redacted] pg 18
1350 [redacted] pg 18
1351 [redacted] pg 8
1352 [redacted] pg 9

3.1473 It was further noted that "*families were being looked after better across all agencies since 2008*".[1353]

3.1474 From the evidence I have heard it appears that there is still work to be done in this regard. One parent's experience of the CATE Team in 2012 was that "*there were funding pressures…* [and the] *team lacked visibility and was not really known in the wider community… a new parent coming to the service today would still struggle in terms of the language and would struggle to know where to turn in order to access the right services and support*".[1354]

3.1475 All the evidence shows that, where it is possible, parents must be treated as partners, and I have made a recommendation to this effect. A CATE process where parents and children are involved is to be welcomed and must be the way forward.

Missing

3.1476 I consider that this topic is deserving of separate consideration. I believe that the failure of authorities, including the Council, to recognise the links between missing children and exploitation to be staggering, particularly in light of the increasing prominence of CSE nationally during the relevant time period.

3.1477 Indeed, I have heard witness accounts from victims/survivors and professionals which show that children going missing is a clear indicator of risk and has been recognised as such since the early 1990s.

3.1478 Even when the links were recognised and strategies developed, the failure to acknowledge the importance of the issue, to conduct appropriate RHIs or to share information effectively between agencies to support children was not consistent and the problem continued until 2018 when the CATE Team finally assumed responsibility and accountability for dealing with RHIs.

3.1479 I set out below my understanding of the development of 'Missing' services within the Council from 2002 to date.

3.1480 On 1 May 2000, the Department of Health published '*Safeguarding Children Involved in Prostitution',* guidance issued under the LASSO Act 1970, which underlined the significance of a child going missing:

"It is known from research that children looked after who run away are particularly at risk of sexual exploitation. Local authorities should monitor carefully the incidence of children looked after who go missing, particularly from residential care. Local authorities should have protocols in place with the police and other agencies on the action to be taken whenever a child goes missing and when she or he returns."

[1353] [redacted] pg 5
[1354] [redacted] pg 20

3.1481 The Council review of resources in July 2006,[1355] noted that, "*going missing*", was one of the "*immediate risk factors*" which could be used "*as a tool to identify children who could be targeted for specific work*".

3.1482 In November 2007,[1356] WMP stressed to the CATE group the importance of making missing reports.

3.1483 On 20 May 2009, the CATE meeting[1357] recognised that there was now a national performance indicator mandated for missing children, known as '*NI71'*.

3.1484 At the LSCB on 27 January 2010,[1358] it was noted that there was to be a subgroup to focus on missing children.

3.1485 On 5 May 2010,[1359] the CATE subgroup's terms of reference were updated to include "*ensuring effective links are made with related agendas, in particular … missing children*".

3.1486 At the LSCB Missing Persons group meeting on 14 April 2010,[1360] it was noted that a previous missing persons group had been formed but had withered for minimal attendance. It had formed an action plan but had no power to implement it. It was noted that the Government's performance indicator NI71 had brought focus upon the issue, there being a requirement for a quarterly return. WMP indicated that it sent daily notice of children reported missing to Safeguarding, which forwarded the notifications to social workers, the CATE Team and other services indicated on the Safeguarding records. The meeting noted that '*found',* as opposed to '*missing',* notifications were rarely forwarded by WMP.

3.1487 It was suggested that an administrative officer was required to ensure that the right agencies received the information, although there were protocols they were sparingly observed in Safeguarding; the system was *ad hoc* and dependent heavily on the experience of a single individual.[1361]

3.1488 There was a West Mercia group to monitor work and share best practice and a "*Young Runaways Regional Forum*".[1362]

3.1489 At the LSCB Missing Persons group on 9 July 2010,[1363] it was noted that while administrative support would be put in place by the Safeguarding Advisory Service, the level of data received required a dedicated administrator to deal with it properly. Missing persons were still not all being recorded as found.[1364]

3.1490 At this stage there was no formal structure or requirements for RHIs:

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"We didn't have a formal Return Home Interview; there wasn't a formal notification to police or process. If we became aware a child had been missing, if it was reported to us through whatever route, there'd be an expectation that you went out and you visited that child and found out whether they were reporting any concerns but that was about as far as it went and it wasn't probing, as it is now. I don't think there was even the data collected or missing, either."[1365]

3.1491 Though the need for RHIs was recognised, the action plan updated in September 2010[1366] noted:

"Pan West Mercia meeting to be convened in September by [a Detective Inspector] *with Children's Society to consider setting up a Return Interview scheme across four local authorities."*

3.1492 On 15 November 2010, at the LSCB Missing Children group[1367] while a system was agreed whereby WMP would furnish the Council with information on missing children on a monthly basis, it was not recorded on Protocol whether a child was open to CATE, so others - for example, emergency duty team officers - are able to know and respond accordingly.[1368]

3.1493 The same meeting noted that the NI71 performance indicator had been withdrawn upon a change of national government[1369]; that the NSPCC were undertaking RHIs for Shropshire, and that Worcester was looking at involving the Children's Society in RHIs.

3.1494 It was noted that the Council was not going to provide additional funding for RHIs so existing services would have to take responsibility, save in cases where the service itself may be blamed by the child for a missing episode.

3.1495 In January 2011, a review showed "*local procedures to support effective prevention* [of children going missing]" marked 'red' (on a traffic light rating system) and "*creating a comprehensive system for RHIs*" marked 'orange' with the note "*cost implications*". After that there was a suggestion that the Clusters or Connexions (who in my opinion seem always to be the last resort) undertook the RHIs.[1370]

3.1496 In February 2012, the LSCB Executive recorded[1371] that "*support for missing children is a significant gap*". Voluntary group involvement in RHIs was recommended as "*very effective*" as providing an independent person for children to speak to, though resources had been identified in TYS for RHIs and there would be a pilot.

3.1497 On 3 May 2012, the LSCB Executive[1372] touched on missing children with a plaintive comment by a contributor that "*if there are issues with colleagues not doing things then it*

1365 [redacted] pg 35
1366 [redacted]
1367 [redacted]
1368 [redacted]
1369 [redacted]
1370 [redacted]
1371 [redacted]
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should be discussed with partner agencies before going to the media". There is no indication what has triggered this complaint.

3.1498 An Ofsted inspection in June and July 2012 noted that "a*rrangements for responding to children who go missing are effective*".[1373]

3.1499 The LSCB Missing Persons group met on 17 April 2013.[1374] It was noted that "*Family Connect staff cannot record on Protocol; it should stay in Social Care*" and "*the Return interview info needs to go on Protocol*".

3.1500 At the LSCB on 17 July 2013,[1375] the meeting noted that "*significant progress had also been made with Missing Children, although the new arrangements needed a little more time to become embedded*".

3.1501 On 15 January 2014, analysis of a RHIs report[1376] showed there were still gaps in the collection and recording of data. There were only ten outstanding RHIs but there was "*a concern about the chasing of these results*".

3.1502 At a Children Young Persons and Family Board meeting later in June 2014, it was revealed that it had been decided to have a West Mercia Joint Policy on Missing.[1377] It is not clear how this was a joint policy, and between whom, but in any event it was reported that as it had been delayed because there could be no local policy formulated.

3.1503 A Children Young Persons and Family Board meeting in October 2014 noted a "*gap in the process whereby Return Home Interviews are either not completed or recorded*".[1378]

3.1504 At the LSCB on 21 January 2015,[1379] the decision was taken not to stand down the Missing subgroup until questionnaires had been completed.

3.1505 The CSE Multi-Agency Strategic group met on 13 February 2015; [1380] it was noted that Missing data was being developed within Protocol.

3.1506 At the CSE Multi-Agency Operations group on 17 March 2015,[1381] it was noted that all missing notifications were to come through Family Connect. Any missing person open to Cohesion would have their RHI conducted by their allocated case worker; any not open to Cohesion would have an allocation within 72 hours. Once again, an issue had arisen with CATE not being notified that missing children open to CATE had returned.

3.1507 A Missing Persons subgroup on 5 June 2015,[1382] suggested that the target of 90% completion of RHIs was "*on track*" but that it was the same officers each time who did not

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complete RHIs despite email alerts. RHIs, where complete, were being imported into Protocol.

3.1508 At a meeting of the Multi-Agency Operational group on 14 July 2015,[1383] once again WMP raised the issue of RHIs. It said:

"[RHIs] *are becoming a bit of a concern as regards to content as no information is being received from them/information not being shared*".

3.1509 On 17 June 2015,[1384] it was noted that the CSE Multi-Agency Strategic group had responsibility for CSE, missing children and other areas. It was to petition the LSCB for priority group status to cover all child exploitation.

3.1510 The Missing Children priority subgroup of the LSCB published its 'closing down' action plan in September 2015.[1385] Despite this being closed down as a priority subgroup, RHIs statistics were getting worse.[1386]

3.1511 In January 2016, the Assistant DCS made representations that there should be a joint team dealing with CSE, missing and other matters;[1387] a senior officer in Safeguarding became strategic lead for Missing and CSE.[1388]

3.1512 At the LSCB on 13 January 2016,[1389] it was noted that the RHIs completed within the timescale remained poor – only 55% completed in time in November 2015;[1390] it was suggested that the problem lay with "*recording issues*".

3.1513 By 29 February 2016,[1391] the CE Multi-Agency Operational group recorded that RHIs were now 100% complete; there had, though, been a spike in the number of missing children.

3.1514 On 11 March 2016, the CE Prevention group[1392] noted that Safeguarding now also had responsibility for Missing; RHIs were still not being consistently shared with WMP.[1393] All RHIs should now be sent to the HAU (within WMP) and to Family Connect.

3.1515 On 18 April 2016,[1394] the CSE Multi-Agency Strategic group heard that HM Inspectorate of Constabulary's vulnerability inspection of West Mercia and Warwickshire (who at that time were working in alliance) gave a grade of "*requires improvement*" with regard to missing people. One of the main failures was using information from previous episodes to prevent repeat, with completion and sharing of RHIs a significant feature. The subgroup noted that

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of 383 missing episodes between April 2015 and March 2016, only 57 RHIs were shared with WMP. I deal with this issue in further detail in Chapter 5: The Policing of CSE in Telford.

3.1516 The CE Multi-Agency Operational working group met on 3 May 2016. It was noted that all RHIs were being sent to WMP's Missing Co-Ordinator.

3.1517 On 14 July 2016, a Missing Children group met and discussed its draft terms of reference[1395] – it should be noted that this was less than 12 months after the Missing Children subgroup of the LSCB had published its closing down actions.[1396] The group noted that first, not enough RHIs were being done and some were of poor quality. Secondly, that Ofsted may take the view that RHIs should be offered in all missing cases whereas Telford only offered them for missing episodes after the first; nevertheless, no change was suggested. Thirdly, that RHIs for children not open to a service were currently carried out by Cohesion, which had been stood down - it was hoped that PCC funds would be made available to allow an agency to step in.

3.1518 In November 2016, an analysis showed only 50% of RHIs were being completed within timescale and there was an issue with RHIs not being sent to Family Connect or WMP's HAU,[1397] and "*a lack of communication between social workers and agencies regarding the information that is provided on missing children*".[1398]

3.1519 The Missing Operational group was re-established in June 2017[1399] to meet monthly to review children who have gone missing and to provide reports to the Child Exploitation subgroup.

3.1520 When the LSCB became the Joint Exploitation board in September 2017,[1400] it was agreed that the Missing element of the Child Exploitation subgroup could be stepped down.[1401]

3.1521 At a meeting of the Corporate Parenting Strategic Group on 7 December 2017,[1402] there was a Missing Multi-Agency core group proposal "*to meet monthly to consider specific children and young people who go missing and to also identify patterns and missing trends. The Chair of the CSE pathway attends providing the link between the two different but connected areas*".

3.1522 By early 2018, a Missing Co-ordinator had been appointed in the CATE Team.[1403] The CATE Team was now dealing with RHIs when the missing child was open to CATE or had an allocated social worker.[1404] Information obtained was recorded on Protocol and shared with WMP while missing children without CATE or social work involvement would be interviewed by members of the Strengthening Families team. Regardless of whether the interviewer

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was from CATE or from Strengthening Families, the officer would be expected to complete the same form and take any referral to Family Connect.[1405]

3.1523 I am driven to conclude:

3.1523.1 In the early days, it appears that the Council gave no real credence to Missing as a risk indicator for CSE, notwithstanding official guidance having been issued as early as 2002;

3.1523.2 Although WMP developed a response to Missing in the early 2000s (which I discuss in detail in Chapter 5: The Policing of CSE in Telford) the significance of the indicator was not appreciated by the Council for many years after that – for example, the attitude to RHIs being an 'optional extra' in the Safeguarding response;

3.1523.3 Moreover, there appears to have been no formality about RHIs until the Cohesion days, when the system, such as it was, was marked by inefficiency when conducting interviews and disseminating information from them. While innumerable committees had views on RHIs and Missing and received statistics on them, progress with actual improvement was unconscionably slow; and

3.1523.4 As with so much else, this was about money – and only following the Scrutiny Review and the reconstitution of the CATE Team as a properly resourced body under Safeguarding were Missing and RHIs finally given the importance they deserved.

CATE Access to Protocol

3.1524 The Inquiry understands that there is a cost associated with Protocol. The failure to give the CATE Team secure recording and information sharing facility is another failure that I consider worthy of examination in isolation. To help illustrate the delays in providing this access, and the difficulties this caused, I have produced a timeline of relevant events (attached at Appendix G).

3.1525 I understand that at the establishment of the CATE Team, CSE cases would have been stored in Microsoft Word documents that were password protected and only accessible to the CATE practitioner and managers. It is not clear to me why access to these valuable sources of information and intelligence was not shared more widely within Safeguarding.

3.1526 A CATE report dated October 2008[1406] noted that information/data recording systems:

"[needed] *to be considered as part of the Liquid Logic system development as a longer term vision. There needs a spreadsheet to be developed and funded, as an interim project, for the input of the information gathered from the monitoring forms. This will allow reporting*

1405 [redacted] pg 15
1406 [redacted]

on how outcomes achieved fit into the Children's Trust Priorities and the Every Child Matters Outcomes".

3.1527 As previously noted, the reference to Liquid Logic is a reference to what Safeguarding knew as Protocol, a computer information recording and sharing system. It would not be open to CATE for almost a decade.

3.1528 In 2010, it was reported that all concerns passed to the Helpdesk would be tracked on Protocol – but technical support was needed before this could be implemented. This was because of staffing shortages.[1407]

3.1529 On 12 October 2010,[1408] a CATE service update was given. The senior social worker who had been manager was to have a period of absence. An interim replacement had been appointed to allow the CATE Team access to Protocol, which they did not have on their own account.

3.1530 On 15 November 2010, at the LSCB Missing Children group[1409] while a system was agreed whereby WMP would furnish the Council with information on missing children on a monthly basis, it was not recorded on Protocol whether a child was open to CATE, so others – for example, emergency duty team officers – are unable to know and respond accordingly.[1410]

3.1531 On 11 November 2011, a report to the Children and Families Board[1411] referred once again to the problems encountered by CATE's lack of access to Protocol. An internal Council communication dated November 2011,[1412] noted:

"[W]*hen CATE was established no consideration was ever given to admin support for recording or general help. Whilst latterly admin support has been provided by the support officers in* [the Community Social Work] *team, this was out of necessity as opposed to an identified role within their capacity or remit. Activity does need to be recorded in a consistent way and does need to be on the Protocol system – sometimes as cases in their own right and sometimes as activity linking to already open cases.* [A responsible officer] *has expressed concern about the capacity coming from CSWT support officers, but because no resource has ever been identified, my concern is about how this will be picked up within the restructure, whilst ensuring that case records are retained appropriately and that there is adequate resource to minute CATE strategy meetings."*

3.1532 The response came:

"In my proposed structure there will be administration provided to the family intervention team and this includes staff who will be focussing on sexual exploitation. In Cohesion services there is a proposal for both senior administrators and administrators to support the service. It has been agreed that there will be links between Cohesion service and protocol and there will be further developments with this during the development of the

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family connect service and the data systems that are being considered. There is dialogue in place between relevant personnel and cohesion around access to Protocol at this time."

3.1533 The underlining is mine; the "*dialogue*" in respect of Protocol was to prove extraordinarily protracted and it appears there were arguments on both sides – evidence provided to the Inquiry indicates that Protocol had been developed specifically for use with legislatively driven social care pathways and could not be adapted easily to CATE use;[1413] the Inquiry heard:[1414]

"*… that was the bugbear of my life for 5 years probably. I fought for the CATE team to have access to Protocol...* [I was told] *they had it at one stage and it was taken off them or whatever. I think the initial feeling was that because they weren't social workers they couldn't have access to this sensitive information. I think they were forgetting that the sensitive information that the CATE team had access to was probably a lot more sensitive than some of the information that Protocol was holding on some of the cases."*[1415]

3.1534 One view was that the Protocol issue was indicative of entrenched attitudes and poor awareness of the CATE process:

"[CATE] *was very much the poor relation… I think that goes back to one group of teams being social workers and the other group being "just youth workers". They had their own qualifications but weren't social workers. We were almost, and it did feel a bit like Oliver Twist, going cap in hand to social workers and the social work team 'please sir, can I have some more information' and we wasted a lot of time and to be honest we duplicated a lot of stuff because we didn't have that information. We didn't know a particular activity the social worker was undertaking and they didn't know what activity we were undertaking.*

It was, I felt a second class process.. when [we] *went to talk to their teams about CATE and what we could offer and what we did for them the feedback we got was 'we never knew what you did, never knew what activities, never knew what information you needed, I didn't know I could refer into CATE'. It was a surreal process…."*

3.1535 The problems identified in 2008, and discussed above in relation to the delay in CATE access to Protocol, do not seem to have been resolved by 2012. The CATE handover meeting notes from 20 March 2012,[1416] setting out new procedures to begin from 26 February 2012, recorded, "*All CATE referrals will* [be]*… put… on Protocol*".

3.1536 On 23 May 2012, a CATE Pathways[1417] meeting considered data collection and noted that the relationship between the Cohesion Customer Relationship Management System and Protocol was to be "*resolved outside of the meeting*". I have passed comment on this approach of taking matters outside the formal process already in this chapter.

1413 [redacted] pg 28
1414 [redacted]
1415 [redacted] pg 23
1416 [redacted]
1417 [redacted]

3.1537 At the LSCB Missing Persons group held on 17 April 2013,[1418] it was noted that "*Family Connect staff cannot record on Protocol*"; and "*the Return Home Interview needs to go on Protocol*".

3.1538 In April 2014 it was announced:

"... *the CATE workspace is currently being built which will allow CATE to record directly onto Protocol.*"[1419]

3.1539 At a CSE Pathway Operations group meeting on 15 September 2014,[1420] it was noted that a Protocol CSE marker was in place.

3.1540 The CSE Multi-Agency Strategic group met on 13 February 2015;[1421] it was noted that Missing data was being developed within Protocol. Given Missing status was a reliable indicator of CSE, the issue of CATE access to Protocol plainly became more acute.

3.1541 By 5 June 2015,[1422] RHIs were being imported into Protocol.

3.1542 The LSCB CE Thematic subgroup met on 9 March 2016.[1423] The minutes record that RHIs were now all being sent to the HAU and Family Connect, and being recorded on Protocol.

3.1543 On 6 February 2017, a meeting noted that CATE was finally to be granted access to Protocol workspace.[1424] By 25 April 2017,[1425] the new system on Protocol for the CATE Team was in place.

3.1544 In my judgment only one conclusion can be drawn from the longstanding failure to give the CATE Team a recording and information sharing facility, namely that the Council for too long regarded the CATE Team as a temporary project or as a service not worthy of the investment.

3.1545 I am concerned about how the CATE Team would have shared information with the Child Protection/Safeguarding teams prior to being given access to Protocol. The Council told me that CATE was very proactive in engaging with key professionals involved with the child including social workers. CATE practitioners would be invited to Child Protection Conferences, Core Groups and Child In Need and TAC meetings. However, it appears to me that until CATE was granted access to the Protocol workspace, it was impossible for there to be safe and secure information recording or effective information sharing; CATE was deprived of a key source of information.

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HIV

3.1546 In 2012, agencies became aware that a CSE perpetrator was HIV positive. A Trust from a neighbouring area was the first health agency involved and they sought legal advice in July 2012 in relation to how those at potential risk of infection could be contacted, without breaching data protection legislation and associated guidance. The Department of Health and the General Medical Council also have guidelines that advise on the approach to be taken when a positive case is identified, although this was clearly an unusual situation. Careful consideration had to be given to the relevant framework that applied, in order to be able to devise a process to contact those affected.

3.1547 In August 2012, legal advice was provided to the health agencies which, in a simplified summary, said that although there was a risk that the perpetrator may be identifiable, disclosure of the information can be justified because there is a strong public interest in making the disclosure, to allow others to seek treatment, and also because of the risk that they may unwittingly infect others if they remain undiagnosed.[1426]

3.1548 At some point following this, the Council and WMP were informed of the position. The first time it is referenced in meeting notes is during a strategy meeting in October 2012.[1427] (It is not clear whether this was a CATE or Safeguarding strategy meeting). In attendance at the strategy meeting were representatives from the Council, including the CATE Team, WMP and health agencies, including the then PCT and GUM services.

3.1549 The minutes of the meeting confirm that the Council's Cohesion team had been informed that this individual had tested HIV positive and noted *"we have a duty to inform and support the victims who could potentially be infected".*

3.1550 It appears as though a decision was taken at an early stage that *"it's not for us* [Council] *to tell the victims this is for the GU* [sic] *we should be there to support the fallout with the victims, families and the wider community".* The minutes also noted the *"need to have the right people available for when the victims look for support".*

3.1551 This was then followed by a further strategy meeting on 31 October 2012.[1428] By this stage it is clear that communication was taking place between the agencies, as there was reference to discussions having already occurred with WMP and the PCT's legal department.

3.1552 In attendance at the strategy meeting a week later were representatives from the Council, including the CATE Team, and health agencies. The meeting focused on the process by which victims/survivors could be contacted and there was a *"lot of discussions around the legal position in approaching the individuals".* During the meeting it was also shared that the perpetrator had given verbal consent that his contacts could be advised to be tested, although he did not name who they were. Other agencies, notably WMP and the Council, were however aware who some of these contacts were.

3.1553 What was clear from these early discussions was that this was not a situation that had

[1426] [redacted] pg 78
[1427] [redacted] pg 69
[1428] [redacted] pg 66

arisen before for the agencies involved. It was also clear that this was a complex and sensitive situation which required careful handling, and there were clearly concerns about if, and how, information could be shared: *"… clarification is needed as to where we are legally with sharing of this information".*

3.1554 Some of the action points from this meeting included:

3.1554.1 *"Legal advice to be sought from the three lead agencies Health, Council & Police."*

3.1554.2 *"Staff wellbeing addressed."*

3.1554.3 *"Risks about leaks to the press, to be considered ongoing."*[1429]

3.1555 Reference is also made to establishing the perpetrator's "*contacts*" – presumably this means children that the perpetrators had sexually abused - and the fact that some will have already been screened.

3.1556 Between the meeting at the end of October 2012 and following further discussions in January 2013, it is unclear what further steps were taken to address this serious issue, as I have not seen any documents or correspondence from this period. One witness from the Council has told the Inquiry that there were emails between Council and health representatives during this November/December 2012 period, and attempts were being made to identify someone from WMP that would join legal discussions surrounding disclosure, with contact being made later in December 2012.[1430]

3.1557 In January 2013, discussions did continue about what information could be shared between agencies and then shared with children who were known as "*contacts*" of the individual that had tested HIV positive. An internal Council email confirmed that the main issues were:

"… who (which agencies) can share what information (held by which agencies) with whom; the aim being to protect and inform anyone who may have been infected or who could be infected without breaching the rights in a way that would make any agency liable to prosecution."[1431]

3.1558 There was one particular meeting on 9 January 2013, attended by representatives of the Council, WMP and the health agencies (the PCT and GUM services), when the legal position in terms of disclosure to victims/survivors was again discussed.[1432] It was confirmed that there were two issues to consider; one, if data (name and contact details of individuals potentially affected) could be shared between agencies, and two, if so, who should make the approach to these children about health screening.

3.1559 During those discussions, legal representatives for the health agencies confirmed that from the PCT's perspective, it was their public health role to advise on the health risks to the children concerned and oversee the public health response. They advocated that the GUM

1429 [redacted]
1430 [redacted] pg 62
1431 [redacted]
1432 [redacted]

services were best placed to contact the children concerned and manage the process:

"[Name] *stated that it was best for GUM services to contact the girls and not the police or someone from the local authority… as they have trained counsellors who deal with this sort of thing on an everyday basis."*[1433]

3.1560 The contact details for these individuals however sat primarily with WMP, and some with the Council. The PCT also raised the point that some individuals may have already been screened during the relevant period and if names could be provided, such checks could be made, which meant that the risks could be further assessed and direct contact may not be necessary.[1434]

3.1561 The representatives for the Council and WMP raised concerns about how they could share a list of names with the GUM service, without consent of the individuals, and without breaching data protection, asking *"if the law would protect us?"* and if *"…they have the 'power' to share this information";* representatives for health considered that it could be shared in such circumstances as it was in the public interest, but there was not consensus on the legal position. The WMP representative was concerned that this would involve sharing sensitive information, commenting that *"by disclosing the list, wasn't this disclosing the fact that they had all been prostitutes and involved with this* [individual]*?".* Putting aside the use of the term "*prostitutes*" for a moment, the meeting concluded with the Council and WMP representatives confirming that they would speak to their respective agency to explore this further as to if the contact information can be sent to allow this process to commence. All parties were also to clarify what information would need to be provided. A further meeting was arranged for mid-January 2013.[1435]

3.1562 It was clear from the meeting that, notwithstanding the legal advice received, both the Council and WMP still held concerns about their ability to share this information and the legality behind any disclosure of names and contact details of individuals affected, without consent of those at-risk individuals.

3.1563 Legal advisers for the health agencies followed up the meeting by way of an email, asking for details of the number of children that were likely to need to be contacted, in the hope that this could be provided for the forthcoming meeting in mid-January.[1436]

3.1564 In response the WMP representative confirmed such statistical information could be provided but expressed their continuing concern in relation to the ability of WMP to share names and contact details of those individuals who were to be contacted about being screened:

"… I think we do remain somewhat apart in our respective interpretations of the DPA 1998 and its application in these circumstances… I remain of the view that the provision of their names and contact details in these circumstances, does amount to the processing of

[1433] [redacted] pg 2
[1434] [redacted] pg 1
[1435] [redacted] pg 3
[1436] [redacted] pg 2

sensitive personal data and that the explicit consent of the girls is therefore required."[1437]

3.1565 The Council responded on the same date to confirm that the Council's view *"accords with that outlined by* [WMP]*…".*[1438]

3.1566 The mid-January strategy meeting was then held as proposed, again with representatives from the Council, WMP and health in attendance.[1439] It was acknowledged at that meeting that:

"Police and Health legal representatives have different interpretations of the Data protection and sharing of data regarding names and contacts which amounts to sensitive data."

3.1567 Despite the differing interpretations, work was commencing to identify who the children affected were, or might be, using the WMP material and disclosures that had been made, and to clarify which individuals had already received health screenings. The attendees also acknowledged that there would be individuals who had not made disclosures.

3.1568 It does not appear that the differing views on whether data protection legislation prevented the Council and WMP from sharing names and contact details with the health agencies was ever resolved. As the Council and WMP dispute continued, an alternative solution to ensuring the children concerned were screened appears to have developed. This was largely driven by the then PCT.

3.1569 In late February 2013, representatives from the PCT and the Health Protection Agency met with a WMP Detective Sergeant to discuss the anonymised risk features for those who had, or might have been, abused by the perpetrator. Following that meeting, a new approach was devised to ensure the relevant contacts were screened. This was set out in a public health overview assessment prepared by the PCT.[1440] This assessment summarised the potential health risks to those affected and concluded as follows:

"Some contacts have already had SHS/GUM counselling and that could be verified…";

"Those at-risk and not known to Sexual Health/GUM (or otherwise tested by NHS) would need to be contacted and also offered this opportunity"; and they

"… should be offered counselling and follow up unless there is clear evidence that this has already occurred."

3.1570 The assessment then provided an overview of the different at-risk groups and what action was required, which was to be subject to further refinement and discussion with other agencies, who held information about these individuals.

3.1571 Following receipt of this assessment, it appears that steps were then taken by the relevant agencies to ensure that the children concerned had either already been screened during the relevant period, and if they had not, or if the information was not available, they would

1437 [redacted] pg 1
1438 [redacted]
1439 [redacted] pgs 24-26
1440 [redacted] pgs 12-21

be sensitively contacted. I have not seen evidence of the contact between agencies when this information was shared, but a strategy meeting in April 2013 confirms that the agencies had started to cross-check health information to establish whether screening had already taken place for some children. It is clear from these minutes that this work was continuing, and where prior screening information was not available, those children still needed to be contacted.

3.1572 The minutes of the April meeting do also acknowledge that:

"The sharing of [children's] *names has been by far the biggest challenge in this piece of work and agreeing ways to do it between the Police, Local Council and all Health leads has caused significant delay. This was agreed to be a source of frustration given that we are clearly all working to protect* [children's] *health. There is a lot of good practice that has been in place with CATE, we need to be confident that what we do is correct, assure ourselves that the sexual health advice was robust."*[1441]

3.1573 A further public health update was prepared in May 2013 to confirm the status of contact follow-up with the at-risk individuals.[1442] This was then discussed at a strategy meeting that same month.[1443] Work was continuing to contact children and:

"It was felt that we need to do as much as we can to offer a full screening to those who didn't take it up then…[and] *if* [information] *brings further* [children] *to light then the same protocol will be followed with advice and screening offered."*

3.1574 When the Inquiry asked one Council witness about how this matter was managed by the agencies, there was limited recall of the issue and the ultimate outcome about how these children were contacted. The Council witness had to rely on the contents of documents that were provided by the Council by way of disclosure, rather than their own recall. This individual also seemed to suggest that the issue was being taken forward by other agencies: *"... the health side of things were leading on that, weren't they?";* and *"public health was leading because obviously it was a GUM clinic issue…";* and *"So very much the Police were taking the lead on this subject to having obviously appropriate consent forms etc. in place*".[1444]

3.1575 This issue was dealt with some eight or nine years ago and therefore being unable to immediately recall detailed events is not a surprise. That said, given the gravity and seriousness of the issue, it is surprising that more information could not be provided.

3.1576 I have very recently been provided with material from WMP and from the Council's solicitors which confirms that all relevant children were contacted to offer counselling and testing; and that these contacts were made by the end of June 2013.

3.1577 This was clearly a legally complex situation and the differing interpretations of the application of the Data Protection Act 1998 and associated relevant guidance and legal framework are not under scrutiny. I am not going to delve deeply into the advice that was

1441 [redacted]
1442 [redacted]
1443 [redacted]
1444 [redacted] pg 68

provided to, and accepted by, the different agencies but do note that in respect of children, the welfare of the child should be paramount; and that though the Bichard Inquiry had underlined years before that it is a feature which overrides considerations of data protection, the point does not appear to have been made. What is a concern however, is the delay caused by these discussions; from the point of the positive diagnosis, it took at least nine months to resolve and take action. The agencies themselves recognised this was a failure during the meeting in April 2013. Discussions seemed to focus on potential breaches of legislation and the possibility of agencies being prosecuted for this; in contrast, while there were often references to support needing to be put in place, there was very limited focus on the gravity of the situation for the individuals affected and the need for this to be resolved as quickly as possible.

3.1578 The HIV diagnosis was a concerning development, and the documentation I have seen suggests that the agencies, particularly the Council and WMP, failed to apply sufficient urgency in resolving the matter and finding a solution, given the seriousness of the situation. I have made a recommendation to the effect that processes which govern information sharing between key stakeholders in such a scenario should be reviewed, and if such processes do not exist, they should be created.

3.1579 A further point arises in respect of the HIV issue. I have seen information which shows that some years after the matter first came to light, WMP received information that the perpetrator had exploited another child some years before. Information shows that the relevant individual was referred for sexual health support, albeit by luck, as opposed to as a result of being notified of any risk to her health. I asked WMP what procedures existed in such cases to ensure that the victim/survivor was provided with suitable advice and assistance, and heard that Force Orders have, since 2003, made clear that HIV status should only be recorded against an individual's name where "*threats are made to infect others*".[1445] I have not heard the position in respect of the Council but would be extremely surprised if the Council was able to justify holding such data if the police were not.

3.1580 This leads to a situation which seems to me to be shocking, and wholly unsatisfactory; that there is no effective method for the Council or WMP to consider subsequent exploitation complaints – particularly complaints about non-recent exploitation - against a list of perpetrators known to be HIV positive; such a comparison exercise would depend upon retention of staff with personal knowledge of the case, which is clearly no answer at all. I make it clear that this is not a criticism of the Council or of WMP, but it is a situation that plainly demands both urgent local consideration and perhaps thereafter a national conversation; and I have made a recommendation to that effect.

Key Reviews

3.1581 Under my Terms of Reference I have examined the findings of three existing reviews/reports and considered whether they drew accurate conclusions. In this section in particular, I have been greatly assisted by the social care expert to the Inquiry, whose input is much appreciated. The reports are:

1445 [redacted]

3.1581.1 Telford & Wrekin Council's/ *'Safeguarding Children Board's report on Child Sexual Exploitation Learning'*, April 2014 (the "2014 Learning Report");

3.1581.2 Telford & Wrekin Council's *'Children and Young People Scrutiny Committee's review of Multi-Agency Working Against CSE'*, May 2016 (the "Scrutiny Review"); and

3.1581.3 The Ofsted 2016 Inspection, which I have already dealt with above.

2014 Learning Report

3.1582 This report is to be read in conjunction with the NewStart Review dated October 2013[1446], analysed above. The LSCB had commissioned NewStart Networks to undertake a review of how the Council and its partners had responded to CSE between 2008 and 2013. This followed a decision by the Chair of the LSCB that the Chalice cases did not meet the threshold to conduct SCRs for any of the children impacted, nor to complete a thematic review of multi-agency response to CSE. Instead, it was decided that a "*broader*" (the definition of which is not provided) learning review would better hear the voices of victims, survivors and their families than through a SCR.[1447] The rationale for this is not clear as an SCR would, in my judgment, have heard the voices of families and victims/survivors. The final report of the NewStart Review made a series of recommendations which the CATE Pathways group oversaw implementation of, as well as other recommendations identified by this 2014 Learning Report, which was prepared by the Council's Principal Child Protection Officer in order to highlight the learning from the NewStart Review.[1448]

3.1583 The 2014 Learning Report[1449] was designed to "*address the key learnings that took place from 2006 and how the Council responded to these learnings*". It provided a history of the development of the response to CSE and the development of the CATE Pathways group.

3.1584 Key areas for development identified by the NewStart Review, which were carried forward by the 2014 Learning Report,[1450] were noted as:

3.1584.1 CSE Care Pathway Group - to continue with the ongoing development of a multi-agency response that supports a needs-led and flexible culture when responding to the particular needs of the children subjected to CSE;

3.1584.2 Education - a central theme for both children and parents in the NewStart Review, in terms of improving awareness of CSE amongst school-age children and their parents;

3.1584.3 Support to family - support to children's parents and siblings is crucial. Information and arrangements to ensure that parents are aware of support services that they may wish to access will be improved, as well ensuring that children and their families understand the different roles of the various agencies

1446 [redacted]
1447 [redacted]
1448 [redacted] pg 20, [redacted] pg 2
1449 [redacted]
1450 [redacted]

working with them. Service user feedback has been built in to some elements of the CSE Care Pathway and this will be developed further with particular emphasis on the CSE strategy meeting process;

3.1584.4 Work with communities – perpetrators' families and their communities is an area for further learning which will take place at a later time (it was not felt appropriate to progress this work directly at the time due to the known impact and pressure of Chalice);

3.1584.5 Therapeutic services – it has been accepted that there can be long-term damage and impact for children who have been subjected to CSE. The 2014/2015 action plan will consider how to take this forward, ensuring that support offered to children is appropriate to meet their individual needs;

3.1584.6 Post-18 support – the impact of CSE has lasting implications into adulthood, including when children themselves become parents. This needs to be explored more to design services and pathways accordingly; and

3.1584.7 Staff training, support and communication – the multi-agency training programme has been reviewed and developed. Further evaluation will take place, particularly in relation to identifying and targeting of specific staff groups who would benefit from accessing CSE training. This will include how to ensure that managers supervising staff while working with children subjected to CSE have the appropriate knowledge to do so effectively.

Response to the Report

3.1585 The 2014 Learning Report notes that a number of actions had already been undertaken in terms of addressing the learning points set out above. The detail of these is as follows:

3.1585.1 A Strategic Management framework was developed and implemented including a CSE Pathway group, chaired by the Head of Service for Safeguarding (Assistant DCS level), reporting to the Strategic Management group. The purpose of the group was to develop and oversee the implementation of an agreed model of protection and support for children identified as being at risk from CSE.[1451]

3.1585.2 A multi-agency CSE Care Pathway was developed and implemented that was, and remains, proactive and integrated in its approach, enabling agencies to work together to:[1452]

3.1585.2.1 Implement local preventative strategy;

3.1585.2.2 Identify those children at risk of sexual exploitation;

[1451] [redacted] pg 4
[1452] [redacted] pg 4

3.1585.2.3 Take action to safeguard and promote the welfare of particular children who may be sexually exploited; and

3.1585.2.4 Jointly take action against those people intent on abusing and exploiting children in this way.

3.1585.3 It was also noted that:

3.1585.3.1 LSCB multi-agency CSE training was also made available to staff;[1453]

3.1585.3.2 The CATE project has been mainstreamed and developed further within the Council's Cohesion services;[1454]

3.1585.3.3 A three-tiered CSE training programme has also been developed to enable staff from across the children's workforce to gain the right level of training appropriate to their role;[1455]

3.1585.3.4 Families are able to access support separate from the CATE practitioners through Council family support services or PACE;[1456]

3.1585.3.5 A Telford Muslim Forum has been established, involving members from all the mosques in Telford. This approach enables partner agencies to develop better working arrangements with communities;[1457]

3.1585.3.6 The LSCB procedures for CSE have been reviewed and now includes the CSE Care Pathway; and[1458]

3.1585.3.7 Core ingredients for a performance dataset have been agreed.[1459]

3.1586 The report concluded that:

3.1586.1 The Council had been aware of and working actively to reduce the risks of CSE to children for a number of years. With the support of the Council and other partner agencies, a significant WMP operation had resulted in the successful prosecution of a number of perpetrators of CSE.

1453 [redacted] pg 4
1454 [redacted] pg 5
1455 [redacted] pg 5
1456 [redacted] pg 5
1457 [redacted] pg 5
1458 [redacted] pg 5
1459 [redacted] pg 5

3.1586.2 A significant amount of learning had taken place to develop multi-agencies and partnership response to tackling and supporting children and their families at risk from CSE.

3.1586.3 The learning has enabled the development of a CSE Care Pathway which offers an effective model for addressing CSE.

3.1586.4 Partnership arrangements and the commitment to continuous learning and development of the Council's response and services to children and their families are fully supported by the LSCB.

Overview

3.1587 Finally, as detailed above, this report was designed to be read in conjunction with the NewStart Review. The decision to commission NewStart Networks, rather than a thematic SCR, meant that the report was a feedback process – not a critical review of multi-agency practice – as it related to a number of cases about which there were considerable concerns. There was no detailed analysis of practice, for example how the processes to address CSE were actually working in practice. This methodology was flawed in its approach and therefore the report could be nothing more than unfiltered feedback.

3.1588 In terms of the learning emanating from this report, it is difficult to gauge, as the report is focused on generalities and a belief that all the hard work was making a difference to front line practice. There was no reflection that wider concerns about staff shortages might be having an impact. It is also hard to identify how this learning was implemented, put into practice or reviewed. There is no evidence that it was.

3.1589 The report also concluded that an action plan to address CSE in the period 2014/2015 needed to be agreed. There is no record in the evidence submitted to the Inquiry by the Council that this action plan was developed or agreed, and therefore no scrutiny of it. The issue of the need for therapeutic support continued as a theme.

3.1590 This was an internal review and it shows. It offers no real analysis of the Council's CSE provision and is almost entirely uncritical. It regurgitates lots of achievements without any consideration of what might have been failures. It is, in my view, superficial.

3.1591 That being said, I consider that its author, though relatively senior, did not have the status or position to be able to conduct a serious assessment comfortably. The failure is not on the part of the author, but the officer who commissioned the author; I suspect, given that I have concluded that the Council was sensitive to criticism throughout, that the decision was quite deliberate.

The Scrutiny Review (May 2016)

3.1592 In its Corporate Submission to the Inquiry, the Council noted that, following the reports by NewStart Networks and the Council's Principal Officer for Child Protection, it was determined to ensure that learnings about CSE continued to be developed and addressed. It was keen to ensure that the local approach incorporated national lessons learned, and adopted recommendations made by national bodies where appropriate. For example, Professor Jay's

report into sexual exploitation of children in Rotherham criticised the child protection system and made numerous recommendations for government, local authorities and other agencies to consider and learn from.[1460]

3.1593 As discussed above, the Scrutiny Review which commenced in November 2014 involved the Scrutiny Committee spending the next 18 months engaging with partners, communities and survivors of CSE and their families to provide them with an understanding of "*how well organisations in Telford and Wrekin are working together to prevent CSE, protect and support victims and their families and prosecute perpetrators*".[1461]

3.1594 The findings of the Scrutiny Committee were that:

3.1594.1 Statutory organisations recognise CSE as an ongoing issue both nationally and locally and demonstrate their commitment to the work of the LSCB and CSE partnership group;

3.1594.2 Training opportunities are generally good and key partners' frontline staff all receive training in some form;

3.1594.3 Organisations are working well together to respond to known cases of CSE;

3.1594.4 The work of the CATE Team, the CSE Pathway and the Family Connect service demonstrate a joined up approach across the organisations in the borough;

3.1594.5 The Family Connect service has been likened to a MASH due to the co-location of a number of partner agencies, but it noted that a MASH functions on a more operational level;

3.1594.6 Family Connect is of the view that GPs make appropriate referrals but, in contrast, the CATE Team find obtaining information from GPs difficult on occasion;

3.1594.7 The CATE Team have caseloads which are almost double the NWG recommendation;

3.1594.8 Because the CATE practitioners are youth workers, not social workers, they do not receive access to the same professional supervision arrangement as social workers and which they felt would benefit them;

3.1594.9 Reduced capacity means the CATE Team is not able to meet the targets in terms of meeting children;

3.1594.10 Cross boundary working can be an issue, for example staff in WMP and NHS trusts need to understand the different CSE pathways for different local authority areas;

1460 [redacted] pg 21
1461 [redacted]

3.1594.11 No systematic failings or denial that CSE is a serious problem were identified;

3.1594.12 Officers in Telford & Wrekin and Shropshire identified the need for a common database for local authorities to share information about taxi drivers;

3.1594.13 Further deregulation enacted on 1 October 2015 allows Private Hire Vehicle operators to hold licenses with more than one authority and to sub-contract bookings to drivers licensed in other licensing areas, adding complexity to enforcement activity;

3.1594.14 Some gaps in services have been created by the complex new arrangements for the commissioning of sexual health services, where responsibility is fragmented between local authority, CCGs and NHS England;

3.1594.15 Some victims and survivors of CSE and their families have not received the support they needed and do not understand the support that is available or how to access it;

3.1594.16 In the aftermath of Chalice, local Muslims had felt somewhat "*targeted*" and "*isolated*";

3.1594.17 There are far more victims/survivors than are currently recognised and accessing services. There is no national data set for CSE;

3.1594.18 There is not enough therapeutic and counselling support for victims/survivors of CSE. The services available are unable to respond to the current level of known need.

3.1594.19 Support should be available for parents of victims/survivors of CSE.

3.1595 The recommendations made by the Scrutiny Committee are all available in Appendix F to this Report, using the same subheadings as were used in the report.[1462]

3.1596 In addition to recommendations to the Council and partners, the Scrutiny Committee made three recommendations for national bodies, which are listed in the Council's Corporate Submission to the Inquiry.[1463]

3.1597 Two of the Scrutiny Committee's findings were further emphasised in the Scrutiny Review's conclusion. These were that:[1464]

3.1597.1 Organisations in Telford & Wrekin are working well together to respond to known cases of CSE. The focus of the Scrutiny Review was on partnership working across Telford & Wrekin. Whilst no recommendations were made regarding cross-boundary working, as it was deemed to be a matter for each local authority

[1462] [redacted] pgs 68-83
[1463] [redacted] pg 22
[1464] [redacted] pgs 65-66

area, the pressure this places on frontline staff and the importance of maintaining effective partnership working across the region was stressed.

3.1597.2 The Scrutiny Committee did not identify any systemic failings or denial that CSE is a serious problem, however they did acknowledge that some victims/survivors of CSE and their parents had not received the support they needed. From the evidence received, the Scrutiny Committee believed that there were far more victims than were currently recognised and accessing services, although acknowledged that this was a national issue and that there was no dataset nationally for CSE. The report made the point that local knowledge is essential to inform the awareness raising and prevention work needed.

3.1598 The Scrutiny Review also identified a series of recommendations against improvement themes[1465], emphasising the need to:

3.1598.1 Understand the scale of CSE to keep children safe - I note that the need to monitor and map CSE had been repeatedly remarked upon in meetings across key stakeholders for years, without progress, and it is a key theme I have taken into consideration as part of my Recommendations at the beginning of this Report;

3.1598.2 Raise awareness of CSE in educational establishments, agencies and communities for prevention purposes and, if identified, refer appropriately to Family Connect and WMP;

3.1598.3 Map the multi-agency support which is available for children and victims/survivors as they journey through the CSE Pathway, including making further improvements in support services, including CAMHS and sexual health services for victims, survivors and their families - this theme had emerged from the audit activity referred to above;

3.1599 Annually review the CSE strategy;

3.1599.1 Audit of all current CSE cases to ensure that children and their parents have a safety plan in place - there is no evidence that this took place – or that there was a reflection on very recent audit activity;

3.1599.2 Map out the support available for parents and develop the possibility of a support group - again this was a long standing concern raised by previous audits and analysis;

3.1599.3 Look at role of IROs in identifying concerns of CSE – this was a recommendation for the LSCB, however I have seen no confirmation that this happened or what the exact issue was;

1465 [redacted] pg 22

3.1599.4 Conduct an audit of 10% of CSE referrals to gain assurance that appropriate follow up action has been recommended – I have seen no evidence that this took place – or that there was a reflection on very recent audit activity;

3.1599.5 Improve Family Connect data collection of CSE cases – the Inquiry has seen no evidence of action to address this recommendation;

3.1599.6 Review caseloads of the CATE Team;

3.1599.7 Ensure that supervision of the CATE Team is by a qualified social worker; and

3.1599.8 Seek to add additional resource to the CATE Team, if the recommended maximum caseload, a figure to be set by the LSCB, is consistently breached.

Overview

3.1600 In addition to the comments above, I do have concerns about the rigour of some of the scrutiny process in the Scrutiny Review, for the following reasons:

3.1600.1 Whilst it was found that training was happening, there is no sense that this was making a difference or indeed that training effectiveness was monitored.

3.1600.2 In terms of organisations working together well to respond to known cases of CSE, I am not persuaded that clear evidence of this was provided to the Scrutiny Committee and I question at what level this conclusion was formed. Indeed the audits which took place during that period, and which did not influence this report, provide a more critical picture.

3.1600.3 In respect of the finding that the work of the CATE Team, the CSE Pathway and Family Connect demonstrated a more joined up approach across local organisations, again it is unclear why this conclusion was reached. There had long been concerns about information sharing and working arrangements between the two services. It does not appear that sufficient evidence was provided that this had been recognised with action outlined for change (beyond computerised record keeping).

3.1600.4 There does not appear to have been any critical analysis of the view of the CATE Team that obtaining information from GPs was difficult; contrasted with the evidence of Family Connect, which found that appropriate referrals were made by GPs. Indeed this issue emerges as a theme in my analysis of the case studies, detailed in Chapter 8: Case Studies later in this Report.

3.1600.5 Finally, in identifying that the CATE Team had caseloads almost double the NWG recommendation, the Scrutiny Committee is surely implying that increased resource was urgently needed, however no such recommendation was made. Instead the matter is referred to the LSCB to decide caseload numbers and for increased resource to be considered if these caseload limits are consistently breached, at which point the LSCB and partner organisations are advised to review the matter.

3.1601 The significance of the Scrutiny Review was, it seems to me, that it was politician-led. There is a preliminary point to be made here. I regard it as remarkable that, given the history of CSE in Telford, there had been no previous investigation by elected members. This is of particular concern regarding looked after children, for whom the Councillors have corporate parenting responsibility. The absence of commentary on looked after children/children in care in the Scrutiny Committee's report is troubling and, referring back to my analysis of the case studies, this was a historic issue. That the nature and scope of CSE was not regarded sufficiently seriously by the majority of Councillors is further illustrated by the Scrutiny Committee's own recommendation that there should be CSE awareness training for elected members.

3.1602 The most important point about this review being politician-led is that it actually generated positive results. There are two very obvious examples of this: it was after the Scrutiny Review that CATE finally settled to its natural home in Safeguarding, with an expanded team and increased budget; and it was after the investigations of the Scrutiny Committee that the Council accepted that Family Connect did not qualify as a MASH, and that further efforts were made to change its working practices with co-location of WMP.

3.1603 The areas of concern identified by the Scrutiny Committee were those which I have already set out and which had existed for years if not decades. Examples include support for victims/survivors of CSE and for their families; support for, and consideration of the safety of, those workers helping victims/survivors of CSE; effective mapping of the incidence of CSE; and IT provision for the CATE Team.

3.1604 In short, I take the view that while there were some troubling omissions in the Scrutiny Review, it nevertheless came to some conclusions about the Council's CSE response which were obviously accurate and necessary ; and in so doing it drove the Council to change that response materially.

3.1605 I do, however, regard it as surprising given Telford's history that no such review had been carried out before.

3.1606 Lastly, I note that the Council was the subject of a 'focused visit' from Ofsted on 20 and 21 April 2022.[1466] Headline findings were that "*senior leaders have maintained a focus on keeping children safe and maintaining the quality of social work practice in Telford & Wrekin*". It was noted that "*there continues to be significant investment in the children's social care workforce to increase capacity in response to the increased demand*" and that "*demands on the service remain high and caseloads have not reduced to the target set by senior leaders*", but that "*senior leaders are evaluating what further recruitment is required to ensure a more effective service to children through reducing caseloads*". That is not a picture of a problem solved – demand for Safeguarding will, sadly, never go away - but of one being appropriately and determinedly addressed.

Education sector

3.1607 In accordance with section 11 of the Children Act 2004, school bodies have a statutory responsibility to make arrangements to safeguard and promote the welfare of children.

1466 [redacted]

There is also a statutory duty to promote cooperation between the local authority and schools, in order to protect individual children from harm.

3.1608 The Council was asked to provide the Inquiry with details of its interaction and involvement with any schools in Telford & Wrekin regarding CSE. There are two types of schools within the borough; those maintained by central government grant, initially known as 'grant maintained schools' from 1988-1998, then 'academy schools'; and those who derive their income from the local authority. The Council only has direct influence over the latter class of school. That influence is contained within rules set out in the School Governance (Roles, Procedures and Allowances) (England) Regulations 2013 (the "Regulations"), which set out roles of the Governing Body and the Head Teacher. The Governing Body holds responsibility (at strategic level) for safeguarding matters and the Head Teacher holds that responsibility at operational level.

3.1609 The Council retains its statutory responsibility to safeguard and promote the welfare of children regardless of the funding mechanism of the school they attend. The Council told the Inquiry that it discharges this responsibility by ensuring that its multi-agency safeguarding arrangements are effective and that schools are aware of the methods by which referrals can be made. The Inquiry has not seen documents to support how this is achieved.

3.1610 Schools have a vital role in recognising and monitoring the safety and welfare of their pupils and in tackling CSE. As I have explained earlier in my report, the Inquiry has clear evidence that children were suffering CSE long before the period of my Terms of Reference. Victims were targeted whilst they were pupils at local schools but their exploitation was not identified as such, and it was not adequately acted on by those working in the local schools.

1989 to 2004

3.1611 A witness told the Inquiry that, in the 1990s, pastoral teams within local schools were largely concerned with behaviour management and dealing with children who broke the rules or who struggled with school life.[1467] There were no formal policies and practices in place for dealing with issues of CSE, or indeed child sexual abuse.[1468]

3.1612 Furthermore, any involvement with social workers at the schools related to children who were deemed to be at risk, most often as a result of neglect. The Inquiry heard that, unless the issues were very serious, which usually amounted to neglect cases, social workers were very rarely involved. Largely, the school would deal with any issues itself. The witness further recalls that there was simply not the same access to services or the same level of cooperation between agencies which exists today.[1469]

[1467] [redacted] pg 3
[1468] [redacted] pg 3
[1469] [redacted] pg 3

3.1613 I remind myself that a former social worker for the Council also told the Inquiry that, prior to the Council gaining unitary status, there were no formal referral pathways for what would now be known as CSE.[1470]

3.1614 At that time, four secondary schools (here referred to as Schools A, B, C and D) were located in close proximity to Wellington, and to each other.[1471] Concerns about children at these schools being sexually exploited began to arise in the 1990s, with a staff member of one of the local schools recalling that three of the schools' head teachers used to meet and were:

"… *sharing information at that stage,* [the late 1990s]*, about the concerns* [they] *had about these girls… and what might or might not be happening."*[1472]

3.1615 A school nurse for these schools described the concerns as "*chatter*" amongst the students, about locations that children would be taken to. They said there was a sense that something wasn't right, "*but people didn't know how to manage that and how to put their finger on it".*[1473]

3.1616 At the time, one of the schools, which accommodated approximately 800 pupils, aged 11 to 16 years, was seen as "*a mixed ability school… which used to get the best results in Telford after* [Name of unrelated school]*".* Evidence indicated:

"It was always seen that if you couldn't get into [Name of unrelated school]*, you'd get into* [School A] *… it's a comprehensive intake, but probably skews to the more middle class top end".*[1474]

3.1617 A staff member at School A told the Inquiry it was "*predominantly a white school*" and that Wellington was a "*lovely quintessential… English market town".*[1475] The Inquiry understands that the school was not without its challenges, noting:

"… *it had its problems. It had about 20% free school meals. We were in a housing estate with poverty, drugs…."*[1476]

3.1618 Over the period of one staff member's time at School A, approximately 15 years, the ethnic minority cohort grew from almost nothing to approximately 15%.[1477]

3.1619 The Inquiry heard that suspicions grew amongst staff members about behaviour which would now be classed as CSE, though a senior team member at the school at the time said that there was never any direct evidence or proof.[1478]

[1470] [redacted] pg 17
[1471] [redacted] pg 3
[1472] [redacted] pg 9
[1473] [redacted] pg 4
[1474] [redacted] pg 9
[1475] [redacted] pg 31
[1476] [redacted] pg 6
[1477] [redacted] pg 31
[1478] [redacted] pg 9

3.1620 The Inquiry also heard about there being a climate of "*fear and mistrust*"[1479] around the Pakistani community within School A. Disclosures by pupils were often made to staff about other issues, such as smoking, teenage pregnancy or bullying, but never about CSE, until the later Chalice investigations.[1480] As the Inquiry has so often heard, this lack of concrete evidence, coupled with the lack of awareness about the crime, meant that the staff largely did not act upon their concerns or suspicions, or were not listened to when they did.

3.1621 A witness told the Inquiry that the Council's approach was "*structuralist, rule-based, evidence-based*" and that while one incident was viewed as insufficient, schools were not encouraged to "*build the incidents*" into an overall picture.[1481]

3.1622 Following the Children Act 2004, schools were required to have Designated Safeguarding Leads ("DSLs"). I heard that before this title existed, a member of staff would have had specific responsibility for child protection. The Inquiry understands that, at School A, the holder of this role was firmly of the view that confidentiality overrode disclosure and they would not share any information which had been disclosed by pupils to them in confidence. This could not be successfully challenged because, as one witness put it, "*there was no safeguarding system".*[1482] This approach was plainly wrong, and easily means that crucial information about the exploitation of pupils at the school may not have been shared or acted upon.

3.1623 The Inquiry understands that not all staff within the hierarchy at School A accepted the view expressed by the staff member with responsibility for child protection, and that teachers with management responsibility sought to raise the issue of child exploitation with Council officers. The Inquiry understands from the evidence that one staff member told the Council that there was a "*problem in this authority with Pakistani youths",* only to then be accused of being racist by one Council officer.[1483]

3.1624 Contact between the schools and the Council continued to be limited:

"*The only real contact you have with anybody from social services was about children who were … on the looked after register."*[1484]

3.1625 Further:

"*…you couldn't get that kind of support, getting Social Services out to a child was like … they just weren't available. The service wasn't there."*[1485]

3.1626 Another issue seemed to be the fact that School A was grant-maintained and, as such:

"*… our relationship with the authority was not a good relationship really. They resented us being a grant-maintained school and politically, the sort of micro politics of education of the*

1479 [redacted] pg 17, [redacted] pg 10
1480 [redacted] pg 4
1481 [redacted] pg 26
1482 [redacted] pg 14
1483 [redacted] pg 15
1484 [redacted] pg 16
1485 [redacted] pg 16

time was there was funding available for new builds and we weren't getting a new build and other schools were and there was a lot of, you know, it wasn't dreadful but the relationships were not really knitted. We had moved away, we had taken our HR away from Telford and Wrekin, we took it to [Name of a neighbouring authority]*. We had, and we had managed, the school in a completely different way. So we weren't closely allied really. We grew further and further and further apart from the authority really as a grant-maintained school and then as a, just a school managing themselves basically."*[1486]

3.1627 It was the Human Resources support, sourced in the neighbouring authority, which provided the first child protection training to the school, in 1997. This included information about grooming, which one staff member recalled, "*even in* [a large city where they had previously worked] *we'd never really heard of that"*.[1487]

3.1628 The Inquiry has heard evidence that, in the absence of support from the authorities locally, these issues continued to be managed by the school itself, as best it could. An example of this is the spike in teenage pregnancies which occurred over a period in the late 1990s. There was no multi-agency response to the issue, as far as one staff member was aware, and therefore the school developed classroom learning around topics such as contraception, which the Inquiry was told had a positive effect on the figures.[1488] Another example is the fact that, when two teachers heard a rumour about a pupil being "*in a house of ill repute*"[1489] in Wellington, they went round to that house and knocked on the door, bringing the pupil back to school. They then reported the matter to Safeguarding. It is not clear what response, if any, this engendered; it is obvious, though, that school staff should not have to put themselves at risk in such a way, but the fact that they did so shows commitment and bravery.

3.1629 There was also a "*rumour book*"[1490] at the school, which pupils were encouraged to use to report any concerns about other pupils confidentially. The Inquiry understands that this was a new concept for the school, at that time in the late 1990s, but that it had been custom and practice in Telford and in Shropshire for some time. Whilst helpful, the issue with the book was:

"… *there were plenty of rumours around… but we didn't have the girls saying this has happened to me. We didn't have that."*[1491]

3.1630 As a result, the school felt unable to share any further concerns with Safeguarding or WMP. When asked why more was not done in terms of taking concerns forward, the Inquiry was told:

1486 [redacted] pg 20
1487 [redacted] pg 7
1488 [redacted] pg 4
1489 [redacted] pg 8
1490 [redacted] pg 16
1491 [redacted] pg 16

"*Because there is no evidence to the contrary. It's that that people want to see and we were obedient people, we were law-abiding, obedient teachers and teachers have rules and social services have rules and the police have rules. They can't go accusing*...."[1492]

3.1631 It is clear from this that school staff felt restricted by a mistaken interpretation of data protection and privacy, and they did not understand when a risk to safety outweighed questions of privacy.

3.1632 Concerns grew in the early 2000s. Although there were still no disclosures forthcoming from pupils. The Inquiry heard that there were obvious indicators of sexual activity amounting to CSE:

"*It was thought that it was consensual although there were staff beginning to think maybe it isn't because of the way the girls general … you know, they stopped talking. So girls usually are bubbly aren't they, and they'll chat about things and form tutors were very aware of that girls were clamming up. So if a form tutor was sitting down with somebody they wouldn't give any information. So they were becoming more secretive. And I know that parents were called in where there was concern and some parents were saying, "well, I'm not a racist, I don't mind if she's got a Pakistani boyfriend". Others were concerned. And that is the context of where we were at the time, it's so different to how it is now.*"[1493]

3.1633 Further evidence about the parents' situation was that:

"*… parents in those days* [didn't have] *a clue about what the girls were at, and if they did have a clue about what the girls were at, they didn't have any control over the girls and were mortified.*"[1494]

3.1634 The Inquiry heard that when one senior member of a school reported concerns about sexual abuse to Safeguarding in respect of one particular pupil at the school, they were told that "*what we deal with is far worse than that, that's nothing,*" and that there was nothing that could be done. This appears to be another example of the Council not taking action in respect of concerns raised about CSE,[1495] although contemporaneous material shows Safeguarding was well aware of an exploitation problem around schools from the late 1990s onwards.

3.1635 Lucy Lowe was a pupil at one of these local schools. Lucy's murder, and that of her mother and sister, far from raising awareness or encouraging children to speak out, appears to have frightened pupils into continued silence, for fear that they or their families might share Lucy's fate.

3.1636 I have read evidence that:

"*Form tutors, Year 11 form tutors, would often report a girl had been dropped off in a taxi at school when there was no reason why they should have been dropped off by a taxi at school. There were rumours around about girls being taken up the Wrekin before school in*

[1492] [redacted] pg 17
[1493] [redacted] pg 13
[1494] [redacted] pg 13
[1495] [redacted] pg 17

taxis. But I never had a girl who would either write that down or say that to me. They were frightened and they were frightened because of the Lucy Lowe situation[1496]*…. Now, that torching of the house was the Pakistani community's greatest strength because every single girl knew about that. Every single one* [of] *our girls that was involved with the Pakistani community in any kind of part of their lives that we might be concerned about, and might be talking to them about, they were all clamming up big time because,… Lucy had lost her life. And they knew."*[1497]

3.1637 At a strategy meeting in November 2000,[1498] attended by senior social workers, members of staff of School A and the Domestic Violence Unit at Malinsgate police station, concerns were raised relating to past and present pupils of the school mixing with older Asian men in Wellington. At this meeting there was reference to concerns raised "*2½ years ago*" of schoolchildren "*being collected from school by older Asian 'boyfriends'"* and references the model of exploitation. It is unclear what action was agreed and the Inquiry has heard evidence that, despite evidence of the problem now being blatant for some years, nothing was done aside from the fact of the meeting itself being convened. One of the attendees does not recall anything significant resulting from that meeting, in terms of actions.

3.1638 The Inquiry has heard evidence that school leaders felt isolated and without support in tackling CSE. As a result, one of the schools began to work on the issue of CSE on its own in earnest, introducing a new pastoral support team, from different backgrounds, as a further source of support for pupils.[1499]

3.1639 I have seen some evidence of an increased awareness of CSE on the part of the Council, in relation to schools: a member of staff working in a school in 2001 recalled receiving a questionnaire from the ACPC, asking for any information they had about possible CSE issues. Although they only knew about "*rumours and hearsay"*[1500]*,* the questionnaire was completed and returned. I have not seen any evidence of what analysis was made of these questionnaires, however, or how they were taken forward by the ACPC.

3.1640 It is clear from documents I have seen, however, that the issue was under discussion within Council meetings. In May 2003, a Sexual Exploitation meeting took place[1501] to discuss the case of a child from Telford who had been introduced by a friend to a group of Asian men and groomed by them, before being raped.

3.1641 The WMP contribution in this meeting was a focused question about where the men lived – a particular street was mentioned – and the observation was made that this sort of situation had occurred before. WMP representatives noted that officers had previously visited the particular school but the children in question would only refer to the men as their boyfriends, so no further action was taken. It was said at the meeting that something should be done in local schools at an early age to help prevention, and that more information needed to be sought on how the group of men were operating.

1496 [redacted] pg 10
1497 [redacted] pg 12
1498 [redacted] pgs 60-63
1499 [redacted] pg 17
1500 [redacted] pg 7
1501 [redacted]

3.1642 ACPC minutes dated May 2003[1502] again show that the problem within the schools was known about and under discussion by the Council, noting two cases of sexual exploitation:

"… *where those involved are afraid to report it. Two strategy meetings have been held and both are now active in terms of being pursued by police and social care. This is a big issue for schools and* [the attendee speaking] *would be keen for schools to get hold of it and take it forward in terms of policy and planning.*"[1503]

3.1643 Following this meeting, a sexual exploitation policy was ratified and it was agreed that it would be sent to area schools. It is not clear from the evidence whether this sexual exploitation policy is the same as the Children Abused Through Exploitation protocol. The Inquiry has not seen a separate sexual exploitation policy. The Inquiry has heard no evidence to suggest that the policy was promulgated to staff within schools.

3.1644 Evidence suggests that in around 2003, schools were heavily encouraged by central government to become academies out of local authority control. Some witnesses have surmised that secondary schools, as a result, were less likely to engage with the TAC process and further were less likely to engage with the idea of taking responsibility for the safeguarding of their pupils outside the school environment. There were "*difficult*" conversations with secondary schools who were focused on academic achievement and keen to rid themselves of any children with "*behavioural issues".*[1504]

3.1645 This policy of excluding children for behavioural issues or for other factors which would now be recognised as CSE indicators, was summed up by one witness as follows, when asked about the level of awareness in schools at this time:

"… *I'd still say they lacked awareness and the difficulty was that the reaction could be an exclusion and an exclusion is always the worst outcome for the child because it means they're not safe because then they're out of school and we know, nationally, statistically, that if you've been excluded from school you're going to be at a higher level of risk of exploitation*…."[1505]

3.1646 However, I read evidence in counterpoint:

"*Inevitably if there are behavioural issues that result from abuse or exploitation … that obviously is a matter of concern for a school, of course, that would have to be addressed but actually the Heads of those schools … were extremely sensitive to the challenges that home and outside school circumstances would be presenting for children and young people. They would be as sensitive and as alert to those as they would be to the behavioural issues. If you're the Head of a school, you've got to address behavioural issues and it may be that your view is that the school, despite its best endeavours, cannot continue to support or work with a young person, that is not unreasonable but that's when the work of our Special Services would be brought to bear.*"[1506]

1502 [redacted]
1503 [redacted] pgs 4-5
1504 [redacted] pg 10
1505 [redacted] pg 50
1506 [redacted] pg 43

3.1647 When asked whether directly funded schools were more likely to exclude "*difficult*" children, a witness told the Inquiry:

"*I certainly didn't feel that there was any negative impact for the young people there and I do feel like the Head and the senior leadership team were keen to ensure the safety of the children. I just think, on reflection, I've been thinking about this and thinking about what were some of the challenges and I do think that one of the challenges, both for staff in the school but also the local authority and the safeguarding board as it was then, is that sort of disbelief that anything like this was happening in Telford. I just don't think they were able to think the unthinkable and I think that, having that culture of no, this doesn't happen here, really hampered their ability to make progress.*"[1507]

3.1648 I saw further evidence that suggested another potential source of information about exploited children were Education Welfare Officers ("EWOs"). The Education Act 1996 places a duty on local authorities to monitor school attendance in their areas and take the appropriate supportive and enforcement action, which allows for the prosecution of parents.[1508] If children were frequently missing from school, the EWO would meet with the family and put a plan in place. Local authority schools automatically received the support of a EWO and, in the case of academies, only when those schools opted to buy in the local authority services.[1509]

3.1649 Apparently, the criteria at the time for involvement by the EWO was that the pupil's attendance level at school had dropped below 89%. Should that occur, a letter would be sent to the family asking why the attendance was low and asking them to encourage the child to improve his or her attendance.

3.1650 I heard that the EWO would visit families regularly, sometimes on a daily basis, in a role almost akin to that of a family support worker.[1510] They therefore had crucial access to the children and their families and would have been in a position to pick up concerns and gather intelligence had there been better awareness of CSE.

3.1651 The Inquiry heard that information-sharing between the EWO and Safeguarding team was not good:

"*I think we all worked in silo and I think where we had concerns about particular children I don't feel like those concerns were shared … I don't really feel like I ever met a threshold to get action from a social worker or proactive action from a social worker.*"[1511]

3.1652 The observation about schools and Safeguarding teams operating in silo mirrors the experience of the Clusters and the Safeguarding team as well as the later experience of the CATE Team and Safeguarding team.

3.1653 Attempts at awareness raising amongst parents were not always welcomed:

[1507] [redacted] pg 45
[1508] School attendance and Schools Duties to Safeguard Children. - NWG Network July 2016
[1509] School attendance and Schools Duties to Safeguard Children. - NWG Network July 2016
[1510] [redacted] pg 11
[1511] [redacted] pg 14

"… they're walking a sensitive path between that accusation that parents either would say "you're teaching my children things that I don't want them to know about" … back when we were doing it in 2003 we had some parents, fathers particularly, not being happy with what we were delivering and feeling like we were scaremongering them."[1512]

3.1654 The Inquiry was also told:

"... now some parents were very grateful to us, other parents tore us off a strip as it's got nothing to do with you what my child does on a Saturday night. So that's the kind of conflict you were in."[1513]

3.1655 Evidence was also given to the Inquiry stating that a local Catholic school preferred the focus to be on school attendance and was particularly wary of raising the pupils' awareness about sex education, alcohol or drugs. It was noted that the school in question did not want to be "*as creative around helping young people come back to school. They could be quite authoritative".*[1514]

3.1656 In 2004, the ACPC considered the position with regard to schools and the group heard that there was no single worker on any team who had a significant role to respond to sexual exploitation, though hope was expressed that someone could be trained to take a lead, "*or to point people in the right direction*". It appears that the role being contemplated was a training role, not an intervention role, although it was stated that there was "*a lot of anecdotal evidence of child prostitution".*[1515]

3.1657 At an ACPC meeting on 11 May 2004[1516] it was noted that a training day for school staff had been arranged, to raise awareness of sexual exploitation, delivered by the ACPC's recently acquired inter-agency training coordinator.

3.1658 At a later meeting, there was a report of the content of that training:

"… we provided specific training for the Wellington schools [in 2003/2004]*, and developed specific PSHE which is personal social and health education, which was part of the curriculum, specific PSHE modules for teachers and young people on grooming and awareness of sexual exploitation. So we developed these modules and we invested money into the development of these modules we used, I can remember all these very clearly, we used the Barnardo's videos on grooming, awareness of the use of the internet, awareness of girls receiving gifts, we developed training materials and modules of work for both teachers and for pupils. And particularly for Year 7 upwards. We also provided specific support for* [School A] *and* [School D] *in relation to training for their pastoral staff. We had a named linked police officer. We involved school nurses, the* [Connexions] *Service and the Multi-Cultural Development Service too, in terms of developing awareness about perpetrators and victims. We did some specific work… with the community leaders at the mosque in Wellington with the Madrassa and we did twilight training sessions for governors*

1512 [redacted] pg 9
1513 [redacted] pg 28
1514 [redacted] pg 13
1515 [redacted]
1516 [redacted]

and senior staff. And we also worked with other schools in south Telford and indeed north Telford and [School C].*"*[1517]

3.1659 The Inquiry was told about cooperation to put in place disruption measures at schools which had raised exploitation as a concern:

"*We did specific things like having joint police and education welfare patrols physically outside school gates at* [School D] *and* [School A]*."*[1518]

3.1660 I heard evidence that witnesses regarded the approach of School A in particular as creative:

"*I felt like their SEN and their pastoral services were well-resourced and were quite forward-thinking."*[1519]

3.1661 Despite this apparent early focus on training and raising awareness of CSE, the evidence suggests that there was still a need for training and awareness of the CSE referral process as late as 2015, as I explain in further detail below.

2004 to 2012

3.1662 The Inquiry heard that, by 2005, a new pastoral system at School A was embedded, with non-teaching support members of staff having been employed. The Inquiry heard that the school bought in services from whoever they thought was the best provider.[1520]

3.1663 The Inquiry heard that there was:

"*… an army of people whom staff could get to and who could spend more time with children and they really took over the management of the pastoral care and had lots and lots of confidential information about children*".[1521]

3.1664 It was also explained that the school became:

"*… a bit of an island in a way as we got more and more running ourselves as our own business, a grant maintained, an ex-grant maintenance that became a self-running school, and so I didn't go to the child protection meetings at all."*[1522]

3.1665 The Inquiry understands that while this school had set its own course, many local schools had opted into Council-provided CSE awareness raising training sessions, delivered to school staff. This three hour course included information about CSE and, in addition, schools' DSLs were given further training and expected to disseminate this to staff.[1523]

1517 [redacted] pg 41
1518 [redacted] pg 42
1519 [redacted] pg 45
1520 [redacted] pg 32
1521 [redacted] pgs 8-9
1522 [redacted] pg 9
1523 [redacted] pg 23

3.1666 It must be remembered, though, that the sexual exploitation project was at this stage funded for only four hours' work per week. I heard that there was to be a new PSHE advisory service within the borough from April 2006 which, it was hoped, would bring consistency to PSHE; I have seen no indication that the high hopes were fulfilled.

3.1667 Minutes of a Sexual Exploitation meeting dated 18 October 2005[1524] show that there was a discussion around teenage pregnancy prevention and work being undertaken by school nurses with children in terms of relationships. Some of that information was being passed by school nurses. One witness told the Inquiry that the link between CSE and teenage pregnancy was established at this stage, but was "*quite fragile*".[1525] I pause to note that a number of other witnesses have not accepted that any such link had been made at this stage.

3.1668 The Inquiry heard evidence that there was[1526]:

"*… work in two particular secondary schools… one would have been* [School A] *and then I think the other school is called* [another named school]…. *This work was effectively the forerunner of the CATE project. We did work in both of those schools and again it was initially work with young people who weren't necessarily achieving, but where a school had picked up from conversation with young people whereby they were concerned that they were being more open in their conversations about sex and sexual activity than they should be for their age. So we were asked if we would develop some projects that were, and again it was probably at the time on the back of the teenage pregnancy work that we'd been doing for a number of years, but it was really about trying to keep young women safe and preventing them getting pregnant.*"

3.1669 Whilst awareness of CSE within schools appears to have improved during this period, the Inquiry has seen evidence that a number of pupils were still being exploited and that the exploitation was left unremarked by members of staff, despite what we would now recognise as common indicators being present. By way of examples given to the Inquiry:

3.1669.1 One pupil who was under the age of consent told a teacher that she was speaking with a GP about obtaining the morning after pill.[1527] This did not prompt any further concern or exploration by the teacher.

3.1669.2 The same children would often be absent from school, but this did not prompt the school staff to explore the circumstances of those absences.[1528]

3.1669.3 There were behavioural difficulties, including fighting, and some children lost interest in activities which they previously enjoyed.[1529] Victims and survivors

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1524 [redacted]
1525 [redacted] pg 24
1526 [redacted] pg 11
1527 [redacted]
1528 [redacted] pg 9, [redacted] pg 11, [redacted] pg 7, [redacted] pg 3, [redacted] pg 48, [redacted] pg 7, [redacted]
1529 [redacted] pg 11

told me their changing behaviours went unremarked by the schools.[1530] Two such accounts are as follows:

"*I'd turn up when I wanted to. So, if it was like ten o'clock in the morning I'd turn up there because I was always on a hangover drinking like the night before after school. Then I would go to school half cut… and they didn't even say anything. They didn't pick it up. They just thought I was lazy and just slept, like just tired.*"[1531]

"*The school never challenged my behaviour,* [following an incident which caused damage]*… the school contacted my mum, saying that she would have to pay for* [the damage]*. She refused. The matter was dropped. No one asked me why I had reacted that severely...sometimes I didn't come home until a couple of hours before I had to be up for school, but I still didn't skip any days at school and no one seemed to notice that I was exhausted.*"[1532]

3.1669.4 There was little support in school for victims of CSE. Name-calling and bullying were common.[1533] Teachers were unlikely to become involved. Often school work deteriorated[1534] as did self-care, sometimes obviously, with one witness commenting to me that no one noticed how tired she looked or indeed that she had been wearing the same school uniform all week.[1535] Another striking example of lack of support, and indeed victim-blaming, was given by a witness who told the Inquiry of being excluded, then being reprimanded by a teacher: "*stop sleeping with these boys or* [you will] *never make anything of* [yourself]*".* [1536]

3.1669.5 I have seen evidence that some limited support was occasionally provided, and there was little questioning about upset or changes in demeanour; a victim/survivor witness told the Inquiry of a teacher assuming she was having "*boyfriend problems*" and making no further enquiry.[1537]

3.1669.6 CSE was plainly being perpetrated around schools. The Inquiry has heard that children would be picked up from the schools at the end of the day and even during the lunch breaks by men in cars, including taxis.[1538] I understand that it was known that perpetrators would enter the school's grounds.[1539] Concerns about this issue were to be repeated at various local schools and colleges over the years to come.

3.1670 The Inquiry has heard that there was ongoing frustration from head teachers about the lack of competent social workers, and a feeling that educators were being asked to fulfil a social

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[1530] [redacted] pg 13
[1531] [redacted], pg 46
[1532] [redacted] pgs 5, 7
[1533] [redacted] pg 20, [redacted] pg 6, [redacted] pg 4
[1534] [redacted] pg 4, WIT237136, pg 7
[1535] [redacted] pg 31
[1536] [redacted] pg 4
[1537] [redacted] pg 4
[1538] [redacted] pg 7
[1539] [redacted] pg 48

work role for which they were not trained or otherwise equipped.[1540] This was a lament also heard by the Inquiry from WMP officers who had worked on Chalice.

3.1671 A Sexual Exploitation meeting in November 2005[1541] heard that the sexual exploitation project work was only funded for four hours a week, and that much of this was taken up by running the sexual exploitation course. The meeting noted that there were to be pilots within schools of a new PSHE advisory service within the borough from April 2006 which, it was hoped, would bring consistency to PSHE.

3.1672 The Inquiry was told that the school pilots were seen as "*healthy relationship workshops*" that were to be given to the children in the schools and then to parents and carers in the evening.[1542] In July 2006 a review of available CSE resources was completed by the Council and dealt with the specific work undertaken to raise awareness in schools:[1543]

"From this project a workshop has been developed with the Education welfare service which aims to raise awareness of young people. This has been piloted in a selection of secondary school in the area with success. Evaluations from school have always been positive. However there is no resource to enable this workshop to be delivered Borough wide. The pilot is coming to an end and consideration needs to be given to how Telford will continue to develop preventative strategies and raise awareness for young people."

3.1673 A package of support was offered to schools, which some took up and others did not. It was suggested that a named member of staff in a particular school be spoken to as they had a "*wealth of knowledge".*[1544] I have not heard that this suggestion was followed up.

3.1674 As a Senior Officers' Coordination group meeting later in November 2007[1545] it was noted that there were difficulties meeting school heads and a feeling that head teachers would not attend meetings if they felt the subject did not relate to their own school. I have seen evidence suggesting that the engagement of head teachers was *"variable".*[1546]

3.1675 There was a CATE meeting in October 2008.[1547] A referral form had been developed and would be circulated to schools and other agencies; it was thought this would increase referrals "*perceptibly*".

3.1676 Minutes of a CATE Team meeting dated January 2009[1548] show that there was WMP involvement in a case, arising from a cluster of reports in a particular school, where Safeguarding had declined to act.

3.1677 Later that month a CATE meeting reported the delivery of workshops at a particular school,[1549] which would serve as a model for work in other schools, but there were only the

1540 pg 10
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1542 pg 28
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1546 pg 17
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resources to work in one school at a time. It was identified that there were still known issues in two local schools. I detect a slight nervousness in the line from the minutes "*all are mindful capacity may become an issue, if referrals are raised following these* [school] *workshops*". That the problem was widespread was already known, even if its true extent was not. To be concerned about capacity so early in the delivery of the workshops tends to show a failure of preparation of response, or a suggestion that telling children about risk would keep them safe – plainly, it would not.

3.1678 The LSCB, on 27 January 2009, recorded that the work to mainstream exploitation awareness into PSHE in schools was outstanding – in the sense of 'not done'. The Inquiry heard:

"… the Catholic schools were quite reluctant."[1550]

3.1679 In the same vein, the Inquiry learned that, for School C:

"*… it was quite a leap for them to say that they needed help and they needed support because they were a strongly religious school who had … I think they'd had difficulties with even having sex education on the agenda … so then to add on sexual exploitation and what that might mean for a school…."*[1551]

3.1680 I pause to make the obvious point that to seek to raise awareness is not to admit a problem; and admission of a problem is not necessarily a sign a school is failing. There is no balance to be struck between a school's reputation and children's safety.

3.1681 Minutes of an LSCB meeting on 15 July 2009 shows that there was insufficient capacity for preventative work in schools. CATE resources were to be considered as an "*urgent priority*" and the Council was to reinforce that CATE training should be mainstreamed within PSHE.[1552]

3.1682 The evidence shows that from 2010 onwards, there appears to have been increased discussions about implementing the CATE strategy in schools. A CATE Care Pathways meeting on 5 March 2010 decided to adopt a training programme with specific modules on CSE, into PSHE lessons in 11 schools, with targeted work for key children in a particular school. [1553]

3.1683 On 30 April 2010, there was an update of the LSCB action plan.[1554] Priorities included developing and implementing a CATE schools strategy.

3.1684 At a CATE Gold meeting on 23 November 2010,[1555] it was noted that a resource was available for prevention in the shape of a DVD titled "*My Dangerous Loverboy*", a narrative about a child who was targeted, groomed and abused. There were resource packs for

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1550 [redacted] pg 26
1551 [redacted] pg 57
1552 [redacted]
1553 [redacted]
1554 [redacted]
1555 [redacted]

teachers and parents. On 26 January 2011,[1556] the LSCB noted that the DVD was to be used as part of a preventative programme in schools.

3.1685 The next day, at the CATE Gold meeting, "*My Dangerous Loverboy*" was shown to the attendees and it was decided that it was felt to "*not be the best vehicle to deliver a message*".[1557] The Chief Executive was not willing for it to be used in schools and the minutes dutifully record this was "*agreed by all present*". The Inquiry was told that the Chief Executive (who at the time was also holding the post of Director of Children's Services) had in fact walked out when the DVD was shown, saying it was too graphic.[1558]

3.1686 On 16 May 2011, CATE Gold said again that there was a need to get the prevention message into schools and tasked the 'Silver group' (CATE Pathways) with looking at it.[1559] It is impossible not to reflect that while discussions had increased, accompanying action was not entirely evident.

3.1687 In August 2011 it was noted at a CATE Pathways meeting that there had been a large increase in CATE referrals, an average of five per month, which was "*due to awareness.*"[1560] Referrals came mainly from schools.

3.1688 I do not consider it was helpful or correct to regard the increase as simply "*due to awareness*"; that tends to avoid questioning whether there was in fact an increase in CSE.

3.1689 I have seen documentary evidence indicating that, in November 2011, there was no CATE training being delivered in schools.[1561] The same document suggests that it was recognised within the Safeguarding team that there was a need to collectively focus on how to raise awareness in schools, "*especially in the light of the demise of Daphne*", which suggests to me that it was recognised that the loss of the Daphne project was likely to impact negatively upon awareness raising in schools.

2012 to Date

3.1690 The NewStart Review in 2013 identified education as "*a central theme for both young people and parents*".[1562] It was noted that time in school was seen as an opportunity to introduce information regarding CSE to schools as an integrated part of the PSHE programme and that schools have a key role in recognition and monitoring the safety and welfare of children.

3.1691 In 2013 a CATE Training Plan[1563] restated a desire to deliver CSE awareness training to local schools. The training was to be delivered by a CATE practitioner, with support from the Education Safeguarding Trainer. An email dated 2013 referenced the fact that "*a <u>small</u>*

1556 [redacted]
1557 [redacted]
1558 [redacted] pgs 51-52
1559 [redacted]
1560 [redacted]
1561 [redacted]
1562 [redacted] pg 36
1563 [redacted]

amount of money has been made available by the TWSCB to deliver CSE training to schools staff".[1564] (The underlining is mine).

3.1692 More positively, a CATE Pathways meeting on 4 October 2013 noted that PCSOs were working in schools,[1565] the PCSO being a position funded by both the Council and the PCC.[1566]

3.1693 Despite the suggestion that there was increased focus upon raising awareness within schools and a greater understanding of the CSE referral process, I have seen a number of documents where concerns have been raised about the awareness of CSE within schools and the training being delivered. An email in early 2015[1567] notes the need to:

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

3.1694 In January 2015, a college's request to the Council for CSE training was rebuffed on the basis that CATE practitioners had no capacity to run the sessions due to their increased workload.[1568]

3.1695 In May 2015, concerns were raised within the CATE Team after a discussion with a member of staff at a school who was "*unclear about the CATE service and the whole process in relation to CSE in Telford*".[1569] The fact that a senior member of staff at a local school was unclear about the CATE process after almost a decade of its existence is scarcely credible and speaks to failures in training.

3.1696 The response to these concerns was, in my view, surprising; it was said that the Council was looking at external funding to support training and awareness raising in schools, but "*the danger is always about opening floodgates…"*.[1570] The reference to 'floodgates' by raising awareness of CSE shows a regrettable focus on costs rather than outcomes for children; furthermore, there was extreme pressure on the CATE Team at this time so one would imagine every reason why external training should be sought. Nevertheless, the issue of capacity had not been resolved in July 2015 when there was an apparently serious suggestion that member of "*affected communities*" be called upon to deliver CSE training; which strikes me as ill thought out and even bizarre; but perhaps not so mystifying as the fact that just a year later, the LSCB dispensed with the services of its longstanding Training Coordinator.

1564 [redacted]
1565 [redacted]
1566 [redacted] pg 58
1567 [redacted]
1568 [redacted]
1569 [redacted]
1570 [redacted] pg 1

3.1697 The Inquiry has seen a further email dated May 2015 illustrating that the pressures on the CATE Team were exacerbated by the diversion from direct work with victims of CSE to training; in my judgment, still further reason to seek alternatives providers:

"*I am reluctant to agree to providing training as much as I think we should be part of this. There is no respite from cases coming in and the staff are already over capacity in my view. Training is a time consuming activity with preparation and delivery as well as the number of sessions that should be delivered throughout the schools in T&W. I have suggested this discussion is taken to senior managers to decide but the capacity issue is still relevant to the staff*."[1571]

3.1698 On a separate, but related point, it is clear that there remained misunderstanding about age thresholds for CATE (and indeed Safeguarding) support; the Inquiry heard the belief expressed that:

"[The] *CATE team do not accept referrals made about girls under the age of 14 years. These girls are referred back to the school to manage*"[1572]; and

"*… when we asked to put forward a referral to CATE,* [Name] *said that they told her she was too young at 12, which is concerning*".[1573]

3.1699 I note that this was at a period when the CATE Team was under pressure and had few staff.

3.1700 The CSE Task and Finish group met again on 28 July 2015.[1574] The relevant issues for the group were said, following a survey, to have been those identified at the last meeting: training, particularly in schools, and awareness raising amongst colleagues. The group also resolved to work with school governors to attempt to underline the importance of training in schools, as take-up had been poor – only three or four schools. It was further noted that capacity was an issue: it was suggested that members of affected communities could be prevailed upon to deliver training. It is difficult not to wonder what had happened as a result of the innumerable meetings reaching the same conclusion over the last decade.

3.1701 The LSCB agreed on 18 November 2015[1575] that "*ensuring that all schools are up-to-date and following training requirements in respect of CSE is a challenge"*. Further, "*keeping unwelcome visitors linked to CSE out of education facilities*" was a "*key challenge*" (the underlining is mine). Key challenge it may have been, but this issue was hardly new.

3.1702 In 2017, a Learning Community Trust (the "Trust") was created,[1576] incorporating seven local secondary and primary schools, including the ones about which the Inquiry has heard the most evidence. The Trust has since purchased a Service Level Agreement, designed to

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1571 [redacted]
1572 [redacted] pg 15
1573 [redacted] pg 23
1574 [redacted]
1575 [redacted]
1576 [redacted] pgs 2-3

provide support for safeguarding practices. This gives schools access to a 'hotline', from which they can gain immediate advice.[1577]

3.1703 Disappointingly, on 19 April 2018, the Exploitation Subgroup of the LSCB[1578] discussed CSE and again identified schools as being a gap in service provision. More positively, something appears to have been done relatively rapidly, in that on 4 June 2018 it was reported that a CSE education and awareness post had been created with funding from the PCC.[1579]

3.1704 In 2017, the Child Protection Online Monitoring System ("CPOMS")[1580] was introduced.[1581] I heard that it was seen as a move forward from the previous hard copy paper filing system, and that it enabled staff to log any incident including CSE concerns; and that by capturing concerns in this way schools were able build a picture of the safeguarding history of an individual.

3.1705 As I have noted elsewhere, WMP had no access to CPOMS. In terms of the Council's access to, or use of, CPOMS, this question was raised in the course of the Inquiry's disclosure requests, and the Inquiry was informed by the Council that the choice of recording system rests with each individual education setting and is not a local authority decision; the Council suggested that for schools to give it a right of access to CPOMS would mean the school was in breach of data protection duties[1582]. This seems unduly cautious on the Council's part. The Inquiry has not seen any evidence to suggest that intelligence captured by CPOMS which does not meet the threshold for a referral would be shared with the Council.

3.1706 I understand from the evidence that there is still work to do in terms of information sharing. I heard of frustration by head teachers who would not be told of a child being made subject to a child protection plan. I heard the topic was raised at LSCB meetings and, as a result, each school's DSL now works with the Council to access these records.[1583]

3.1707 When asked why schools did not pick up on CSE issues earlier; this sort of response from witnesses was typical:

"*I don't think it was anybody's major fault, nobody did anything deliberately wrong but we weren't, as a society, open to hearing children.*"[1584]

Conclusions

3.1708 The Council's responsibility to protect children in need and at risk of harm has endured throughout the period of my Terms of Reference.

3.1709 It is clear that head teachers in the three schools around Wellington were aware of children being exploited and that they shared information about this amongst themselves. It is also

1577 [redacted] pg 23
1578 [redacted]
1579 [redacted]
1580 [redacted] pg 5
1581 [redacted] pg 35
1582 [redacted]
1583 [redacted] pg 19
1584 [redacted] pg 26

clear that there was no understanding of what should be done with this information and no understanding in schools as to the proper referral pathway for victims of CSE, or children suspected of being at risk of exploitation. This is hardly surprising; as I have shown elsewhere, there was a reluctance on the part of Safeguarding to engage with CSE cases, and this is borne out in relation to schools by the evidence that "*the service wasn't there*".[1585]

3.1710 The evidence has further shown that in schools, as in Safeguarding, there was a reluctance to engage or report concerning activity unless there was "*proof*" (or even "*concrete proof*"[1586]). This was, in my judgment, an overly cautious approach; the nature of exploitation is such that child victims often do not perceive themselves to be victims. Additionally, there was a misapprehension about the circumstances in which disclosure could and should be made. The Inquiry heard directly that confidentiality was thought to override concerns about risk. School staff were afraid to make disclosures because they thought that to do so would be breaking the rules. I have made recommendations around information collection and information sharing training in schools as I regard this issue as pressing.

3.1711 In the particular case of one particular school, the Inquiry heard that attempts to raise concerns about the involvement of the Pakistani heritage cohort in CSE led to overt allegations of racism on the part of school staff from Council personnel; it is difficult to conceive of a more wrong-headed response or one more designed to discourage complaint.

3.1712 I have no doubt that the issues encountered when attempting to raise concerns led this school to move further away from the Council; seeking its child protection and grooming prevention training from outside the local area. It is a failing that at a time when such training was available from other local authorities that none was available in Telford. The evidence the Inquiry has heard of school staff rescuing children from a *"house of ill repute"* shows dedication and some bravery; but it was not, fundamentally, their job to do so. There should have been a safeguarding and almost certainly WMP response but, as I have noted, when staff tried to follow ordinary safeguarding referrals they were rebuffed and their concerns were dismissed.

3.1713 The evidence tends to suggest that official recognition of CSE – for example, the ACPC questionnaires – came after the Lowe family murders in August 2000. It is impossible not to consider whether that tragedy would have occurred if Lucy's school had been able to summon a proper multi-agency response which might have served to discourage those so blatantly subjected to CSE.

3.1714 It seems to me that the EWOs were a potentially very valuable resource who could provide an early indication as to which children may be at risk of CSE – attendance being an obvious indicator (see, for example, the case studies of Children A, B and G, as discussed in Chapter 5: The Policing of CSE in Telford). Nevertheless the persistent silo attitude of Safeguarding, and its reluctance to engage with non-social workers reduced the effectiveness of the system. I understand from the Council that the role of EWO still exists, based in the Attendance Support Team ("AST"); these posts are funded through Service Level

[1585] [redacted] pg 16
[1586] [redacted] pg 11

Agreements with some schools and most of those schools that have chosen not to enter into this arrangement employ their own officer to undertake school attendance related duties. The Inquiry was informed that the AST now has responsibility for all of the statutory duties that are traditionally associated with the Education Welfare Service, following the dissolution of the original Education Welfare Service in 2012, as part of a Council restructure. The current team includes five EWOs, who support schools and have other responsibilities; some of which include the statutory duties related to attendance.[1587] Given this information about the use by schools of independent, rather than Council, attendance monitoring services, all must be careful to ensure that the importance of attendance data is recognised and that schools share it appropriately and if necessary use it as a basis for referral.

3.1715 I do take the view that the inter-agency Training Coordinator worked hard to produce CSE modules for PSHE lessons and for pastoral staff in some local schools in the early 2000s, and that combined with some CATE-forerunner work this was a sensible effort at prevention. Of course, as I have noted elsewhere, the budget for training was relatively modest and for intervention was essentially non-existent at that time.

3.1716 The Inquiry heard that although there was some WMP and EWO presence at school gates, it appears this was ineffective to stop adult men coming onto school premises to collect children. This was still a problem ten years later; it is clear that no effective solution had been found. It is a statement of the obvious that this is wholly unsatisfactory, and that it is incumbent on all agencies to ensure that children are safe on school premises and around them. I have made a recommendation that all schools and colleges review site security annually.

3.1717 Despite these efforts, the evidence tends to suggest that obvious CSE indicators such as markedly changed behaviours; use of emergency contraception; absence; and teenage pregnancy often went unremarked by school staff. Victims of CSE were bullied by other children without enquiry from staff as to the underlying causes. Shockingly, the Inquiry heard that a head teacher's reaction to a child's pregnancy was simply to berate the child and exclude her from school – plainly exclusion from education merely serves to isolate a child victim and put them at even greater risk.

3.1718 Undoubtedly the situation improved when the CATE Team was formed, as it was prepared to act where Safeguarding had declined. I am disappointed though that at this time, in the early part of the 2000s, when the issue was more fully recognised, some schools were reluctant to accept exploitation PSHE input. To recognise and address a problem is not a reputational ill but a sign of effective child protection. Similarly, that the Chief Executive should decline to endorse use of a professionally produced training film because of his squeamishness about the content suggests in my view a warped sense of priorities. I am quite satisfied that the refusal to use this film and the demise of the Daphne project set back awareness-raising within schools materially.

3.1719 I accept the evidence that even in 2015, there was little capacity on the part of the Council to run training for schools; this is unsurprising, as at that time the CATE Team was in one of its regular troughs. This has consequences, as shown by the evidence that local school

[1587] [redacted]

staff were unclear about the CATE referral process after it had existed for almost ten years. It is basic, but school staff need to be trained to know how to help children who may be victims of exploitation, and if the CATE Team is unable to provide that training, then it is incumbent on the Council to provide a properly funded training post – not to scrabble around for cheap alternative solutions as it did in suggesting "*members of affected communities*" could deliver the training. The problem was discussed interminably and it seems no solution properly found.

3.1720 I note that so far as the merged Wellington schools are concerned, the evidence I have heard suggests that training is now regularly provided by the Council and school staff are focused on CSE. There is access to immediate safeguarding advice through a 'hotline' for local schools, as part of a Service Level Agreement.[1588] I understand from the Council that this hotline is believed to refer to a service provided by the Council, although funded by the partnership, where education settings can have access to the Education Safeguarding team for general advice and guidance.[1589] This is plainly a transformation; but I am compelled to note that like so much I have examined in the course of this Inquiry, the transformation is relatively recent. For too long schools in Telford were struggling with a problem they did not know how to deal with; with a Safeguarding department that gave the appearance of being dismissive; and with inadequate resources to train teachers or raise awareness in children.

Overall Conclusions

3.1721 It seems to me that, as per the November 2018 NWG review, the work of the CATE Team has always been particularly impressive, but it is necessary to be clear eyed about the circumstances in which it came into existence and did its work.

3.1721.1 From the 1990s, it was clear that there was a problem with CSE in Telford.

3.1721.2 It was also clear that information was coming from the community, from schools, and from youth workers; it was even reported in the local press.

3.1721.3 Such attempts as there were to address CSE were ad hoc groups or projects put together by concerned individuals, though none then worked directly with victims/survivors of CSE.

3.1721.4 Both the ACPC and LSCB procrastinated in terms of addressing any sort of response.

3.1721.5 The CATE project itself was another ground level scheme, conceived and staffed by individuals who had knowledge of the problem and who were unprepared simply to stand by.

3.1722 The understaffed and resource-poor Safeguarding system also showed a number of failures. Examples of this are as follows:

1588 [redacted] pg 23
1589 [redacted]

3.1722.1 It rejected referrals and refused to consider re-referrals of CSE cases from early intervention (both Clusters and later, CATE);

3.1722.2 It failed adequately to take into consideration or ignored obvious markers such as teenage pregnancy and missing; and

3.1722.3 It failed to consider the question of significant harm properly in CSE cases, particularly where parental support was available.

3.1723 In the result, the Safeguarding system quite simply failed to recognise that CSE was a child protection issue. If, as seems to be the case, this was because of a view that safeguarding was only appropriate when parents were failing to ensure their children's safety, that was in my view an unnecessarily narrow approach and a false reading of the statutory test.

3.1724 The initial form of CATE was ad hoc. Although it was suggested that it followed the Sheffield model of CSE provision, the reality was that it adopted *Working Together* terminology but without the crucial involvement of Safeguarding. The terms 'initial assessment' and 'strategy meeting' meant something different to CATE than they did in *Working Together*, or would have meant to a social worker. The initial assessments in CATE were risk assessments and the CATE strategy meetings were not the holistic assessments contemplated in *Working Together*. This was not a joined-up response.

3.1725 Further, there was no safeguarding model of CSE intervention; in those early days the CATE project (and later, team) were offering essentially a youth worker service – seeking to educate and change victims – rather than actively to safeguard them. The Inquiry has heard it described as a 'fix the child' rather than a 'fix the problem' approach. This is no criticism of the team members in those early days: that model of intervention was what they knew and, in the context of preparing victims for Chalice, was effective. It does underline, though, that CATE was not part of a holistic response to children at risk or in need.

3.1726 As I have noted in the case studies referred to herein and in other chapters of this Report, there were clear examples where section 47 procedures were not, but should have been, instigated.

3.1727 During the initial years, there was no attempt by the LSCB, by Safeguarding or by any politician to put the CATE project on a sound, sustainable financial footing. It was forced to borrow workers from Connexions with some cost to that service and at great personal cost to those workers, all of whom initially did demanding and emotionally draining work while trying to juggle responsibilities for other areas; the team reached an early low point in 2009, at the height of the Chalice investigation, when it amounted to a single individual, working alone and without supervision.

3.1728 While the CATE Team was, happily, taken under the wing of Safeguarding soon afterwards and the team was expanded and given senior social worker support, the Council itself had no long term plan for the team and intended its effective erasure. The consequence of the decision to remove a senior post in the 2012 restructure inevitably meant there would have been no CATE Team thereafter; the suggestion that the work be "*mainstreamed*" makes no sense without someone to pass on expertise unless the view was taken that the work required no training and that the experience accumulated over the past six years was

valueless. I consider it more likely that those responsible for planning structures simply had no familiarity with the CATE Team or the work that it did, and had not given it any thought.

3.1729 The move to Cohesion was a mistake; that was no surprise, it had not been planned. I have no doubt that on the evidence CATE was not housed within Safeguarding at that stage because of a desire to preserve Safeguarding's resources. CATE survived but was a one person team with a manager who had no experience of CSE. For the first time it had a base budget, though this was plainly inadequate. The team was short of people, resources, supervision and (notwithstanding the LSCB and its innumerable sub-committees) had no effective oversight. Once again, CATE was a youth worker response rather than a safeguarding response, an alternative provision rather than a complimentary one, and there was no clear pattern for why some children would be dealt with by CATE and others by Safeguarding.

3.1730 Despite the plain evidence that Chalice had not ended CSE in Telford, the Council's attempted 2014 restructure showed that it still regarded CATE experience as dispensable. Moreover, that the attempt was made to remove its senior, essentially founding, practitioner when that practitioner was absent – and the immediate reversal of the decision upon complaint, as in 2011/2012 - suggests a desire to make the decision quickly and sweep it away. That there apparently remains no documentary record of this proposed reorganisation shows that the Council had a tendency to keep significant changes closely guarded secrets, as had been the case with Family Connect in 2011/2012.

3.1731 While the demise of Cohesion afforded an opportunity for CATE to move to its natural home in Safeguarding without an admission that its placing had been a mistake, I consider the real impetus for the move – and the team's subsequent transformation into a well-resourced and supported unit – was likely the Scrutiny Review.

3.1732 I recognise that following CATE's rehoming in Safeguarding, the current CATE procedures – even if not crystallised in its Pathway – allow appropriate joint working and flexibility in response between CATE and Safeguarding.

3.1733 The Scrutiny Review made patent the concerns expressed privately about CATE workload, resourcing, and supervision. Most importantly it was a politician-led review. I am quite satisfied that it was this political intervention that made CATE whole and sustainable. The Inquiry has not seen or heard evidence of any other significant political intervention. Given that the problem had been apparent on the ground for over twenty years by the time of the review, this is certainly regrettable; and, as politicians, particularly local politicians, are also members of the public, it speaks at least initially of a societal reluctance within Telford to acknowledge CSE victims as anything other than badly behaved children on the margins of society.

3.1734 What is less obviously explicable by outdated attitudes is the fact that post-Chalice there was not more engagement with CSE. I do not underestimate the degree to which Local Government budgets were diminished in the second decade of this century, or the difficulties that this caused in terms of apportioning precious resources. The economist Galbraith said that "*politics is the art of choosing*…", and choices were made in respect of CATE: how it was funded, and where it sat, under administrations of varying political colours. Those choices very nearly led to its withering away in 2009, in 2012 and in 2014.

The choice was also made, again and again, from as early as 2000 until at least as late as 2015, not to seek the assistance of experienced voluntary or third sector bodies in the CSE response. The Inquiry has seen no evidence that those choices were made by politicians, and I do not suggest that it is practical for elected members to make every decision necessary in running a council. It is, however, the responsibility of the elected members, particularly the cabinet members, to give direction and to assert priorities; to determine what is essential and what may be foregone. I have seen in my review of the evidence no indication that a CSE response was ever regarded as an essential service. I consider that a glaring failure on the part of a generation of Telford's politicians.

3.1735 Why was engagement so lacking? It may be that CSE was seen as a reputational problem and indeed I have seen this concern noted in minutes of a Joint Exploitation meeting, in response to the negative publicity the issue had attracted locally.[1590] The Inquiry has heard evidence from witnesses who suspected this was the case, but none (unsurprisingly) from any who confessed to that view. I certainly saw signs of an instinctive defensiveness in the recorded responses of the LSCB to the commissioning of this Inquiry. Civic pride has value, but a repudiation of criticism or refusal to acknowledge problems for fear of reputational damage are gross failures of perspective.

3.1736 I acknowledge that when things have gone wrong around the safeguarding of a child, examining what went wrong can be an incredibly difficult and painful exercise. However, there is no room for corporate pride when the welfare and safety of a child is concerned. The importance of being able to reflect and understand what has gone wrong and to consider what lessons can be learnt cannot be overestimated. I have seen evidence of a long standing culture of resistance to ever admitting that provision was imperfect.

3.1737 A culture of learning must be embraced. I am not confident it currently exists. For example, the Council's Corporate Submission claims that it has been:

"… at the forefront of working to address CSE over a twenty year period... over that time innovative practice has been developed and the Council has always been open to challenge about how it has addressed CSE, learning lessons and acting upon them."[1591]

3.1738 I confess that I take the view that this approach is certainly not apparent in the reports, minutes, and audits provided, or from the information given by witnesses. There were processes of review in place, but the Council's Corporate Submission provides either no information or inconsistent information about exactly what changed as a result; it does not provide a narrative of success and failure, nor the journey the Council has been on, (alongside all other councils) to grow and develop the response to CSE. It does not explicitly evidence learning and development. This is not to undermine the hard work of all those on the front line, but instead it reflects that there was an absence of a learning culture when it comes to the response to CSE in Telford and Wrekin.

3.1739 The Munro report highlighted how important a culture of learning is in the effective safeguarding of children. Learning from successes, as well as accepting that errors are inevitable in the complex and uncertain world of safeguarding. These errors need to be

1590 [redacted] pg 5
1591 [redacted]

acknowledged, people must be able to discuss them, and they must be a springboard for development and growth. Without this, defensive cultures within organisations develop and there are less opportunities for learning.

3.1740 I detect that defensiveness as a core characteristic of the Council. It must henceforth work actively to promote a learning environment that recognises that the effective response to CSE is achieved through continuous assessment and development of the strategic and operational response: not only learning from and celebrating success, but also recognising errors and building consequential change.

3.1741 I have made a number of recommendations that seek to address the key issues explored in this chapter, which can be found at the beginning of this Report.

Victim/Survivor Voice

"I was only just 14 when this all began, I became friends with someone who was already involved within the circle. Truanted from school due to being bullied for the life I had found myself in, I lost me in my circle of friends. They started calling me names like 'Paki shagger'. At this point I turned to a new circle of friends that where outside the school, this then escalated into years of abuse that at the time I didn't realise was happening.

It started with what I thought were innocent nights at the local park or church yard, where me and my friend would meet with young Asian lads (not much older than us). They could drive so would take us places where we were coerced into giving them blow jobs in exchange for becoming their girlfriend.

This quickly escalated into being invited into shared accommodation, that several men lived in and paid towards the bills. Or family or friends fast food restaurants where we were at first plied with drugs, alcohol and food. When it came time to repay them for these gifts we were taken into a room one by one, sometimes together and repeatedly raped by the staff members of the fast food restaurant who smelled of stale body odour, bad breath, and stale fat.

Before I knew it my phone number was being sold to Asian men wanting sex who blackmailed me into this rape with threats about me and my family getting hurt if I didn't do things. They would turn up on my walk home from school, they would know personal information about me and my family and I would be forced to get in the car with them. To start with we just talked about life and went for a drive, a few weeks passed and they had given me money for top up for my phone, got me food, given me nice things and not asked for anything in return.

This if I look back was the point where things went wrong with my family and I hid everything from them more and more, this added distance between us and we drifted further apart.

These events went on for months them saying that he knew my mother and if I stopped then they would tell her I was a prostitute by choice. They didn't rape me every time we met, sometimes they would just bring me food and money and we just talked, on the times they did rape me they were always angry, I still don't know why.

When I eventually got out and home, I didn't tell anyone, I felt numb, at this point I didn't have any friends, it had been drummed into me that if I said anything about any of the events that happened to me that my mum and dad were going to get hurt. I continued meeting them and their friends through fear of what they would do to me and my family.

This went on for so long I don't remember when or how it changed, but we ended up at parties with more drugs and alcohol, sometimes I would not even know what I was doing and would get flash backs the next day of different men raping me.

Before I knew it I was sneaking out of the house in the middle of the night collected by him and dropped off at different houses and restaurants where he would collect money off people and I would be put in a room and told to make myself comfortable. Men would queue up in line to get on top of me and rape me with no protection. I was forced to attend parties and passed around many different men for sex, collecting money at the end of the night — trivial amounts of money at that, I found I drank more and took drugs to numb the feeling of what was happening.

I was shown a video while still at school about child prostitution/child exploitation and becoming dragged into things that young girls shouldn't be. It was a very new thing at the time. This made me feel sad. I needed help. I didn't fully understand the control these people had on me. I thought these people cared about me. I didn't want to believe it, that I had been sucked into that life."[1]

1 [redacted] pgs 1-5