



**Newcastle Safeguarding Children Board and
Newcastle Safeguarding Adults Board**

**Joint Serious Case Review Concerning Sexual
Exploitation of Children and Adults with Needs for
Care and Support in Newcastle-upon-Tyne**

Independent Report Author – David Spicer

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1. Introduction

This is a report of a Thematic Serious Case Review carried out jointly by Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board to consider and learn from sexual exploitation involving children and young adults in Newcastle.

It was decided to carry out the Review when there was increased awareness of the prevalence of sexual exploitation that had taken place and was continuing in the Newcastle area.

The decision was not taken as a result of any exposure of persistent disregard of whistle blowers' allegations or public concern which was ignored or any scandals uncovered by investigative journalism¹ that drove the need to carry out high profile reviews and inquiries in some other areas.

Early in 2013, briefings to the Newcastle Safeguarding Children Board included cases of child sexual exploitation occurring elsewhere, initiatives by the Children's Commissioner, the local Child Sexual Exploitation Action Plan and arrangements in place for prevention and the management of cases. A local profile of known cases confirmed previous judgments that child sexual exploitation was not a significant problem in Newcastle.

Continuing work to review the situation by public authorities and community and voluntary organisations confirmed previous assessments, that while individual cases were identified, there was not an extensive problem.

However, over Christmas 2013, a 21-year-old woman who has a learning disability began to speak to her social worker about experiences of sexual exploitation over a long period. With encouragement, support and great courage, in January 2014 she gave a statement to the police in which she detailed her abuse and concerns about other children and young people. She identified places to which she had been taken.

This account and other intelligence suggested the extent of sexual exploitation was greater than previously identified and required a strategic, well-resourced, victim focussed multi-agency response. Proposals were taken to the Northumbria Police Chief Officers' Team and to senior officers in partner agencies. A police-led multi-agency investigation, Operation Sanctuary, was launched in January 2014. Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board provided interagency strategic commitment and there was strong political support.

Operation Sanctuary led initially to arrests of over 30 men, accompanied by a publicity campaign. Two 19-year-old women in February 2014 reported to the

¹Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013: Alexis Jay OBE Rotherham Metropolitan Borough Council. 2014; Report of Inspection of Rotherham Metropolitan Borough Council: Louise Casey CB. House of Commons. 2015; Broken and Betrayed: The true story of the Rotherham abuse scandal by the woman who fought to expose it. Senior. Panmacmillan. 2016

police that they were victims of rape, sexual abuse and exploitation by a number of perpetrators over a period of years. Their accounts and subsequent inquiries confirmed that sexual exploitation was occurring in the Newcastle area on a much larger scale than previously recognised.

The victims of exploitation were, as in high-profile cases elsewhere, young children but were also children approaching adulthood and adults with vulnerabilities. A picture emerged that suggested that over a period of years some perpetrators had abused hundreds of victims, some over many years during childhood and early adulthood. The extent of targeting of adults with vulnerabilities appeared not to have been identified elsewhere in the country.

1.1 The Decision to Carry out a Joint Serious Case Review

In February 2014, Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board established a Joint Case Review Committee, the remit of which included considering from an inter-agency perspective, the progress of investigations and whether the criteria for carrying out statutory Reviews in relation to the child and adult victims were met.

The circumstances suggested that lessons would be learnt from examining the experiences of victims, the strategic arrangements and the effectiveness of the responses of agencies over the period that it was becoming apparent exploitation had taken place. The Safeguarding Boards encourage continuous learning and improvement across organisations² and a number of reviews of cases were carried out.

In September 2014, the Joint Case Review Committee recommended that the criteria for carrying out Serious Case Reviews and Safeguarding Adults Reviews were not then met and this was agreed by the Independent Chairs of the two Boards. Ofsted and the Department for Education were notified of the circumstances and regular updates provided. The National Panel of Independent Experts on Serious Case Reviews was also consulted. As investigations progressed, the Committee met on a 3-monthly basis to review the position.

The proactive approach of Operation Sanctuary and establishment of a Multi-Agency Sexual Exploitation Hub led to a rise in the number of cases and further clarity of the extent of exploitation. Having regard to the growing body of knowledge nationally, by May 2015, the Joint Case Review Committee concluded that unless the background was examined thoroughly in the context of current arrangements, it could be not be said definitively that there were no concerns about interagency working.

While some very effective practice had taken place, some victims experienced exploitation which had not been identified and had received no agency intervention; for others interventions had limited impact. It was likely that the criteria for carrying

² Chap. 4. Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. HM Government. 2015; Para. 14.138. Care and Support Statutory Guidance Issued under the Care Act 2014. Department of Health. 2014

out Reviews were met in a number of cases and it was recognised that Boards should consider conducting reviews on cases that did not strictly meet the criteria.

The Committee recommended to the Chairs of the Boards that Serious Case Reviews and Safeguarding Adult Reviews should be carried out.

The Chairs consulted senior officers in partner agencies and agreed that a more rigorous, comprehensive process of review with an independent element providing an overview of the circumstances should be carried out. There was an opportunity to review evolving knowledge of abuse of older children and vulnerable adults and working arrangements between adults' and children's services. A focus on improvements and good practice was likely to build on issues identified in other reviews and contribute to national learning.³

It was clear that carrying out a Serious Case Review would have significant time and resource implications. Advice was taken from Leading Counsel on the appropriate model to adopt to be consistent with statutory obligations and maximise learning.

It was not practical to carry out individual reviews in relation to the large number of victims being identified. The process needed to be proportionate to the scale and complexity of the issues and the learning that would be likely to arise. It was important to ensure that if every case was not to be reviewed, this should not suggest that the experiences of victims who were not included were less serious or deserving of consideration. The safety and welfare of all known victims were considered through interagency safeguarding processes.

Safeguarding Boards have a discretion within National Guidance⁴ concerning learning models to be employed. In October 2015, the Chairs decided that the Safeguarding Boards would jointly carry out a thematic Serious Case Review to look beyond specific incidents or individuals and focus on identifying, examining, and recording patterns or themes that are likely to apply in other circumstances.

The National Serious Case Review Panel, Ofsted, the Health and Care Quality Commission and National Health Service England were notified of the intention to carry out a Joint Serious Case Review on this basis.

1.2 Terminology

Throughout this Report, except where the context requires otherwise, the term:

- “the cases” is used to refer to the cases considered during the Review;
- “child” is used rather than “young person”. Many teenagers may prefer not to be described as children, but because child sexual exploitation involves the manipulation and gaining total control over those who cannot consent to sex

³ Chap. 4. Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. HM Government 2015

⁴ Chap. 4. Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. HM Government 2015; Para. 14. Care and Support Statutory Guidance Issued under the Care Act 2014 Department of Health 2014

either by virtue of age or capacity, it is important to refer to anyone under 18 as a child so their status is never overlooked.⁵

- “community and voluntary sector organisations” is used to refer to agencies and services sometimes referred to as the “Third Sector”;
- “Hub” is used to mean the Multiagency Sexual Exploitation Hub;
- “Newcastle” is used to mean Newcastle-upon-Tyne;
- “Newcastle Children’s Social Care” and “Newcastle Adults Social Care” means the statutory social care services provided for children and adults by Newcastle City Council;
- “NSCB” and “NSAB” mean Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board respectively;
- “Practitioners” means professionals involved in the cases and who attended the Learning Events;
- “the Newcastle Safeguarding Boards”, “the Safeguarding Boards” and “the Boards” means Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board;
- “the Panel” means the Joint Serious Case Review Panel.
- “the Review” is used to refer to the Joint Serious Case Review;
- “sexual exploitation” includes “child sexual exploitation” and “adult sexual exploitation”.
- “victim” is used to include “complainant” or “survivor”;
- “vulnerable adults” or “adults vulnerable to exploitation” are used, adopting the approach of the Law Commission and High Court, rather than terms used in recent legislation.⁶

⁵ Report of Inspection of Rotherham Metropolitan Borough Council: Louise Casey CB. House of Commons 2015.

⁶ Mental Capacity and Deprivation of Liberty. Law Commission Vulnerable Adults Bill proposal. 13th programme of Law Reform. 2016

2. The Review Process and Methodology

2.1 Governance

The Safeguarding Boards established a Joint Serious Case Review Panel of representatives of partner agencies to manage, oversee, scrutinise, challenge and quality assure the process. The Panel worked with and supported the Lead Reviewer, contributed to discussions, and ensured compliance with and approved any amendments to the Terms of Reference. It met regularly and reported progress to the Boards.

A Lead Officer was appointed to Chair the Panel and manage the process on behalf of the Boards, report to the Chairs and work closely with the Lead Reviewer.

The membership of the Panel was:

- Service Manager and Principal Social Worker, Children's Safeguarding Newcastle City Council (Chair and Lead Officer)
- Newcastle Safeguarding Adults Board Coordinator
- Newcastle Safeguarding Children Board Coordinator
- Assistant Director of Children's Social Care - Newcastle City Council
- Assistant Director Adult Social Care – Newcastle City Council
- Vulnerable Learners Manager and Safeguarding Lead for Schools
- Assistant Director Legal Services - Newcastle City Council
- Detective Chief Inspector - Northumbria Police
- Service Manager Safeguarding Adults - Newcastle City Council
- Executive Director of Nursing, Patient Safety and Quality – NHS Newcastle Gateshead Clinical Commissioning Group
- Nursing and Patient Services Director – The Newcastle upon Tyne Hospitals NHS Foundation Trust
- Safeguarding and Public Protection Manager - Northumberland Tyne and Wear NHS Foundation Trust
- Improvement Manager – Children and Family Court Advisory and Support Service

The Panel appointed additional members to represent community and voluntary organisations from:

- The Angelou Centre
- Newcastle Council for Voluntary Service

Guidance⁷ requires one or more appropriately qualified individuals to be appointed to lead the Review. After a procurement process, taking account of knowledge, skills, competence and availability, I was appointed as Lead Reviewer for the Review.

⁷ Checklist for Serious Case Reviews: Chap. 4. Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. HM Government 2015; Para. 14. Care and Support Statutory Guidance Issued under the Care Act 2014. Department of Health. 2014

My name is David Spicer. I am a Barrister and trustee and former chair of the British Association for the Study and Prevention of Child Abuse and Neglect. I am independent of the Safeguarding Boards and the organisations involved in the cases. Until 2009, I managed a legal service for a large local authority, specialising in responsibilities for child and adult welfare, and practised and advocated in public law jurisdictions for over 30 years. Since 2009, I have acted as the Independent Author of more than 30 Serious Case Review Overview Reports, Child Practice Review Reports and Multi-Agency Vulnerable Adult Review Reports in England and Wales and undertaken consultancy and training.

The National Panel of Independent Experts was provided with the name of the Lead Reviewer.

Due to the scale and complexity, an Independent Review Team was appointed to work with the Lead Reviewer. The five professional members have experience in practice and strategic roles in safeguarding adults and children from police, health, education, and social work perspectives and contributing to review processes.

A Joint Serious Case Review Business Group of four Panel members including the Lead Officer had responsibility for planning the Review and ensuring tasks were completed. The Group worked closely with the Lead Reviewer and the Independent Review Team.

This Review was carried out in as transparent a manner as possible, balancing areas of public interest.⁸ To prevent trials being undermined by material reaching the public domain or potential witnesses being influenced, careful attention was given to a court order restricting publicity. National Guidance informed the process⁹ and advice was taken from the police and Crown Prosecution Service.

This Review considered significant amounts of information, all of which cannot be included in a Report. Some sensitive issues if published would inappropriately alert perpetrators and allow them to consider how to avoid measures taken to prevent their offending. Assertions of fact and expressions of opinion in this Report are supported by a clear evidence base which is available to the Safeguarding Boards.

I agreed with the Chief Executive and the Director of People of Newcastle City Council that if the Review identified any individual at immediate risk that was not being addressed, I would refer the circumstances to them. There were no circumstances that required this to happen.

⁸ Chap. 4. Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. HM Government 2015

⁹ Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews: A Guide for the Police, Crown Prosecution Service and Local Safeguarding Children Boards; Association of Chief Police Officers and the Crown Prosecution Service. 2014

2.2 The Victims and the Eight Cases

Arrangements were made to invite contributions to the Review from individuals who have suffered sexual exploitation and their families and friends, if appropriate. Early discussions took place with them to agree how they might be involved and how their expectations could be managed appropriately and sensitively.¹⁰ A sheet was printed with information about the Review for professionals to use when speaking to children and adults who might be involved in the Review.

Contributions in the form of conversations were made by a number of victims and the mother of one victim. Some victims who gave evidence in criminal proceedings prepared Victim Impact Statements to be considered by the sentencing judge and gave permission for these to be considered within the Review. One victim prepared a short statement in addition. The victims' contributions included in this report appear in italicised type.

“I have sent you a short statement of facts I believe should be reported and would be grateful if you could pass this to the author. If subsequently this is not in the report then at least I have tried to show where things went wrong from my side. It seems the only chance of putting this out so I just needed to do that even though it's been very difficult to put down.”

During the conversations, I thanked the victims for meeting with me and, having included extracts within the Report, I have asked for them to be thanked again for their contributions, which have been invaluable. The feedback on the process from victims has been positive. They have appreciated being able to share their views and have them heard.

Agencies were asked to review their involvement in eight cases. These were selected from a large number to maximise learning, reflect the different circumstances in which victims had suffered sexual exploitation and include factors likely to be present in other cases. They included circumstances where:

- The sexual exploitation began and ceased when they were children;
- The sexual exploitation began when they were children and continued into adulthood;
- The sexual exploitation began after they became adults.

The cases included six victims who were white and two who were from different Black and Minority Ethnic backgrounds.

The time periods for the reviews of the cases were:

- For child victims, the start date was when it was known or suspected or is now known that the individual suffered, or was likely to suffer sexual exploitation;
- For adult victims, the start date was when they reached their 18th birthday.

¹⁰ Chap. 4. Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. HM Government 2015; Para. 14. Care and Support Statutory Guidance Issued under the Care Act 2014. Department of Health 2014

The end date for child and adult cases was 10 July 2015, when it was decided to carry out a Review. The total period covered 2007 to 2015. Action taken after this period in response to the Review and otherwise and strategic arrangements and national developments before and after this period were also considered.

The cases involved different models of sexual exploitation. All the victims suffered extreme, calculated abuse and were very damaged by their experiences. Following the first series of criminal trials Newcastle City Council Chief Executive paid tribute to all the victims, whether or not they were able to give evidence, for their courage in helping to put the people convicted behind bars:

“No-one should underestimate the trauma that these young women and children have gone through but undoubtedly they have helped to make our communities safer places by their actions.”

2.3 Participating Services

Services	Relevant Functions
Newcastle Adult Social Care	Newcastle City Council services supporting adults with care and support needs; carrying out and coordinating enquiries; taking action to safeguard vulnerable adults.
Newcastle Children's Social Care	Newcastle City Council services for children in need of services; carrying out and coordinating enquiries, taking action to safeguard children and caring for children looked after by the Council.
Newcastle Environmental Health and Pest Control	Newcastle City Council services; standards of premises, food hygiene and safety, pest control.
Newcastle Housing Advice Centre	Newcastle City Council advice, assistance services; housing, housing benefits and homelessness.
Newcastle Legal Services	Newcastle City Council in-house legal service for the Council and Service Departments; specialist advice representation for safeguarding vulnerable children and adults.
Newcastle Schools and Learning	Newcastle City Council services; information, advice on education and support for children, young people and their families, school attendance, support and training for school and colleges on safeguarding.
Newcastle Youth Offending Team	Newcastle City Council service working with representatives from range of services responding to needs of young offenders.
Your Homes Newcastle Limited	Private company controlled by Newcastle City Council providing, managing council housing and housing services for tenants on behalf of the Council.
Durham Children's Social Care	Durham County Council services for children in need; carrying out and coordinating enquiries, taking action to safeguard children; caring for children looked after by the Council.

Gateshead Adult Social Care	Gateshead Council services supporting adults with care and support needs; carrying out and coordinating enquiries; taking action to safeguard vulnerable adults.
Northumberland Children's Social Care and Youth Offending Team	Northumberland County Council services for children in need; carrying out and coordinating enquiries, taking action to safeguard children; caring for children looked after by the Council; responding to needs of young offenders.
South Tyneside Children's Social Care,	South Tyneside Council services for children in need; carrying out and coordinating enquiries, taking action to safeguard children; caring for children looked after by the Council.
Stockton-on-Tees Children's Social Care	Stockton-on-Tees Borough Council services for children in need; carrying out and coordinating enquiries, taking action to safeguard children; caring for children looked after by the Council. Statutory social care services provided for children.

These local authorities have statutory duties to establish interagency Safeguarding Boards. They must co-operate with and lead partner agencies to take action to safeguard and promote the welfare of children in need of services and adults in need of care and support, who are experiencing, or are at risk of, abuse or neglect from which they are unable to protect themselves. They must carry out all functions having regard to the need to safeguard and promote the welfare of children.

NHS Newcastle Gateshead Clinical Commissioning Group	Commissions most hospital and community NHS services in Newcastle, including General Practice, and health services to ensure vulnerable children and adults are safeguarded.
Northumberland Tyne and Wear NHS Foundation Trust	Delivers a range of mental health, learning disability and neurological care services across North East England for children and adults.
Newcastle upon Tyne Hospitals NHS Foundation Trust	Delivers specialist acute healthcare services and care to patients from across the country; community services including school health; sexual health services and a range of clinics and outreach services.
Northumbria Police Force	Delivers police services to 1.5 million people from the Scottish border to County Durham and the Pennines to the North East Coast. Responsibilities include prevention and investigation of suspected offences and taking action to safeguard vulnerable children and adults.

These agencies are statutory partners of Newcastle City Council. They must¹¹ carry out all functions having regard to the need to safeguard and promote the welfare of children and cooperate with the Council, each other and other partners

¹¹ Children Act 2004; Care Act 2014

to safeguard children and adults with needs for care and support and ensure inter-agency safeguarding frameworks operate effectively.

CPS North East	Independent Crown Prosecution Service Team for North East Region including Newcastle. Decides on sufficiency of evidence, the public interest and charges in serious/complex cases investigated by police; advises during investigations; prepares and presents cases at court; provides information, assistance, support to victims and prosecution witnesses.
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The Children and Family Court Advisory and Support Service (Cafcass)	Appoints Children's Guardians to represent children in family courts to ensure their voices are heard and decisions are taken in their best interests.
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UK Visas and Immigration	Part of the Home Office; responsibilities include considering and deciding whether foreign nationals may remain in the UK.
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Aycliffe Secure Centre	Durham County Council secure children's home for children the aged 10 to 18 years.
Clare Lodge Secure Children's Home	National provider of secure accommodation for girls aged 10 to 17 years; programmes of intervention and protection.
Keys Limited, Highcroft	Private company providing children's homes/schools and support services including therapy, fostering, education, training and development for children and young people.
Kyloe House Secure Children's Home	Northumberland County Council secure children's home offering group living.
Radical Services	Provides family style homes; care programmes for children and young people experiencing family or placement breakdown or other significant interruptions in their lives.
Right-Trak Limited	Private company providing residential homes in Newcastle for children and young people with emotional and/or behaviour difficulties.
St Cuthbert's Care	Registered charity providing foster homes and residential homes and services to improve the lives of vulnerable young people aged 7 to 17 years.

The establishment and management of residential homes for children is governed by statutory regulation. Only children placed in accommodation registered as secure may have their liberty restricted and the terms of registration may impact on facilities and arrangements. Care and control of individual children are determined by arrangements made with placing authorities. Homes for children are registered, monitored and inspected by Ofsted and, if individuals over 18 years are accommodated, by the Care Quality Commission.

Spark of Genius	National provider of education, autism services, residential care and community support for children and post 16 young people. Registered with Care Inspectorate, national regulator for care services in Scotland and Education Scotland.
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SWIIS Foster Care Limited	Private company providing foster homes for local authorities and support, training and guidance to foster carers.
Team Fostering	Independent not for profit fostering agency that recruits, trains, assesses and supports foster carers for children who are looked after by Local Authorities.

Agencies providing fostering services are registered, monitored and inspected by Ofsted.

BAB Accommodation Ltd	Private company providing supported living accommodation for young people 16 years and over.
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Careline Lifestyles	Independent provider of specialist care and support for people with mental health needs, acquired brain injuries and complex learning or physical disabilities.
Coquet Trust	Registered charity providing support in the home and community for people with learning disabilities.
New Key Support, KPW Newkey Ltd	Private company providing supported living accommodation for people with physical disabilities, mental health and substance misuse, problems, autism or learning difficulties.

These agencies are registered and regulated by the Care Quality Commission.

Angelou Centre	Registered charity offering holistic services for Black and Minority Ethnic women across the North East.
Barnardo's	National registered charity offering services to care for and support vulnerable children and young people.
National Youth Advocacy Service (NYAS)	National registered charity providing information, advice, advocacy and legal representation for children, young people and vulnerable adults.
National Society for the Prevention of Cruelty to Children (NSPCC)	National registered charity providing direct services, advice, consultancy, training, research, campaigning for children; statutory power to take court proceedings.
Safeguarding Children at Risk, Prevention and Action (SCARPA)	Registered charity The Children's Society Programme of targeted support to young people who go missing or are at risk of sexual exploitation.
Streetwise	Registered charity offering confidential advice and support for children and young people aged 11-25 years by referral or walk-in.
Your Voice Counts	Registered charity providing advocacy services; support for self-advocacy and user led groups; runs "drop in" sessions offering help with and awareness raising on a range of issues in local communities.

These agencies' functions are determined by their constitutional documents. They may have specific duties arising from commissioning or grant conditions.

Five Newcastle schools, attended by pupils whose cases were considered, participated in the Review. The Governing Bodies have statutory duties¹² to ensure that their functions relating to the conduct of the school are exercised with a view to safeguarding and promoting the welfare of pupils.

2.4 Timelines and Timeline Reports

Agencies that had involvement with the cases were asked to provide Timelines of their involvement and analytical reports, prepared by senior personnel who had no direct involvement with the cases. Timelines rather than chronologies were provided to emphasise the need not to be drawn into detail that might otherwise be required for a review of a single case.

Report authors were encouraged to involve practitioners to clarify uncertainties and assist identifying themes, why events occurred as they did, good practice and lessons that might lead to better outcomes. They were asked to identify changes that have taken place since the cases arose.

Forty-three agencies were involved in the Review and 113 reports were produced.

2.5 The Learning Events

The report authors were invited to Learning Events to present their information and collectively consider lessons to be taken forward. After victims, the most fertile source of information and opinion is the staff who were involved. Consistent with guidance¹³ Practitioners involved in each case were invited to Learning Events to collectively review and discuss their involvement, that of other agencies and consider what happened and why and what might have led to better outcomes. Events began with a pen picture of the victim whose case was considered.

Reviews that lead to changes in agency behaviours are carried out in a “no blame culture”¹⁴ in which participants do not fear being blamed for actions taken in good faith. This Review was intended to be a trusted and safe experience to encourage honesty and transparency to identify key learning and obtain maximum benefit.¹⁵ The participants consistently evaluated the Events very positively.

158 professionals from 43 agencies attended 16 Learning Events organised over 12 months. There was widespread interest in and support for the Review.

2.6 Acting on Learning During the Review

Victims likely to give evidence were not approached until the criminal trials were completed. Unavoidably some trials were postponed, leading to a long period

¹² s175 Education Act 2002; Keeping children safe in education: Statutory guidance for schools and colleges.

¹³ Chap. 4. Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. HM Government 2015; Para. 14. Care and Support Statutory Guidance Issued under the Care Act 2014. Department of Health 2014

¹⁴ Domestic Violence Fatality Reviews: From a Culture of Blame to a Culture of Safety: Websdale, Town, Johnson. Juvenile and Family Court Journal. 1999

¹⁵ Protecting Children in Wales: Child Practice Reviews: Guide for Organising and Facilitating Learning Events. Welsh Government. 2012

before the Review could be completed. Measures were put in place to ensure learning, dissemination and improvements were not delayed.¹⁶ Progress was monitored centrally and arrangements made to engage with regional and national processes to make them aware of significant issues.

Consequently, most of the local changes described in this Report were made either before the Review began or were implemented during the Review or arrangements are in place to implement them. It is unnecessary to make recommendations in respect of all these issues but it is important for the Boards to ensure that changes, whether or not addressed in recommendations, are sustained and have the intended impact.

Recommendation 1.1

I recommend that:

Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should make arrangements to review the progress and impact of the actions taken and intended to be taken as a result of carrying out the Joint Serious Case Review.

The recommendations I have made concern some national issues.

The recommendations are set out adjacent to the text from which they arise and are listed in Section 15 with references to the Section and page in which they appear, distinguishing local and national recommendations.

2.7 Additional Information

The Review considered what was known and understood about sexual exploitation by agencies and by Safeguarding Boards, the responses, published reviews and relevant research. Agencies were asked to follow up issues and provide information. Meetings were held with agency representatives and staff groups to explore specific areas and agencies arranged meetings of staff, whether or not involved in the cases, to consider what might make a difference.

The Review was inclusive. Numerous conversations and a number of meetings took place with agencies or with individuals who had no or limited involvement with the individual cases but, because of legitimate interests, it was important they were aware of the process and had the opportunity to contribute if they wished. These included:

- Rt Hon Nick Brown MP
- Catherine McKinnell MP
- Chi Onwurah MP

¹⁶ Checklist for Serious Case Reviews: Chap. 4. Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. HM Government 2015; Para. 14. Care and Support Statutory Guidance Issued under the Care Act 2014. Department of Health 2014

- Dame Vera Baird QC, Police and Crime Commissioner
- Colin Morris, Chair of Newcastle Safeguarding Children Board
- Vida Morris, Chair of Newcastle Safeguarding Adults Board
- Pat Ritchie, Chief Executive Officer, Newcastle City Council
- Ewen Weir, Director of People, Newcastle City Council
- Karen Simmons, Assistant Director of Children's Social Care
- Alison McDowell, Assistant Director of Adult Social Care
- Councillor Nick Forbes, Leader of Newcastle City Council
- Councillor Anita Lower, Leader of Opposition, Newcastle City Council
- Councillor Joanne Kingsland, previous Cabinet Member for Children and Young People
- Councillor Nora Casey, Cabinet Member for Children and Young People
- Councillor Karen Kilgour, Cabinet Member for Adult Care and Health
- Councillor Habib Rahman
- Councillor Dipu Ahad
- A foster and adult carer
- Her Honour Judge Rachel Hudson, Designated Family Judge for Northumbria and North Durham
- Her Honour Judge Judy Moir, Lead Court of Protection Judge
- Her Honour Judge Penelope Moreland, Crown Court Judge

Conversations also took place with a representative of The Children's Society and Chief Officers and senior managers in Streetwise and Changing Lives, both of which provided reports covering a number of specific areas.

2.8 Perpetrators' Contributions

Following conviction and imprisonment, a number of Perpetrators' were asked through their Offender Managers whether they were prepared to contribute.

One agreed but declined when a pre-arranged visit to the prison was made.

Another did meet with the Lead Officer and me at the prison in which he is serving a lengthy sentence. His understanding of English was sufficient to have a conversation. He used the time to protest his innocence and maintain that witnesses were paid to lie by the police and the government who with the judge conspired against him.

Nevertheless, some attitudes which he shared were relevant to the Review and are included during the discussion about Perpetrators in Section 6.

3. Summary of Thematic Findings

Some findings from the Review confirm national research and lessons from other reviews. Others relate directly to sexual exploitation as it has occurred in Newcastle.

In early 2014, when a number of victims with growing understanding chose to speak to the police and other professionals about their suffering and the abuse of others, the interagency response was swift, determined and committed. It led to disruption, prosecution and conviction of significant numbers of perpetrators and lengthy prison sentences. Large numbers of victims have been identified, supported and protected. The high quality of services has attracted independent national recognition.

Until early 2014, despite interagency arrangements in place to assess the prevalence of sexual exploitation in Newcastle, this was not fully understood.

Prior to 2014 individual cases received committed and persistent interagency attention to support and address behaviour and the safety and welfare needs of victims. Links between suspected cases were identified, but this had limited impact because it did not involve consistent action to investigate, prosecute or disrupt perpetrators.

This was because of reliance on requiring complaints from victims who were likely to co-operate and be able to give coherent and clear evidence in criminal trials.

There were some weaknesses in practice, familiar from other reviews, and in arrangements for accessing specialist advice and services for victims. While important and relevant for safeguarding generally, if these had been addressed earlier, outcomes for victims would not necessarily have improved unless comprehensive action had also been taken against perpetrators.

When addressing victims' safety and welfare, there is a need to focus on action against perpetrators through effective criminal investigation and prosecution, civil processes and disruption tactics, relying on victims' testimonies only where this is unavoidable due to lack of other evidence.

Despite comprehensive action to disrupt and prosecute perpetrators and the publicity that this has attracted, sexual exploitation continues. Perpetrators show remarkable persistence over long periods in targeting and grooming victims, undeterred by involvement of the police and other agencies.¹⁷ The Review was unable to gain a true understanding of the offending through engagement with perpetrators. This requires further local and national attention.

Information available about likely profiles of perpetrators and what drives their activities, including the extent to which cultural values and attitudes are relevant is

¹⁷Sentencing remarks by HHJ Moreland. Newcastle Crown Court. September 2017

very limited. There is an urgent need for guidance to robustly address these issues.

Sexual exploitation of boys and men is complex and hidden with different models to those identified with female victims. The low incidence of identified cases is likely to be a significant under-representation of the abuse occurring.

In Newcastle, decisions about taking action were not influenced by lack of concern or interest, misplaced fears about political correctness or fear of being seen as racist. Neither was there any evidence of ineffective leadership or inappropriate interference by senior officials or political leaders to prevent action being taken that have been a feature of reviews elsewhere.

Nor is there any evidence that any professional, individual, member of the public, politician or agency attempted to alert the authorities or complain about lack of proactivity or attention being given to addressing large scale sexual exploitation.

Understanding the prevalence of sexual exploitation requires assuming it is taking place and adopting a pro-active approach to look for it, recognising that the most reliable source of information is from victims and those targeted.

The most effective way to address sexual exploitation and safeguard and promote the welfare of victims is to resource multi-agency teams, co-located in the areas in which sexual exploitation takes place, prioritising bespoke victim support and including robust investigation, prosecution and disruption of perpetrators.

The successful, flexible, collaborative and innovative working in Newcastle since 2013 has improved morale and commitment beyond the specific area of service. Relationships between professionals, agencies and different areas of service have improved with a corresponding rise in quality of outcomes for victims.

Effective safeguarding is a collective responsibility and requires a culture of robust interagency and professional challenge of practice and strategy.

Sexual exploitation is not restricted to child victims; vulnerability is not determined by age and it is likely that extensive abuse of vulnerable adults is taking place across the country unrecognised.

The national framework of legislation and guidance for safeguarding adults from sexual exploitation requires urgent review to take account of the growing knowledge of sexual exploitation.

The early development of collaborative planning and arrangements for joint working between Newcastle City Council Children's and Adults social care services and engagement of partner agencies developed over the period reviewed and are models of good practice

Checklists and tools are helpful to identify actual or potential victims but all children and vulnerable adults are at risk; some will not fit the profile and others will do so

but will never be exploited. A particular feature of a number of victims was early history of bereavement or loss which had not been addressed effectively.

Thoroughly researching history from wherever information is held is an essential precondition to forming sound judgments and making effective plans. The impact of lack of history must be considered within assessments.

All the areas of local practice and interagency working that would have benefited from attention during the Review period had either been addressed before the Review began or have been addressed during the Review or there are clear arrangements in place to ensure they are addressed.

The success in Newcastle has depended on flexible and testing interpretations of legislation and processes. Legislation and guidance will never keep up with the changing nature of risks and effective safeguarding depends on adopting an imaginative and creative approach, working closely with proactive, specialist lawyers to explore all options and expose weaknesses.

The framework for addressing sexual exploitation has been subject to piecemeal development and reforms. There is a need for a national review and debate on what is required and to ensure reforms are effectively and consistently implemented.

The early identification of victims or potential victims or activities of perpetrators depends on alert universal services, in particular education, health and community services.

Prevention also depends on awareness and reporting by the public and sophisticated education and awareness programmes which engage with all communities.

Victims are very likely to attend sexual health services or walk-in community support services while being groomed and when they are being exploited. The current approach to and principles applied to confidentiality and assessment of capacity to consent to advice and sexual acts means identifying victims or potential victims is extremely difficult. Unless there is a change, which requires a national debate, sexual exploitation is not likely to be prevented and early identification will remain difficult.

Sexual exploitation is a traumatic event and therefore the use of a trauma informed approach to recognise and address the impact on victims and their families is critical.

Victims require long term support to enable them to recover from trauma and recognise the reality of the abuse they have suffered, acquire the confidence to sever connections with perpetrators, cope with the impact of criminal justice processes and to live a full a life as possible. Child victims are likely to require continuing services during adulthood.

Among the matters that require attention is the detrimental impact that sexual exploitation has on the ability to form trusting relationships and to parent children.

There are similarities between the development of understanding and the responses to domestic abuse and modern slavery and therefore common areas for learning.

Despite comprehensive arrangements to provide support, appearing as a witness in a criminal trial continues to be an abusive and destructive experience for victims which deters potential witnesses from giving evidence.

One community voluntary organisation was unable to play a full part in the Review because records had been destroyed. Consequently, the records will not be available to inform responses in individual cases or for individuals who wish to access their records. Interagency procedures and commissioning should address retention of records to include agencies to whom statutory requirements do not apply.

Sexual exploitation took place in commercial premises and privately rented premises. Social housing tenants have access to support if concerned about activities of other tenants. Consideration needs to be given as to whether landlords' awareness and responsibility for what occurs in privately rented premises and support for their tenants can be increased.

The processes for obtaining authority to restrict the liberty of suspected child victims is inflexible and costly. Consideration needs to be given to allowing placement in semi-secure accommodation which will satisfy the requirements of Article 5 European Convention on Human Rights and Fundamental Freedoms and, for adults and children, not involving huge costs.

The current national scheme providing for compensation to be paid to persons who suffer injuries as victims of violent crime discriminates particularly unfairly against victims of sexual exploitation whose involvement in other criminal activities may be the result of abuse they have suffered but which may disqualify them from receiving compensation for the persistent rapes, serious sexual assaults and ill-treatment they have experienced.

4. Sexual Exploitation – The Complexity

4.1 What is Sexual Exploitation?

In March 2015, the Government indicated the intention for the first time to provide a definition of child sexual exploitation¹⁸ and, in February 2017, published Advice including a definition¹⁹ emphasising that child sexual exploitation is a complex form of abuse which can be difficult to identify and assess:

“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.”

This and previous definitions have not described the sexual activity that actually takes place. Practice suffers from a lack of vocabulary to properly describe what needs to be clearly understood if enquiries, investigations and conversations are to be carried out with a common understanding.

The Government has asserted that:

“There is no culture in which sexual abuse is not a serious crime.”²⁰

However, what is considered abusive might be affected by cultural and legal issues.

Victims, family members, the public, professionals and perpetrators may have different understandings of the terminology used. In some cultures, anything other than vaginal sexual intercourse, for example anal intercourse or oral sex, is not considered to be a sexual act.

The age of consent to sexual activity (not universally defined) varies significantly in different countries; in some, there is no lower age for consent to sexual activity; in some, it is permitted to marry a child under 10 years of age. The age of consent to sexual acts varies across European countries.²¹ In some States of the United States the age below which a child cannot marry with parental or judicial approval is not specified, allowing some children as young 12 years old to be married.

Sexual exploitation may involve horrific acts amounting to persistent inhuman and degrading treatment which most people are likely to consider depraved and not

¹⁸ Para 48. Tackling Child Sexual Exploitation. HM Government. March 2015

¹⁹ Advice, Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. Department for Education. February 2017

²⁰ Changing the Culture of Denial: Page 4. Tackling Child Sexual Exploitation. HM Government. March 2015

²¹ United Nations Committee on the Elimination of Discrimination against Women and the Committee on the Rights of the Child Recommendations on minimum age of marriage laws around the world. 2013

“normal” sexual activity. Victims may be repeatedly raped, forced to have sex, oral and vaginal simultaneously with different men, assaulted while under the influence of drugs or alcohol or while unconscious or asleep and usually contains elements of coercion and control. They may be trafficked locally or to other towns or cities. The arrangements might be well organised or ad hoc sessions at a variety of venues. Much of the detail has only become apparent from accounts given by victims in criminal proceedings.

A Report²² in 2013 described the abuse of Muslim girls;

“Offending behaviour mostly involved men operating in groups . . . The victim was being passed around and prostituted amongst many other men. Our research also showed that complex grooming ‘hierarchies’ were at play. The physical abuse included oral, anal and vaginal rape; role play; insertion of objects into the vagina; severe beatings; burning with cigarettes; tying down; enacting rape that included ripping clothes off and sexual activity over the webcam.”

There is a danger that unless the horror of what is experienced is fully understood, the need to act urgently on suspicions will not be appreciated.

“I never had sex when I was sober.”

“I saw her raped when she was unconscious.”

“I wanted to leave. I was given drink. I kept saying no and fighting them off. I was very tired and fell asleep. When I woke, I had been raped.”

“When I was asleep I was raped.”

“They gave it to the girls – M-Cat was cheap, makes you like a zombie and wanting to keep going. It’s addictive. It makes it easier for them to get what they want.”

“When I was out of it they could do anything they wanted to me.”

Early lack of understanding across the country contributed to victims being regarded as promiscuous, choosing to be involved, being described as having a sexual relationship, as being involved in underage sex, having a boyfriend or partner or being seduced and attending parties, all of which inhibited effective safeguarding action.

The language used when reporting the outcome of trials often perpetuates misunderstandings. Media reports of the Newcastle trials included reference to victims being given drugs and alcohol “in return for sex”, whereas the drugs were given in order to encourage dependence, incapacitate victims and remove any ability to choose.

²²The UK Muslim Women’s Network Report on Child Sexual Exploitation. September 2013. Para 11.15. Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013) August 2014

There is no national definition of sexual exploitation of adults in legislation or government guidance or advice. This is likely to contribute to a lack of public understanding, being informed largely by models of child sexual exploitation, and a reluctance of adult victims to speak out because they may think it only happens to children.

In 2015, Newcastle Safeguarding Boards worked together to develop a definition, included in their joint Sexual Exploitation Strategy, which states that sexual exploitation can affect people throughout their lives and is:

“Someone taking advantage of you sexually, for their own benefit. Through threats, bribes, violence, humiliation, or by telling you that they love you, they will have the power to get you to do sexual things for their own or other people’s benefit or enjoyment (including: touching or kissing private parts, sex or taking sexual photos.)”

Training across agencies in Newcastle does make clear the nature of the abusive experiences.

4.2 Why is Tackling Sexual Exploitation So Difficult?

Nationally practitioners have been shocked that, despite elaborate safeguarding procedures and processes, some of their clients may well have suffered from unrecognised sexual exploitation. Research and government guidance has highlighted the difficulties in recognising and addressing it.

Child and adult protection systems have developed primarily to address abuse and neglect in families²³ or caring environments and do not facilitate a timely response in the detection of victims and perpetrators of sexual exploitation.²⁴ In the absence of concerns, there was little scope for proactively looking for abuse, whereas any child, in any community, may be vulnerable to sexual exploitation and all practitioners should be open to the possibility that the children or adults they work with might be affected.²⁵

While abuse of young children was well understood, it was generally thought that vulnerability reduced as children grow older. In 2011 an Ofsted thematic report²⁶ drawing on serious case reviews across the country indicated that in some respects, rather than diminish, the risks increase as young people approach and enter adulthood.

²³ Supporting parents of sexually exploited young people: An evidence review. Centre of Expertise on child sexual abuse. September 2017

²⁴ The Brooke Serious Case Review into Child Sexual Exploitation: Bristol Safeguarding Children Board 2016

²⁵ Advice, Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. Department for Education. February 2017

²⁶ Ages of concern: learning lessons from serious case reviews. A thematic report of Ofsted’s evaluation of serious case reviews from 1 April 2007 to 31 March 2011. Ofsted. October 2011

In 2017, Government Advice listed factors that might suggest vulnerability to sexual exploitation but acknowledged that research²⁷ indicates not all children and young people with vulnerabilities will experience child sexual exploitation and it can occur without any apparent vulnerabilities being present.²⁸ This is confirmed by the experience in Newcastle. Tools developed in England and Wales may be less appropriate for boys, younger children and disabled children.²⁹

Sexual exploitation occurs in locations not usually frequented by safeguarding professionals and victims may not attract concerns of welfare agencies for any other reason. Indicators can be mistaken for normal adolescent behaviours. The abuse is hidden. Sophisticated grooming means victims may not recognise they are being abused and believe they are in control, in healthy consensual relationships. Apparent close relationships may develop to involve intimidation, threats and coercion.

“I didn’t think what was happening was wrong. I thought they were my friends. They bought me drink and drugs. I thought it was ok because of my family.”

“Then it became more sinister. Different. There were parties with men a lot older. 30/40, when previously 20/21.”

They knew that they had us”.

“They are very skilled at who they target.”

“Judges, social workers - get the police involved. They need to know how hard it is to get out of this.”

“I did not realise what was happening. The men treated me nicely but not everyone else. Some men were horrible. They left their countries in lorries – they’d done bad things - they have done bad things elsewhere in other countries – they said they had done bad things.”

“I didn’t think it was out of the ordinary. We stayed there for days. My Dad used to worry. I said I was just sleeping over. I didn’t think anything bad was going on.

I didn’t tell my friends I had been raped. I didn’t think they would believe me. They thought I wanted to go with him. It was on my birthday. I thought no-one would believe me.”

Potential victims may not appear vulnerable but something may happen - a change of school, lack of friends, bereavement or difficulties at home that creates vulnerability.

²⁷ Child Sexual Exploitation: Understanding risk and vulnerability. Brown et al. Early Intervention Foundation. London. 2016

²⁸ Advice: Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. Department for Education. February 2017

²⁹ The use of tools and checklists to assess risk of child sexual exploitation. An exploratory study. Brown et al. Coventry University. Centre of expertise on child sexual abuse. October 2017

“I had a horrific time at school. I was bullied. I had no help with it. I have had mental illness since I was 11 or 12. Severe depression. If this hadn’t happened I don’t think the exploitation would have happened.”

“I had no attention at school and then suddenly I got attention from everyone. Sexual exploitation comes from wanting attention and affection.”

“I had not seen my father for a very long time and I had to act as if he was my Dad. I couldn’t. My parents started arguing over anything and everything – all the time.”

“I grew up quickly. I looked older than I was and acted older. It’s difficult if you grow up too quickly.”

“I suffered a significant early bereavement. I was really down and started drinking a lot of alcohol from when I was 14 years old”.

“I was sexually abused as a child and there was domestic abuse at home. I began running away when I was 13 years old.”

Victims may have mild cognitive difficulties that do not impact significantly on ability to cope with education or functioning as an adult. However, involvement with perpetrators, use of drugs and alcohol and the abuse itself may increase vulnerability.

Perpetrators demand extreme loyalties and create dependence so victims maintain links even after attempts to protect them and resent inquiry by agencies, actively mislead or avoid professional contacts. Victims may, while needing protection themselves, become involved in recruiting other victims and facilitating abuse. They will have been separated from friends and family and peer groups so that offering alternatives that do not leave them isolated may be difficult.

The application of the law and professional standards of practice relating to consent, capacity and the right to choose is complicated and uncertain. The presence of some form of exchange or benefit complicates assessments. Working with challenging adolescents and adults requires particular skills. Lack of progress may be frustrating and time limited interventions may not have a significant impact. Progress might be limited to keeping a victim as safe as possible while continuing to be abused.

Bad experiences of the criminal justice system deter victims from coming forward or persisting with complaints. Perpetrators will adopt cruel tactics and, being aware of agencies’ processes, become skilled at undermining attempts to safeguard victims.

“I was too scared to tell the police and the social worker rang on my behalf.”

“I was frightened of being killed and the children being hurt.”

Perpetrators display an arrogance and persistence that suggests power.

Criminal and civil legislative frameworks have not developed to respond to what is occurring. Managers and practitioners have found that they need to act imaginatively with legal advisers to fit circumstances into complex legal and procedural provisions.

4.3 Modern Life, Attitudes and the Impact of Technology

Perpetrators have been empowered by technology which allows for unprecedented and easy access to sexually exploitative materials and provides increased opportunities for sexually exploitative acts or sexual offences.³⁰ Sexual exploitation could not happen on such a scale without mobile phones, the internet, and social media, being used to maintain contact with and control victims and arrange activities.

The attitudes of children and young people to sexual relations and what they expect to happen are rapidly changing. Technology offers many positive opportunities for learning and social interaction but it also provides perpetrators with new opportunities and pathways to target potential victims³¹. Sexual Health Service's staff commented that now:

“Porn is the norm – it encourages normalisation of abusive sex and exploitation. Everything they see is sexualised.”

Teachers have highlighted³² that pupils watch pornography to educate themselves, are being coerced into doing things they later regret and the language used is degrading and lacking understanding of consent and mutual respect.

4.4 What is the Impact of Sexual Exploitation?

Research indicates that victims of child sexual exploitation, have been diagnosed with borderline personality disorder, psychosis and suffer feelings of trauma, betrayal and stigmatisation. They may blame themselves.³³

In 2017, the Government emphasised³⁴ the devastating, long-term consequences, impacting on every part of life and future outcomes – physical, sexual and mental health and well-being, education, training, future employment prospects, family relationships, friends and social relationships and relationships with their own children.

³⁰ National Plan to Prevent the Sexual Abuse and Exploitation of Children developed by the National Coalition to Prevent Child Sexual Abuse and Exploitation. March 2012

³¹ Report of the Parliamentary Enquiry into the Effectiveness of Legislation within the UK 2014

³² BBC coverage 5 October 2017

³³ Para. 77. Child sexual exploitation and the response to localised grooming Child Sexual Exploitation: scale and prevalence. House of Commons Home Affairs Committee. June 2013

³⁴ Advice: Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. Department for Education. February 2017

Historically work with adults has focused on sex work and prostitution and the Review found no current research on the impact of sexual exploitation on vulnerable adults. The cases and experience from supporting adult victims in Newcastle indicates that sexual exploitation of adults gives rise to the same devastating consequences as for children.

“I suffer from mental health. Personality disorder. It impacts on every part of my life, including my family because of the trauma and abuse that I suffered.”

“After the abortion, I got quite depressed. I had no support. I started self-harming.”

“I went to the emergency department and said I was suicidal. I did that a few times. I lost control.”

“No-one understood what was happening. I had voices in my head. The perpetrators were continually in my head. I was sectioned and detained.”

“I keep getting flash backs of the rape.”

The sentencing remarks³⁵ made by the judge at the trials in September 2017 included:

“...You used drink to facilitate offences... She was at a low point when you targeted her, drinking heavily, and you are responsible for significantly worsening that addiction. She was particularly vulnerable because of her learning disability and other difficulties.

She has flashbacks and is unable to sleep. She expects that the consequences of the offending against her will affect her for the rest of her life.

She is now suffering from severe depression and anxiety: she can't sleep for nightmares.... has suicidal thoughts.... has serious mental health problems and has been detained under the mental health act on three occasions in the past year.

In her words “I was harmed beyond imagination physically, emotionally and psychologically”.

³⁵Sentencing remarks by HHJ Moreland, Newcastle Crown Court, September 2017

5. The Newcastle Response to Increased Awareness

5.1 Operation Sanctuary

Accounts of victims and increasing intelligence led Northumbria Police in January 2014 to launch Operation Sanctuary as the overarching police investigation into sexual exploitation across the Force area, predominately in Newcastle.

Large numbers of leaflets were distributed in Newcastle City Centre publicising arrests. More victims came forward and described being taken to sessions involving young women and children at which drugs and alcohol were supplied and at which they and others were raped and abused.

Protection of victims and addressing the scale of exploitation required a programme of action against the perpetrators, significant resources and effective strategic and multiagency arrangements. Northumbria Police Chief Officers Team established a dedicated full Gold Command structure - a framework for delivering strategic, tactical and operational responses involving escalation of decision making and clear lines of accountability and responsibility. Senior officers across agencies discussed what resources and services were required.

Within weeks, a team, led by a Detective Superintendent, was brought together including experienced officers from the police Protecting Vulnerable People Team, major crime, forensic services, homicide, intelligence and research with skills in conspiracy investigation, covert strategies and enquiries. Dedicated officers focused on undermining the activities of perpetrators. The Operation was supported by an information technology system³⁶ used for the investigation of major incidents.

Senior staff and practitioners from Newcastle City Council, the lead agency for safeguarding adults and children, were involved from the outset. Staff from health, education and community and voluntary organisations were brought in. Agencies prioritised Operation Sanctuary victims and identified single points of contact.

The collective commitment was to develop a model of best practice accessing advice from the College of Policing, the National Police Child Sexual Exploitation Co-ordinator and the Home Office. Senior police officers and managers from Newcastle City Council Children's and Adults' Social Care visited Rochdale and Oxford to learn from their experience of large scale sexual exploitation investigations. An experienced psychotherapist and expert on trauma was commissioned to provide advice.

Involvement of and focus on victims improved knowledge of the abuse and prevention.

To alert them to the likely impact on criminal justice processes and high costs, discussions were held with the Crown Prosecution Service and Newcastle Crown Court. Trial slots were identified and a trial judge nominated to avoid delay. The

³⁶ Home Office Large Major Enquiry System

Crown Prosecution Service allocated resources for early instruction of Leading Prosecuting Counsel, Junior Counsel and a Junior to act on disclosure. Prosecutions were dealt with by the specialist Rape and Serious Sexual Offences Team led by an experienced lawyer and case worker. This Team worked closely with and provided ongoing advice and consultation to the investigation team.

5.2 Perpetrators' Families

During Operation Sanctuary, arrangements were in place to promptly assess the welfare of children in the families of suspected perpetrators and to consider the need for support of adults who had no involvement in abuse.

Your Homes Newcastle works closely with the Hub and has a single point of contact to consider re-housing requests related to the Operation. All staff were made aware of the potential for neighbourhood unrest and to be vigilant and report concerns. A multi-agency team involving children's and adults' social care teams, tenancy services and the police gathers information on support needs and identifies and manages risks to individuals and the community.

5.3 Paid Police Informant

Following the ending of reporting restrictions reports appeared in the press about a paid police informant who was also a convicted child rapist. This was not an issue included within the scope of this Review.

The Chief Constable responded robustly to questions about the use of this informant. He acknowledged this carried risks but emphasised that sexual exploitation requires thinking outside the box. Appropriate procedures were undergone and many victims had been protected. It sent a message to perpetrators that people will inform against them. Public comments received were overwhelmingly supportive.

During conversations with some victims, they expressed concern that this informant may have abused them and they were reassured there was no evidence of this.

5.4 Disruption

The significant issue that prevented interagency working from having the intended impact until 2014 was that perpetrators were insufficiently targeted.

"I felt I was being punished. It would be better if the men were dealt with."

"They should have punished the men that were doing it and not me."

"Something should have been done against the men – a lot have not been prosecuted."

"They should have punished the men that were doing it and not me. I was the one in the wrong."

“I was in a care home – but those men were walking about free.”

The SCARPA Squad (a group of young people) told the Review that we need to change the people, not the city, by doing something with the perpetrators.

Although Complex Abuse Investigation processes brought together experience from different cases, the focus of interventions was on individual cases rather than the wider picture. There was little disruptive action to curtail the activities of actual and potential offenders, which was seen as a police and criminal justice responsibility.

Practitioners described their frustration that while trying to influence victims' behaviour, sometimes through coercive measures, perpetrators continued to abuse. Confidence was lacking in what could or could not be done.

The period leading to a criminal trial can be lengthy and perpetrators and people close to them can use it to threaten victims:

“I was really scared –.... their family members were sending threats. I was frightened of being killed. I had seen rapes and was too terrified to say anything.”

“At the care home, I had a call said I would be killed”

It was a driving principle of Operation Sanctuary that while securing convictions is important, other steps should be taken immediately to interfere with and disrupt the activities of perpetrators without putting responsibility on victims. Resources to identify and carry out effective disruption were made available. Two dedicated intelligence teams developed disruption strategies and tactics are embedded in daily business.

Applications for Sexual Harm Prevention Orders and Sexual Risk Orders³⁷ are routinely considered and significant numbers of Child Abduction Warning Notices are issued to prevent contact with children by adults suspected of grooming. Following arrests, bail conditions are carefully considered to have maximum impact. Information on the Police National Database and Police National Computer is interrogated to ensure intelligence held by other Forces is available.

Disruption is an inter-agency responsibility and close working relationships have been established across Newcastle City Council departments and with partner agencies that have regulatory and inspection functions, including border agencies, Trading Standards, Licensing, Consumer Services, Environmental Health and the Fire Service. There is close liaison with children and adult safeguarding services.

Using overt and covert investigation strategies, activities of perpetrators which can attract action are identified. There are good arrangements in place to ensure that actions taken are proportionate to the risks identified.

³⁷ Anti-Social Behaviour, Crime and Policing Act 2014; replacing Sexual Offences Prevention Orders, Risk of Sexual Harm Orders and Foreign Travel Orders

All hotels within Northumbria Police area have been visited and leaflets and posters left at the premises. Officers visit hot spots and local shops licensed to sell alcohol.

It is not appropriate in a public document to set out in more detail action which might be considered against actual or potential perpetrators or people associated with them.

The arrangements are an excellent example of pro-active disruption and have had a very significant impact. A consistent comment from Practitioners was that the tactics involving partners are well developed and comprehensive. This view was shared by Ofsted in 2017³⁸ which found that highly effective intelligence-led disruption and prevention strategies are making children, young people and vulnerable adults in the city safer.

This is consistent with the Government's expectation in 2015 that techniques and resources should be at the same level as for other forms of organised crime. The arrangements go further than the Government suggestions made in 2017.³⁹

The team has attracted a reputation for excellence and a specialist officer advises other Police Forces, speaks at regional conferences and delivers training.

Experience identified a weakness in licensing arrangements for individuals who have a licence to operate a taxi removed but may continue as a private operator of larger vehicles. It was also suggested that because of the large number of licensing authorities for different areas a national data base of individuals who have been refused a licence or had one removed should be kept.

Recommendation 2.1

I recommend that:

The Government should carry out a review of vehicle licensing for driving vehicles that transport members of the public, to include arrangements for private operators of larger vehicles, and taking account of the body of knowledge about sexual exploitation.

Newcastle City Council Legal Services' reviews of the cases included considering action that might be taken in Family Court jurisdictions to interfere with perpetrators' activities. In 2014 injunctions made in open court⁴⁰ in Birmingham restrained a number of defendants from contacting children and attracted publicity. It is uncertain how many other local authorities make such applications as generally proceedings are in private.

³⁸ Newcastle Upon Tyne Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board. Inspection date: 24 April 2017 – 11 May 2017. Ofsted Report. 7 July 2017

³⁹ Tackling Child Sexual Exploitation. HM Government. 2015; Annex B - Guide to Disruption Orders and Legislation: Annexes to "Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation". Department for Education. 2017

⁴⁰ BCC v Riaz et al [2014] EWHC 4247 (Fam)

Since 2014, doubt has been expressed⁴¹ about the availability of injunctions since the advent of Sexual Risk Orders in a case in which a Local Authority made an application in relation to children who were not known and not subject to any family court proceedings. This needs clarification by the Court of Appeal or, as the judge suggested, legislation. Sexual Risk Orders and Sexual Harm Prevention Orders are narrow in their scope. They require acts of a sexual nature to have been committed whereas interference with statutory welfare responsibilities and the likelihood of sexual exploitation may arise before that can be sufficiently established.

The Government included considering making applications for injunctions in the Advice published in 2017⁴².

If granted, injunctions may contain conditions relating to the welfare of a victim and restrain individuals from interfering with the exercise of statutory functions relating to children and vulnerable adults. Breaches are likely to lead to imprisonment.

The Review gave the opportunity to consider a proactive, cooperative approach to disruption arrangements whether action is taken by the police or Newcastle City Council. Training for Newcastle City Council Legal Services staff on the range of powers available has taken place and there are good links with the specialist police officers leading on disruption so that information and evidence can be shared and actions co-ordinated.

5.5 Establishment of the Multi-Agency Sexual Exploitation Hub

Early in 2014 assessments confirmed that significant resources were required to sustain Operation Sanctuary. An application for funding to develop multi-agency co-located victim support teams was made to the Home Office Innovation Fund, supported by 16 public, community and voluntary sector and academic agencies in the region. Funding of £3.5M was secured allowing the expansion of the Victim Team to include additional resources and expertise from social care, community and voluntary sector and health agencies.

From April 2015, the police operation was enhanced by the establishment in separate premises of a co-located, victim focused Multi-Agency Sexual Exploitation Hub working alongside the Police Victim Team. The staff involved are social work practitioners and managers from lead agencies for safeguarding adults and children in Newcastle City Council, and staff from Barnardo's, the Children's Society, Bright Futures, an organisation supporting young people and adults with complex needs, and Changing Lives, a charity that supports vulnerable people to make positive, lasting changes in their lives. A Safeguarding Nurse Advisor (Children's and Adults) was appointed and supervised by NHS Newcastle Gateshead Clinical Commissioning Group with effect from July 2016.

A Safeguarding Adults Manager was immediately appointed to the Hub as a single point of contact for sexual exploitation within Adult Social Care.

⁴¹ London Borough of Redbridge v SNA [2015] EWHC 2140 (Fam)

⁴² Annex B - Guide to Disruption Orders and Legislation: Annexes to "Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation". Department for Education. February 2017

There was a commitment at senior levels across agencies to address sexual exploitation effectively and secure significant resources at a time when all budgets were under pressure. The intention was to embed cultural change, focussing on evidence but with a prime objective for all agencies to support and protect victims and recognise that no evidence of abuse is not evidence of no abuse.

Initially based in Newcastle, covering three local authority areas in the North Northumbria Police area, from April 2016 a similar team was based in Sunderland to cover the three local authorities in the South Northumbria Police area.

The Hub is located where sexual exploitation is most evident and so attracts confidence from victims. The victim focused approach is helped by the building which is not obviously public service offices or police premises. The rooms for interviews with victims are as close to nicely furnished living rooms as is possible. There is a suite to carry out interviews compliant with guidance requirements⁴³ and a separate complainant interview room and facilities for group work.

In Newcastle, all children's safeguarding concerns are considered and screened by a Multi-Agency Safeguarding Hub. Any suspicion of child sexual exploitation is routinely referred to the Multiagency Sexual Exploitation Hub with which allocated safeguarding children social workers work closely.

For adults, proposals for a similar co-located Multi-Agency Safeguarding Hub to receive referrals are being considered by the Newcastle Safeguarding Adults Board. Referrals are currently made through Social Care Direct to the Adults Safeguarding Unit where they are screened and sexual exploitation concerns referred to the Hub with which allocated safeguarding adult social workers work closely.

The Hub has developed exceptional team working recognised by the National Policing lead on Child Sexual Exploitation as a unique example to be recommended elsewhere. Victim engagement has been recognised as national best practice.

A key strategy is a persistent and patient approach towards a victim through a trusted professional, identified by all agencies within the victim team and other safeguarding agencies. This requires working with the victim at their own pace and capturing evidence in a way that they are comfortable with, understand and want, adapting rather than applying standard responses.

The care with which the arrangements have been put in place is very evident. The Team has no backlog of work, and the investigators meet the victim team every week to discuss cases and actions.

The developments reflect expectations set out in the College of Policing CSE Action Plan 2014 – 2016⁴⁴. Following evaluation, the Home Office recommended other Forces to adopt similar models.

⁴³ Achieving Best Evidence in Criminal Proceedings Guidance on interviewing victims and witnesses, and guidance on using special measures. Ministry of Justice. 2011

⁴⁴ Pursue: Disrupting, arresting and prosecuting Child Sexual Exploitation offenders, ensuring a victim centred approach at all times. College of Policing CSE Action Plan 2014 – 2016

In 2017 Ofsted⁴⁵ highlighted the excellence of the provision and will be promoting the Hub in a national resource as an example of good practice.

In March 2017, HMIC found⁴⁶ that victim contact and support is excellent and is bespoke to each victim who receives “a very high standard of service”. During an inspection the Office of the Surveillance Commissioners commented that the proactive and covert investigatory approach is at the forefront of covert policing activity and its use to combat sexual exploitation.

The success was recognised nationally in November 2017 when the Team received:

The Children and Young People Now Safeguarding Award for “the initiative that has made the biggest contribution to prevent and protect children and young people from abuse and neglect through exceptional team work and multi-agency working”

and

The Social Worker of the Year Award as Team of the Year – Adult Services for “excelling and making the difference to adult service users” through “outstanding team working in Adult Services”.

It was emphasised that:

“This team is the first of its kind nationally to address sexual exploitation of adults, and making it of equal relevance to adults as children. This is a national beacon of best practice”

Arrangements are in place for an on-going evaluation of the service.

5.6 Victims’ Mental Health Needs

Experience in the Hub and consideration of the cases identified difficulty and delay in accessing appropriate assessment and mental health support for victims. Action was taken to address this by the introduction of an interagency Mental Health Triage Meeting which has become known as “The Huddle”.

Victims and potential complainants within the scope of Operation Sanctuary are promptly triaged and assessed and fast-tracked to mental health support.

Staff have benefited from regular sessions and support, training, advice and guidance on the impact of trauma from an expert independent psychotherapist. Home Office Innovation Fund money was used to pay for these services for 12 months throughout the investigation. Thereafter, Newcastle City Council has continued to fund this support for Children’s and Adult Social Care Services staff.

⁴⁵ Newcastle Upon Tyne Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board. Inspection date: 24 April 2017 – 11 May 2017. Ofsted Report. 7 July 2017

⁴⁶ The Report of HMIC’s PEEL: police effectiveness inspection of Northumbria Police Force 2017

5.7 Impact of Operation Sanctuary and the Multi-Agency Sexual Exploitation Hub

It is difficult to overstate the positive impact on culture and practice and as a consequence improvement in addressing sexual exploitation, improving victims' welfare and restricting and preventing abusive activities by perpetrators. The success has given more victims confidence to come forward.

Success improves morale and commitment. Practitioners consistently remarked on the benefits of a bespoke victim strategy and multi-agency working with flexible, collaborative and innovative working. Relationships between agencies generally have improved and between interagency children's and adults' services particularly.

Co-location of specialist staff from children's social care, adult social care, police, community and voluntary organisations and a safeguarding nurse adviser encourages spontaneous sharing of expertise and information and a collective responsibility for promoting victims' interests and securing their trust and confidence. Links from the Hub to agencies ensure effective access to services for support, welfare and to meet the physical and mental health needs of victims.

Lack of pressure of a case load, recognising that progress is in tiny steps and it may take months to encourage a victim to speak to police and sexual health services and that disclosures may occur during routine activities, allows a different way of working. There has been encouragement to think outside the box. If one or two agencies commit resources it has an impact on others and increasing knowledge has led to initiatives across agencies to improve practice.

"I have support now – I now know what would happen much better. I could not have better support than Sanctuary. I have support coping with my son's issues. No-one can do more now."

"The support I have had has been exceptional."

"From court to now has been fabulous."

"The support from the Hub is brilliant."

"I appreciate the support now. Because I have had a bad time. If I had had it then then – the police and others - it would have been good. Later (social worker) came to court. She was my rock."

In 2017 Ofsted⁴⁷ found "outstanding multi-agency practice" and a highly effective response to sexual exploitation, successful use of court orders disrupting offending behaviour and reducing risks and excellent interagency work by Newcastle City Council and its partners which has resulted in a high number of convictions of perpetrators.

⁴⁷ Newcastle Upon Tyne Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board. Inspection date: 24 April 2017 – 11 May 2017. Ofsted Report. 7 July 2017

During the Review the staff working at the Hub were asked their views on what contributed to the effectiveness of the unit:

- Co-location of expertise in a non-police, non-threatening environment
- Victim focus
- Flexibility and what works approach
- Good, comfortable, interview facilities; supporting vulnerable victims
- Commitment from key services from statutory and third sector partners to joined up working – not just being in one place
- Understanding roles, sharing good practice and different expertise
- Robust, effective management oversight and governance
- Early information sharing and risk assessment; spontaneous conversations
- Weekly meetings look at emerging issues; flexibility of short notice meetings
- Tasks fast-tracked - access to services not co-located
- Implementing immediate safeguarding plans
- Consistency
- Joint training
- Psychological support for victims and staff welfare
- Strong links with community support, missing from home and human trafficking services
- Community involvement
- Financial savings from reduction in the need to arrange partner meetings

Investigations have led to successful prosecutions for sexual assaults, rapes, conspiracy and drug offences. Trials that concluded in September 2017 involved 25 defendants and 22 victims and resulted in substantial terms of imprisonment up to 28 years. The defendants included men aged between 34 and 47 years old.

Large numbers of victims have been protected and supported. Across the Northumbria Police Force area approximately 700 victims have been identified of which 108 were linked to Newcastle including those who gave evidence.

5.8 Complex Abuse Meetings held in relation to Sexual Exploitation

In 2002, Government Guidance⁴⁸ addressed undertaking complex abuse investigations that involve one or more abusers and a number of children. The intention was to ensure thoroughness, commission of sufficient resources, working together, sharing information, acting on risks as they emerge and prompt support for victims and their families. The Guidance was most commonly applied in cases involving historical abuse within an institution, and for allegations against staff.

In response, Newcastle Safeguarding Children Board developed Complex Abuse Procedures which were applied in relation to child sexual exploitation as far back as 2008, including in a number of the cases considered during the Review. The guidance was also applied to complex investigations of abuse of vulnerable adults.

⁴⁸ Complex child abuse investigations: inter-agency issues guidance. Home Office. Department of Health. 2002

This has been an effective process for multi-agency planning, identifying links between suspected cases and protecting victims using powers and court applications to control their behaviour. However, action against perpetrators did still rely on co-operation and disclosures from victims to satisfy evidential requirements for criminal proceedings.

The process was revised and updated in 2014 and since then action is taken to disrupt activities of perpetrators and reliance on victims' disclosures and co-operation is kept to a minimum. It has also been applied to cases involving forced marriage and organised criminal and drug related activity.

There were early examples of adult social care workers attending child centred meetings when suspected victims were approaching adulthood. Now when vulnerability is likely to extend into adulthood or a perpetrator may require adult services, a representative from Newcastle City Council Adult Social Care attends the meetings. Strengthened arrangements ensure consistent attendance of legal advisers at meetings and chairing is limited to senior experienced staff.

Any agency can request that a Complex Abuse Investigation meeting be held.

An annual overview report on cases when they are large scale, highly sensitive, or linked to a police operation are made to the Safeguarding Boards. Quarterly reports are provided to the Newcastle City Council Chief Executive, the Director of People and the Assistant Director for Children's Social Care.

In the main, only the Police and the Local Authority attend the Gold Command meetings. In view of this it was decided that Operation Sanctuary should in addition be subject to Complex Abuse Investigations processes. This was a positive step and ensures agencies have a forum to facilitate interagency working and robust planning, are kept up to date, information is shared promptly between adults and children's services and identify and challenge any gaps in services or resources.

5.9 Safeguarding Adults

When Operation Sanctuary was launched in 2014 safeguarding adult's procedures operated within a statutory guidance⁴⁹ framework dating from 2000 in which powers, duties and authority to act to protect vulnerable adults were uncertain. The main provisions of the Mental Capacity Act 2005, implemented in 2007 and 2009 and the 300-page Code of Practice⁵⁰ were not directly concerned with safeguarding but had a significant impact on the approach to assessing capacity to make decisions and powers to deprive an individual of their liberty.

The definition of vulnerability was prescriptive and did not include adult sexual exploitation as it was being understood in Newcastle.

⁴⁹ No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. Department of Health and Home Office. 2000

⁵⁰ Mental Capacity Act 2005 Code of Practice. Office of Public Guardian

The cases illustrated that during the early period, leading adult protection, Newcastle City Council Adult Social Care adopted a creative and flexible interpretation of criteria to ensure that victims of sexual exploitation were supported.

The national adult safeguarding framework was revised significantly by the Care Act 2014, implemented in 2015 when the Care and Support Statutory Guidance was published. Local authorities were required to carry out safeguarding enquiries and establish a Safeguarding Adults Board with a statutory remit. The definition of an Adult at Risk broadened eligibility criteria but the cases illustrated that intervention and continued involvement, consistent support and protection for adult victims continued to require a generous and flexible interpretation of statutory provisions by Newcastle City Council Adult Social Care and partners.

This approach required proactively exploring with the Council's legal staff the options available and testing legislation and court jurisdictions to secure powers to control individuals' behaviours and where they live. When capacity to make a decision is compromised not because of a disturbance in the functioning of the mind or brain, but because of constraint, coercion or undue influence or for some other reason, the inherent jurisdiction of the High Court⁵¹ has been invoked.

Funds were provided to access additional specialist legal advice to support this approach, driven by a determination to safeguard when what was happening was clearly abusive, even when assessments might suggest that an individual had the capacity to choose.

Conversations during the Review with the Judge leading on Court of Protection processes confirmed her willingness to respond positively to the proactive approach taken in Newcastle. Every application to the Court has been successful.

Steps have been taken to ensure the "legal literacy" of social care and legal staff is kept up to date. A Legal Options training course has been launched and is mandatory for all Adult Social Care staff.

There is considerable evidence that despite resisting attempts to help, the persistence and availability of support, if and when wanted, and encouragement to see themselves as victims has had a significant impact on a number of the victims whose circumstances were considered.

"They were worried about my capacity and went to the Court of Protection for deprivation of liberty. If they had not gone to the Court, I would have ended up dead. Looking back, I know I am much better now. It was the right thing to do but I hated it at the time."

The difficulties in the current legislative provisions arise because there is a significant number of individuals who do not lack capacity for the purposes of the Mental Capacity Act 2005 but are in some way vulnerable to coercion or duress by others and are outside the scope of domestic violence legislation. Local authorities have statutory duties to inquire into the circumstances but it is unclear what steps

⁵¹ Lord Justice McFarlane. DL v A Local Authority [2012] EWCA Civ 253

can be taken thereafter to secure protection. Court action is expensive and cumbersome and does not cover all situations.⁵²

The state is not permitted without legal authority to intervene to protect adults from making bad choices or forming inappropriate relationships. Human rights issues are engaged. As with children, it was clear that adults at risk were being targeted, groomed and exploited and that perpetrators targeted vulnerability and undermined ability to make choices. But the circumstances that justify or require intervention by a state agency are not well defined.

There is a proposal to pass legislation that will clarify the scope of those who should be protected and the basis of and the rationale for intervention in the affairs of those considered vulnerable and the powers of courts and agencies.

Safeguarding Adults national guidance and practice advice within the current framework is not as extensive as for safeguarding children. The Newcastle experience confirms that, while there are similarities, adult sexual exploitation requires a different way of working. The vulnerabilities and practice skills required may be different. The Newcastle City Council Safeguarding Adults Manager working in the Hub encourages the police and other agencies to continue to develop their practice.

When providing protective services for young adults, adult services experienced the same frustrations as their children's services colleagues. No effective action was taken against the perpetrators and victims who at the time, because of grooming, threats influence and coercion by perpetrators, resented and resisted intervention in their lives:

"I pushed the help away. I knew professionals were trying to see me and I cancelled appointments."

Some cases include individuals who had some cognitive impairment which had not required formal assessment, or who had experienced dysfunctional, difficult childhoods but would have been unlikely to have attracted the attention of adult services without concern about the increase in their vulnerability caused by grooming, abuse, exposure to drugs and alcohol and coercion and threats.

In the absence of national guidance for adults, local arrangements were developed, taking into account national children's safeguarding guidance and the experience of colleagues in children's services. Existing safeguarding adults policies and procedures were used which provided a framework and information sharing protocol. Information sharing meetings, interagency and adult safeguarding meetings were convened and Core Group Meetings of professionals planned and monitored the delivery of adult protection plans.

Difficulties in securing information from health agencies identified by Practitioners at the Learning Events have during the course of the review been addressed through the Newcastle Safeguarding Adults Board by a multi-agency information

⁵² Mental Capacity and Deprivation of Liberty. Law Commission Vulnerable Adults Bill proposal. 13th programme of Law Reform 2016

sharing protocol. Where there might be concerns there are processes in place for protocols and agreements including the need for any alterations to be considered promptly by the Case Review Committee.

Newcastle City Council Adult Social Care have arrangements in place whereby the safeguarding adults function and management is independent of Adult Social Care and a Safeguarding Adults Manager, who is independent from operational functions, chairs safeguarding adults' meetings.

Reviewing the cases included checking the consistency of arrangements for ensuring all relevant historical information is available at Safeguarding Adults meetings, relevant professionals are invited and do attend and that Newcastle City Council Legal Services routinely take part. These issues are subject to quarterly audits which are discussed by the Newcastle Safeguarding Adults' Board.

It has been recognised by Newcastle City Council Adult Social Care and Newcastle Safeguarding Adults Board that adults requiring safeguarding services may have lifelong needs. There is little published experience of addressing long-term needs of victims of sexual exploitation. In Newcastle, continuing support is being provided in relation to emotional and mental health needs and dealing with problems associated with the care of their children, some of whom are children of abusers. Established interagency processes including Multi-Agency Public Protection Arrangements and Multi-Agency Risk Assessment Conferences related to domestic abuse have been utilised.

This approach is supported by the independent psychotherapist commissioned for training, one to one counselling for workers and group support in relation to specific cases.

The conversations with victims illustrated that for some it may be difficult to disengage from services, while others see the commitment to be available if needed as sufficient reassurance:

"I know support will always be there for me."

Recommendation 2.2

I recommend that:

The Government should urgently issue guidance or advice on addressing sexual exploitation of vulnerable adults.

5.10 Transition

A striking feature of the cases involving older teenagers and young adults was the early development of collaborative planning and working between Newcastle City Council Children's Social Care and Adult Social Care and the engagement of partner agencies. As early as 2007 there were examples of outstanding practice

and the application of principles later set out in statutory and practice guidance and legislation from 2011 to 2016.⁵³

These included early assessment of a child's likely needs for care and support when becoming an adult; early planning for adult services; persistence of staff always being there; continuity of staff where possible; tailoring responses to individual needs; identifying a named worker to coordinate care and support and ensuring no young person should be made to feel that they should "leave care" before they are ready. Adult safeguarding staff were involved in planning the responses if it was likely vulnerability of a child would continue into adulthood.

Examples of good practice included the involvement of a Barnardo's high-quality Foster Carer who trained as an adult carer to ensure continuity of care and availability even when the victim was absent for periods. Children's services worked with adult services until the victim was 25 years of age. In another case ongoing support was provided from the Community Mental Health and 16 Plus Teams in addition to the assistance from support workers who during crises provided support day and night.

A protocol now provides for involvement of adult social care in reviews of children looked after by Newcastle City Council from age sixteen. Consideration of a looked after child's needs as an adult is a standing item on agendas for social workers and Independent Reviewing Officers to consider at each review of a child's case.

The arrangements have been reviewed and refined in the light of the legislation, guidance, and experience. Adult Social Care staff have direct access to Children's Social Care records.

The remit of the Missing and Sexual Exploitation and Trafficking Group operates as a sub group of both the Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board and the Safeguarding Adults Manager attends meetings of the Risk Management Group. As a result of the joint working, definitions of referral pathways have been improved and delays accessing services reduced.

Practitioners highlighted the benefits of early assessments and securing historical information for planning adult services which may not previously have been necessary.

In 2016, the Newcastle City Council Director for People requested that the Local Government Association undertake a Peer Review of the Council and partners to ascertain the effectiveness of the transition arrangements. The Report⁵⁴ found that:

"Work around sexual exploitation is being used to improve communication, service delivery and outcomes for young people by all partners across the city."

⁵³ The Children Act 1989 guidance and regulations Volume 3: planning transition to adulthood for care leavers April 2011 Revision date: January 2015; NICE Guideline on Transition from children's to adults' services for young people using health or social care services. 2016; Transition for children to adult care and support, etc. ss 58;59 Care Act 2014

⁵⁴ Local Government Association Adult Safeguarding Peer Challenge Report. March 2016

Continuing effectiveness of the arrangements is monitored through regular audits.

5.11 Understanding, Informing and Mobilising the Communities

In 2014 The College of Policing⁵⁵ expected Police Forces would conduct community engagement activities. In 2015, the Government emphasised that communities must help tackle child sexual exploitation rather than assume victims bring it on themselves and in February 2017 stressed that those who do not necessarily work with children also have a contribution to make.⁵⁶

The public expects to be made aware of risks from perpetrators and how to minimise them. Sexual exploitation may impact on families and individuals who do not come to the attention of safeguarding agencies for any other reason.

In Newcastle, prior to 2013 the level of engagement with the public reflected the perceived prevalence of sexual exploitation. As awareness grew the need to involve the community was recognised and acted upon. A central feature of Operation Sanctuary has been communication with communities. The Learning Events highlighted the importance of a continuing strategy, involving potential future victims.

Significant investment and a programme to raise local awareness about what to look for and how to report concerns has been overseen by the Safeguarding Boards. This has involved all the features since identified by the Government. Thousands of leaflets were distributed to every hotel, neighbourhood, taxi firm and religious institution, families and to workers including those working during the night and door staff in clubs. The Black and Minority Ethnic Safeguarding Initiative helped to ensure distribution to members of their communities.

These initiatives gave confidence to some victims to come forward.

Northumbria Police launched a bespoke Vulnerability Training Programme, for staff in the night-time economy, door supervisors and staff in hotels. Recommended nationally as good practice, it has been adopted by the Security Industry Authority and is mandatory door supervisor training. Staff from Safe Newcastle and Newcastle Safeguarding Boards have contributed to the delivery.

A growing public health concern is the impact on vulnerable people of changing trends within drug supply, recreational use, and links to exploitation of compounds designed to mimic existing established recreational drugs (Novel Psychoactive Substances - designer drugs, internet drugs, research chemicals, legal highs). Distributing or selling these is a criminal offence but possession is not.⁵⁷ A range of multi-agency arrangements have been put in place in Newcastle to tackle use and

⁵⁵ The College of Policing CSE National CSE Action Plan 2014 to 2016

⁵⁶ Para 4. Tackling Child Sexual Exploitation. HM Government. March 2015; Advice: Educating Communities, and Harnessing the wider community Child Sexual Exploitation Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. February 2017

⁵⁷ Psychoactive Substances Act 2016. Novel psychoactive substances: a practical approach to dealing with toxicity from legal highs: Dignam and Bigham. Vol. 17 Issue 5 172–177. British Journal of Anaesthesia; Oxford University Press May 2017. Novel psychoactive substances: types, mechanisms of action, and effects: Tracy, Wood and Baumeister. British Medical Journal. January 2017;356:i6848

supply. A health needs assessment into the prevalence of children and young people's drug and alcohol use is being carried out to inform practice, the results of which will be reported to the Safeguarding Boards.

In January 2017, the Safeguarding Boards worked with the Black and Minority Ethnic Safeguarding Initiative to organise a conference at a local school. Casey and Jay criticised engagement that restricted communication to older male community leaders.⁵⁸ In Newcastle, over 100 people, mostly women, attended and were very positive about the event. Interpreters and child care facilities were provided.

The Conference included presentations by the Police and Crime Commissioner and the senior investigating officer for Operation Sanctuary, information concerning the Review and group discussions, all of which have fed into the Review.

Publicity is provided at significant community events including Northern Pride.

In 2017 the HMIC inspection identified strengths in Northumbria Police and other public services in raising public awareness and the Ofsted inspection found that positive engagement with minority ethnic communities is ensuring a focus on under-reporting in these communities and raising awareness.

During the Review, conversations took place with members of the Black and Minority Ethnic community who wished to be involved and express personal opinions. When the trials were reported the community was shocked. The abuse was hidden and people were not aware of what was happening. Some people heard things about take-aways and taxis shortly before the launch of Operation Sanctuary but were not aware of the scale. Former school friends were perpetrators. Wives unaware of their husbands' involvement required help to avoid recrimination and ensure their safety.

It was stressed that the community should speak out against the crimes but not be expected to apologise. It should be spoken about but this has yet to take place in religious and social settings.

Victims in minority communities are unlikely to disclose due to shame and the impact on themselves and relationships with their families. Adults may not report suspicions, anxious about whether this would be understood during enquiries. The Home Affairs Select Committee⁵⁹ supported this and Jay criticised the myth that only white girls are victims of Asian or Muslim males which flies in the face of evidence that shows that:

“...those who violate children are most likely to target those who are closest to them and most easily accessible.”⁶⁰

⁵⁸ Report of Inspection of Rotherham Metropolitan Borough Council. Louise Casey CB. House of Commons 2015; Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013 Alexis Jay OBE Rotherham Metropolitan Borough Council. 2014

⁵⁹ Child sexual exploitation and the response to localised grooming Child Sexual Exploitation: scale and prevalence House of Commons Home Affairs Committee. June 2013

⁶⁰ Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013 Alexis Jay OBE Rotherham Metropolitan Borough Council. 2014

Research by The UK Muslim Women's Network published in September 2013, found Muslim girls were not being made aware of the predatory nature of some men and boys, and the consequences of being lured by them – they are not being adequately warned to safeguard themselves:⁶¹

“most victims had not received or been supported by long-term aftercare and when the family became aware of any abuse they re-victimised them, which meant not believing them, blaming them ...”

Jay recommended that Rotherham Safeguarding Children Board should prioritise under-reporting of exploitation and abuse in minority ethnic communities. The College of Policing⁶² has expected the police to address under-reporting in BME communities.

During the Review one victim spoke about Asian heritage victims in Newcastle:

“There were a couple of Asian girls involved.”

There is no reason to believe that vulnerable adults in these communities are not at similar risk to children.

Northumbria Police has arrangements in place to bring together intelligence and experience to better understand profiles of victims and perpetrators which is being shared with partner agencies. Investigations in the North East have involved a significant number of minority ethnic victims.

In Section 6, I discuss the perpetrators within this context.

The conversations highlighted the importance of the community being involved in considering the issues, which are about men and power, early education about attitudes to women, some in particular, women's rights and the lack of open discussion. Concerns are not confined to one minority religious or ethnic community. Some remarks reflected comments by Jay that it was thought for example that some child victims and some perpetrators originated from the Roma Slovak community.

In Newcastle action is being taken. It was suggested that there should be a forum to bring together individuals from the community, ordinary people as well as leaders and scholars, and public authorities to talk about these issues. There are some key people. Talks may need to take place separately with men and women, to encourage expression of views. There needs to be very careful consideration of who should be involved and the scope and practical arrangements.

Councillor Nick Forbes, Leader of Newcastle City Council will lead on bringing about what should be a very positive development and one which may lead to national recommendations.

⁶¹ Unheard Voices: The Sexual Exploitation of Asian Girls and Young Women. The Muslim Women's Network UK Report: September 2013

⁶² The College of Policing Action Plan for Child Sexual Exploitation for 2014 – 2016

Recommendation 1.2

I recommend that:

A report should be made to Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board on the arrangements to take forward the initiative to establish a process for discussion with communities about the issues that have arisen from the Joint Serious Case Review.

6. The Perpetrators

At the Learning Events, all professionals emphasised the lack of information available about the profile, motivation and driving factors for abusing that prevents looking at how to stop people becoming perpetrators and better protect potential victims. This was contrasted with the PREVENT agenda.

The Review was unable to identify any information about work with perpetrators which might help practitioners.

In response to questions after the Newcastle trials, the police confirmed that the defendants were mainly not white but came from a diverse range of backgrounds including Pakistani, Bangladeshi, Indian, Iranian, Iraqi, Kurdish, Turkish, Albanian and Eastern European.

The sentencing Judge concluded that there was no evidence that the defendants were racially motivated in committing the crimes:

“In my view, and speaking in broad terms, these defendants selected their victims not because of their race, but because they were young, impressionable, naïve, and vulnerable.”

It has been properly emphasised that there are thousands of white British males on sex offenders’ registers. But with this particular model of abuse, whilst the individual beliefs of the perpetrators are not known, all appear to come from a non-white, predominantly Asian/British Minority Ethnic culture or background.

In 2014, Ofsted⁶³ highlighted a particular pattern across the country involving predominantly White British girls as victims and gangs of predominantly Asian heritage men as perpetrators. In Rotherham, by far the majority of perpetrators were described as Asian by victims and in files as Asian males, without precise reference being made to their ethnicity. In 2015 Casey commented on unintended consequences of suppression of these uncomfortable issues which has done a disservice to the Pakistani heritage community as well as the wider community.⁶⁴

“It has prevented discussion and effective action to tackle the problem. This has allowed perpetrators to remain at large, has let victims down, and perversely, has allowed the far right to try and exploit the situation.”

In Oxfordshire⁶⁵, the perpetrators were predominantly of Pakistani heritage and all the victims were white British girls. The Review recommended that relevant government departments should research why this is the case, in order to guide prevention strategies.

⁶³ The sexual exploitation of children: it couldn't happen here, could it? Thematic Ofsted inspection to evaluate effectiveness of local authorities' current response to child sexual exploitation. November 2014

⁶⁴ Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013 Alexis Jay OBE Rotherham Metropolitan Borough Council 2014; Report of Inspection of Rotherham Metropolitan Borough Council. Louise Casey CB. House of Commons. 2015

⁶⁵ Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E, and F. Oxfordshire Safeguarding Children Board. 2015

In Bristol⁶⁶ the perpetrators were young men in their early 20s with a Somalian background; many were refugees fleeing violent conflict and trauma in their home country. It was not possible to explore the impact of this background and that review found that there is much more to learn from perpetrators' childhood experiences in order to gain more understanding of risk areas and to identify early warning signs.

In 2017 research by the Quilliam Foundation, found that of 264 offenders convicted for grooming offences in the United Kingdom between 2005 and 2017, 84% were of Asian heritage, mostly Pakistani; 8% were black and 7% were white. Asians or British Asians who make up 6.9% of the population, are responsible for 46% per cent of child sexual exploitation crimes.⁶⁷ The Chief Executive of Quilliam commented that:

“Not talking about it doesn't make the problem go away, and letting bigots hijack the debate creates further division in society. We as a society need to tackle this head on.”

This was echoed by Northumbria Chief Constable Steven Ashman following the sentencing in the Newcastle trials:

"Why is it that there appears to be a predominance of this type of offending in a particular community? I think that community has to be asked that question ... I think we can take part in that debate, but it's not led by the police, it's a job for society itself..."

Some attempts to start a national conversation have not been very successful.

In November 2017, it was reported⁶⁸ that the Chief Inspector of Ofsted has compiled a file of concerning materials found by inspectors in libraries and used for teaching of boys and girls in Islamic maintained schools, independent faith schools and unregistered schools. Out of step with mainstream Muslim thinking, it included examples of discrimination, sexism, and misogynistic material, urging women to be submissive, not to have ambition and never refuse sex to their husbands or leave the house without permission and sanctioning domestic violence by way of correction. Eastern Women were contrasted with internally torn women of the West who attract men and leave home to hang around aimlessly in cinemas and cafés.

In 2016 Casey prepared a report for the Government on opportunity and integration and commented that the Department for Education turns a blind eye and hopes that Ofsted will deal with the problem. "It's all in the too difficult box."⁶⁹

One male perpetrator agreed to contribute to the Review. In prison, he explained that he left his country of origin for a better job, spent 10 years in Turkey, 5 years or so in Greece and some time in Italy and France, before travelling to England on

⁶⁶ The Brooke Serious Case Review into Child Sexual Exploitation: Bristol Safeguarding Children Board. 2016

⁶⁷ Research Report, Quilliam Foundation. December 2017

⁶⁸ Bennett and Sylvester. The Times. 28 November 2017

⁶⁹ The Casey Review: a review into opportunity and integration: An independent review by Dame Louise Casey into opportunity and integration. Department for Communities and Local Government. December 2016

the way to Canada. He was detained by immigration officials who questioned his status and he claimed asylum. Later he was granted indefinite leave to remain in the United Kingdom. He intends to return home at the end of his sentence.

During sentencing the judge commented that:

“Your intention was to incite these young women (aged 15 years) to prostitution, that is, to encourage them to trust you, and to think of you as their friend, whilst also encouraging their dependency on the drink and drugs you provided so ultimately, they would provide you with sexual services.”

“When interviewed you made no comment, except to make remarks which betrayed your complete contempt for the victims of your offending. You described them as “kids” yet your instinct had been, not to protect them because they were children but to exploit them.”

Exploring what might have prevented him from offending was not possible. He displayed no regret, claimed he only had sex with girls over 16 years old and that they knew what they were doing. They were responsible and brought drugs onto his premises. One was homeless so what could he do? He was convicted because of a conspiracy by the government, police and the judge who paid the victims.

If convicted for rape in his home country, he would be beheaded or buried up to the neck and stoned. He was asked about what he thought about the United Kingdom and influences in his education. He said you can get anything here – any sex, drugs, alcohol. There is no control. He spoke in a derogatory way about lack of morals in British girls and did not go with Muslim girls because there are not many of them.

Before his conviction he had been served with a harbouring notice warning that he had no permission to have a 15-year-old in his home but this did not persuade to discontinue his activities. Arrogance and persistence despite authorities clearly investigating is a feature of the cases. Also lack of concealment or care about the arrangements. Sentencing another perpetrator, the judge described how:

“Texts show you encouraging young women to frequent your home, attempting to recruit more young women to meet your friends, advertising to your friends when there were girls available at your home, and boasting of your sexual exploits.”

It was unfortunate that there were not more opportunities to meet with perpetrators and further attempts, if successful, might lead to greater understanding.

Recommendation 1.3

I recommend that:

Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should continue to work with relevant partners to try and encourage conversations with perpetrators to better understand the Newcastle context of their offending.

The Sexual Violence against Children and Vulnerable People National Group Progress Report and Action Plan published in March 2015 committed the government to:

“Develop a stronger evidence base on the motivations for offending and effective interventions.”

“The Ministry of Justice and National Offender Management Service will review what we know about child sex offenders and motivations for offending; and identify the feasibility of further research to improve the evidence base including on what approaches are most effective at reducing the risk of offending.”

In Section 5.11, I highlight the willingness in Newcastle across communities to have conversations but these issues are bigger than Newcastle and there is an urgent need for them to be addressed robustly at a national level, for reliable research to be undertaken and guidance to be issued.

Recommendation 2.3

I recommend that:

The Government should arrange for research to be undertaken concerning profiles, motivations and cultural and background influences of perpetrators of sexual exploitation of children and vulnerable adults and publish guidance for strategists and practitioners on the most effective way to reduce offending.

7. Newcastle in the Context of the National Picture: preparing for, preventing and responding to sexual exploitation

7.1 Response to Legislation and Guidance

Government guidance published in 2000⁷⁰ reflected concern about child prostitution. The title and much of the content focused on children found persistently loitering, soliciting or importuning and in sight and obvious. This had an influence on the steps taken to ascertain prevalence within a particular area.

The materials available to the Review indicate that the Newcastle Area Child Protection Committee, established by Newcastle City Council in response to statutory guidance in 1999⁷¹ provided a good basis for interagency working. In response to the 2000 guidance, the Committee developed a protocol on children involved in prostitution and monitored and reviewed its operation.

Significantly, there was a determined interest in understanding local prevalence and in September 2003, the Committee commissioned Barnardo's to carry out research into Child Sexual Exploitation through Prostitution in Newcastle upon Tyne.

In response to growing concern about the lack of framework to protect vulnerable adults from abuse, in 2000 the Government published Guidance⁷². Definitions of abuse included sexual abuse but no reference to the risk of targeted, organised sexual exploitation or prostitution. Acting on the Guidance, Newcastle City Council established a Multi-Agency Management Committee for Safeguarding Vulnerable Adults which was responsible for developing interagency strategies, policies and procedures.

In 2004, revised guidance and procedures on "Safeguarding Children at risk of Sexual Exploitation through Prostitution" were launched in Newcastle. In September 2005 a comprehensive Report⁷³ on reducing the impacts of sexual exploitation, reflecting research and understanding at the time, was published by Newcastle Area Child Protection Committee, Safe Newcastle and Barnardo's.

The research focused on victims known to agencies and identified low numbers, relative to children within the child protection system. It was not unreasonable for the view to be taken that child prostitution was not particularly prevalent in Newcastle.

⁷⁰ Safeguarding Children Involved in Prostitution: Supplementary Guidance to Working Together to Safeguard Children: Department of Health, Home Office Department for Education and Employment, National Assembly for Wales. 2000

⁷¹ Working Together. Department of Health, Home Office, Department for Education and Employment. 1999

⁷² No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. Department of Health and Home Office. 2000

⁷³ Research Report, Reducing the Impacts of Sexual Exploitation. Newcastle Area Child Protection Committee, Safe Newcastle and Barnardo's. 2005

The 2005 Report included a short section on “The needs of older people” but this was restricted to conversations with “adults involved in the sex industry”.

The legislative framework for safeguarding adults was weak and there was no significant awareness nationally of the prevalence of sexual exploitation of vulnerable adults. It is not surprising that there were no arrangements at that time to specifically address sexual exploitation of vulnerable adults.

In January 2006, in prompt response to legislation and guidance, Newcastle City Council established Newcastle Safeguarding Children Board which replaced the Area Child Protection Committee. Listed partner agencies were required to co-operate with local authorities and proactively ensure that they carry out all their functions having regard to the need to safeguard and promote the welfare of children.⁷⁴

There was a huge amount of work for the new Local Safeguarding Children Boards to undertake. Within this, the Newcastle Safeguarding Children Board gave priority to the issues addressed and recommendations made in the 2005 Report.⁷⁵

By Autumn 2006, a Child Sexual Exploitation Strategy and Plan were in place.

During 2006, Newcastle City Council also established Newcastle Safeguarding Adults Committee to replace the Multi-Agency Management Committee and formed, within Adult Social Care Services, a Safeguarding Adults Unit, a dedicated team responsible for multi-agency safeguarding procedural advice and to lead on complex safeguarding investigations.

In September 2006, the Missing Sexual Exploitation and Trafficking Group involving practitioners and managers in the statutory and voluntary sectors, was set up as a sub-group committee of the Newcastle Safeguarding Children Board. The activities included considering research, sharing information between agencies, identifying hotspots and targeting activity and set the tone for the region.

At this time, the view was that, while child sexual exploitation took place, it was not as extensive in Newcastle as was becoming apparent in some other parts of the country. The 2005 Report identified no visible signs of street child prostitution. Incidents involving young gay men appeared to be limited to public toilets and parks.

As understanding of child sexual exploitation increased nationally, referring to and treating victims of sexual exploitation as child prostitutes properly became unacceptable, although the terminology persists in definitions of some criminal offences.

In a research report published in 2015, the Northern Rock Foundation commented that in 2006 when it began researching sexual exploitation of adults and children in the North East and Cumbria there were few places in the North East where there

⁷⁴ ss 10;11;13 Children Act 2004; Working Together to Safeguard Children. HM Government. 2006

⁷⁵ Reducing the Impacts of Sexual Exploitation. Barnardo's, Newcastle Area Child Protection Committee, Safe Newcastle 2005.

was any awareness of Child Sexual Exploitation “with the exception of Newcastle and Middlesbrough.”⁷⁶

From 2006 to 2008 the approach locally continued to be driven by the national view that teenage victims of sexual exploitation were not victims in the same way as younger children but made choices, may be promiscuous and might be influenced by the offer of money. The multi-agency system was not set up to provide an effective response for adolescents with a complexity of needs, at the time and pace they need it, leaving children with a fragmented and reactive response to different aspects of their behaviour.⁷⁷ An Ofsted Thematic Report drew on serious case reviews carried out from 2007 to 2011⁷⁸ found that older children were frequently treated as adults, because of confusion about age and legal status.

In Newcastle, this changed when a report of a Serious Case Review carried out by Newcastle Safeguarding Children Board in 2008 emphasised that vulnerable adolescent young people are children and their ability to make choices in their best interests can be compromised. Safeguarding duties continue until 18 years old and agencies need to be persistent in delivering services, accepting the difficulties of working with a young person who may not understand the need for a service. The Board published Guidance on Working with Vulnerable Young People in Need and organised multiagency events to reinforce these messages.

As early as 2007, cases of sexual exploitation of adults with vulnerabilities were being identified and cases involving older children attracted close working between children and adults’ services as victims’ vulnerabilities were recognised as continuing into adulthood.

In 2009, the Government published Guidance which set out the minimum requirements for procedures⁷⁹ and contained no references to sexually exploited children being prostitutes. It reflected learning from across the country, particularly from events in Rochdale and Rotherham.

In Newcastle, the Missing Sexual Exploitation and Trafficking Group considered and addressed the implications of this Guidance. Agencies with responsibilities for safeguarding and promoting the welfare of children, including local and national voluntary child and family support agencies and national voluntary child care organisations with a local presence, were involved in drawing up procedures.

Recommendations in the Overview Report of a Serious Case Review carried out by Newcastle Safeguarding Children Board in 2010 sought to strengthen the work with adolescents displaying risk-taking behaviour.

⁷⁶ Child Sexual Exploitation in the North East and Cumbria. Think. Northern Rock Foundation; Barefoot Research and Evaluation. November 2015

⁷⁷ The Brooke Serious Case Review into Child Sexual Exploitation: Bristol Safeguarding Children Board. 2016

⁷⁸ Ages of concern: learning lessons from serious case reviews: A thematic report of Ofsted’s evaluation of serious case reviews from 1 April 2007 to 31 March 2011. Ofsted. 2011

⁷⁹ Para. 4.10 Safeguarding Children and Young People from Sexual Exploitation: supplementary guidance to Working Together to Safeguard Children; Department for Children, Schools and Families 2009

A multi-agency Risk Management Group was set up in July 2012 to consider young people who were considered to be at high risk of harm including those missing from home and local authority care, involved in drug and alcohol misuse, and offending. A learning review carried out in 2013 endorsed the role and functions of this Group and found that it “has a crucial role in the management of some of the most vulnerable young people”.

The Newcastle Safeguarding Adults Board was established in February 2009 and revised Inter-Agency Safeguarding Adults Procedures were published. No government guidance had been issued since 2000 and proposed legislation to address adult safeguarding was still being considered. Consistently with similar arrangements elsewhere there was no specific reference to sexual exploitation but Newcastle Safeguarding Children Board provided both face to face and online child sexual exploitation training from 2009.

Lengthy consultation by the Department of Health began on proposed legislation and guidance for an interagency framework for safeguarding of adults with needs for care and support. Newcastle Safeguarding Adults Board and professionals responded to the consultation with representations about the need to recognise and to reflect the growing experience in Newcastle of sexual exploitation of adults which it was thought would be occurring unrecognised elsewhere.

They also provided a Case Study example which was included in the Statutory Guidance⁸⁰ issued in 2015, which includes one other reference to sexual exploitation, emphasising that people who may lack capacity should be helped to understand that they have the right to say “no”. There is no further exploration or guidance or reference to circumstances in which a victim may not want to say “no” but needs protection.

Newcastle Safeguarding Adults Board policies and procedures and associated guidance documents and training programmes were revised and launched to coincide with the implementation of the Care Act in April 2015.

As the details of high profile cases concerning child sexual exploitation in other parts of the country became available, work continued to understand the likely prevalence in the Newcastle area. In April 2013 a briefing was arranged to inform members of the Newcastle Safeguarding Children Board about Child Sexual Exploitation and the National Context, to review the local situation, and to discuss the local Child Sexual Exploitation Action Plan.

It included reports on cases in Derby, Rochdale and Oxford, work being undertaken by the Children’s Commissioner, information on prevention work in Newcastle schools, arrangements for children considering missing from home, and the use of Complex Abuse Procedures to address the management of cases.

A presentation included reference to a national Report that suggested “If you Shine a Light you will probably find it”. A Local Problem Profile was given by a senior police officer who reported on what was known and understood about local prevalence

⁸⁰ Care and Support Statutory Guidance Under the Care Act (2014) Department for Health 2015 Updated 2016/2017

which confirmed that although cases were identified and the issue was subject to continuing review, it did not appear that sexual exploitation was occurring on a large scale.

Later in 2013, continued profiling suggested that the assessment should not be changed but then accounts of victims, proactive enquiries and intelligence led to a recognition that the extent of sexual exploitation was greater than previously assessed. Operation Sanctuary was launched in January 2014 and the Hub was established.

To reflect growing awareness of the vulnerability of adults, in 2014 representation from adult services was included in the Missing Sexual Exploitation and Trafficking Group and it became a sub-group of the Newcastle Safeguarding Adults Board in July 2015.

In 2017 the Government⁸¹ stressed that all practitioners should work on the basis that sexual exploitation is happening in their area.

At the conclusion of trials in August 2017 Newcastle City Council Chief Executive and Northumbria Police Chief Constable emphasised that grooming gangs are active in many, if not all, other areas of the UK:

“I think we all need to learn from one another in terms of this happening in different places. What’s different here in Newcastle is that we are going out and looking for it.”

“We do not believe that what we have uncovered in Newcastle is unique. Sadly, there is evidence of sexual exploitation in just about every other town and city in the country and anyone who says they do not have it are not looking for it.”

The Newcastle experience indicates that this approach must be taken to safeguarding adults and children vulnerable to sexual exploitation.

Professionals and agencies in Newcastle have been using regional, national and professional networks to stress the need for greater recognition of the need to proactively look for sexual exploitation of adults, close collaboration between Safeguarding Children and Safeguarding Adults Boards and the need for very early involvement of adult services staff with children’s services as victims or potential victims approach adulthood.

The only issue identified by the Review arising from national guidance from 2000 which was not reflected in local arrangements was the expected involvement of the Crown Prosecution Service with the interagency framework in developing procedures and advising on keeping of records to take account of criminal court processes. This would have required national direction to ensure consistency and

⁸¹ Advice, Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. Department for Education. February 2017

is unlikely to have occurred elsewhere in the country. I discuss this further in Section 7.9.

The Newcastle Safeguarding Boards have good arrangements in place to consider the content and impact of newly issued national guidance.

Recommendation 1.4

I recommend that:

When considering national guidance or advice Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should ensure that expectations for engagement with a national agency that is not a local partner are addressed and kept under review.

7.2 Overarching Response

The Review examined carefully the responses of agencies when there was evidence or suspicion of sexual exploitation taking place. There is a stark contrast between the approach before early 2014 when Operation Sanctuary was launched and the Hub established, and the effectiveness of services thereafter.

Because of the success of these arrangements, the impression may be gained that prior to 2014 no effective work took place. The Review identified many examples of excellent practice and consistent, committed support for victims where professionals had gone above and beyond what might have been expected and worked outside of thresholds persistently and tenaciously with a creative approach to safeguard victims.

Practitioners, however, spoke about their uncertainty about how to manage the risks when they were recognised and their disappointment at the lack of progress with victims and cases feeling “stuck”. There was frustration that the approach and commitment did not achieve the outcomes hoped for.

The most significant change that occurred in 2014 was the determination by the police and partners to address more effectively the causes of the exploitation, that is the activities of the perpetrators, through effective investigation and disruption.

7.3 Response prior to 2014

The Review identified many examples of good practice by police officers in relation to immediate victim safety. They responded quickly to requests to locate and return young people missing from the care of the local authority and vulnerable adults who were missing from their placements. If when carrying out other duties, they came across young people drunk or in distress in the company of older men, they acted to take them home to their parents or to their placements. Conversations took place with carers to ensure they were aware of where their children had been found and in whose company.

It is not surprising that there were some examples of frustration or reluctance to respond when police officers received frequent, perhaps daily, requests to find and return a victim, when she appeared willingly to go to abusers and was judged to have the capacity to be able to choose. This was addressed quickly and resolved appropriately by agencies through discussions between managers.

Some criminal investigations and trials did take place but with variable outcomes.

Action lacked consistency and had little impact generally on activities of perpetrators. Perpetrators were not consistently investigated or formally interviewed and background checks were not undertaken. Historical information was not routinely accessed and incidents were treated as separate occurrences with no strategy to pull information together to improve understanding of the whole picture. At the Learning Events, it was felt there was a lack of professional curiosity, thinking beyond the presenting issue, and insight into the actual harm victims were experiencing.

There were no effective inquiries about relationships, why girls were with older men to whom they were not related; explanations were accepted, even when a young girl was found in the bedroom of an older man. There was little inquiry into what other victims there may be or the vulnerability of children, young people, and vulnerable adults in the perpetrators' families and circle of contacts. There was a lack of forensic medical examinations or collection of physical evidence.

Suspected offences were discussed at Complex Abuse Investigation Meetings and this did lead to a limited number of applications for harbouring notices and child abduction warning notices but within the Timelines and Agency Review reports there is little reference to activity to disrupt perpetrators' activities.

While perpetrators were not punished or disrupted, attempts to persuade victims to change behaviours and not return to the abusers led to consideration of deterrent punishments of victims for being drunk and disorderly or for making false allegations when accounts were changed. Some victims were placed in secure accommodation.

This sent an unhelpful message to perpetrators – they would unlikely to be prosecuted or prevented from continuing to abuse - encouraging an arrogant persistence. It also had a significant impact on victims who learnt that nothing would be done against perpetrators.

The absence of criminal processes also led to police officers not consistently attending interagency safeguarding meetings, taking the view that they had little to contribute.

This did not recognise the value to the interagency safeguarding arrangements and family court proceedings of police inquiries and intelligence even if no prosecution takes place or a trial leads to a not guilty verdict. Decisions and outcomes of criminal processes have limited value in considering and acting on risks to vulnerable children and adults. All that is ever decided by a not guilty verdict is that on the

evidence presented (which may be very limited) the jury was not sure of guilt and “found innocent” is not a verdict known to the law.⁸²

7.4 Why were Perpetrators not Investigated and Prosecuted or otherwise Disrupted Prior to 2014?

The Review considered the background thoroughly to better understand the approach by the police over the period reviewed.

In Section 7.6, I highlight that reasons identified for lack of action that have been features of reviews carried out elsewhere, including ignoring whistle blowers or members of the public or families, lack of compassion or empathy, misplaced concerns about political correctness or fears of allegations of racism or inappropriate interference by senior official or political leaders, did not occur in Newcastle.

Practitioners did feel that early responses had the appearance of blaming the victims for their behaviour and allocating them responsibility for making bad choices and the Reports and discussions identified language in records that reflected this.

The perpetrators’ control and influence were not fully understood and uncertainty regarding consent and capacity encouraged the view that some victims chose to be with the perpetrators. This led to frustration that the advice or help offered did not impact on their behaviour.

However, while perceptions of responsibility of victims for their own actions complicated identifying an effective response, there is no evidence that this influenced decisions about whether action should be taken or undermined the determination to safeguard victims.

The need to be cautious to avoid judgemental and prejudicial language in practice and in recording had already been identified and acted upon in Newcastle before the Review began and is addressed in training on sexual exploitation for frontline staff developed by the Safeguarding Boards. This stresses the possible detrimental impact it may have on evidential accounts.

The explanation for the lack of criminal investigation and prosecution of perpetrators is the lack of confidence of police officers, shared by other professionals who accepted their judgments, that there was unlikely to be any realistic prospect of securing convictions.

This was influenced by experience of pursuing cases in which there was a lack of co-operation from victims or inconsistency in their accounts, the courts’ historical approach to the evidence of complainants in sexual assault cases, the undermining of victims in court and past advice from and the cautious approach from the Crown Prosecution Service towards approving cases for charge and trial.

The House of Commons Home Affairs Committee in 2013 confirmed that in the past, police forces were not taking the right approach towards cases of sexual exploitation

⁸² Lord Justice Judge Para. 15. R v Cannings [2004] EWCA Crim 01

and put this in the context of experience of the criminal justice system, which is widely acknowledged to have failed to adequately protect and support victims. The Director of Public Prosecution acknowledged that the Crown Prosecution Service approach to credibility of victims had been inappropriately cautious and risked leaving them unprotected by the criminal justice system. The standard test for credibility would, if unadjusted, almost always find against a victim.⁸³

Some of the relevant factors were: the insistence on having a complainant who was willing to co-operate and who would be a competent witness; the possibility of inconsistent or confused accounts; damaging material in records that must be disclosed; delay allowing pressure and threats and anxiety to affect willingness to take part; the courts' traditional approach to consent; victims may be resistant to intervention and maintain links with abusers, even after attempts to help protect them⁸⁴ and uncertainty about jury members attitudes. Further complications arose if there was any cognitive impairment.

In Newcastle, the early application of Complex Abuse Investigation processes reflected a determination to take an overview of the management of criminal investigations and safeguarding but the focus still remained on obtaining reliable disclosures from victims.

The Oxfordshire Report⁸⁵ referred to police saying that if a child did not disclose it was a matter for social services as they "needed to move on to the next job".

Continuing caution regarding these issues in Newcastle led recently to renaming on legal advice a Victim's Charter as a Complainant's Charter, to avoid any risk of undermining evidence by implying investigations were not being progressed with an open mind.

The Home Affairs Committee reported that the Director of Public Prosecutions had announced new measures to combat the previous failings.

There is no evidence of any reluctance to understand or act upon knowledge of the prevalence of sexual exploitation in Newcastle, but when the prevalence was better understood, it was the catalyst for an immediate change of approach - absence of evidence is not evidence of absence of abuse; safeguarding and support of victims is a priority; prosecution and punishment of perpetrators is part of a range of responses; covert investigative techniques obtain independent evidence to corroborate victims' accounts; comprehensive tactics for disrupting perpetrators' activities and minimising reliance on victims' testimonies.

Northumbria Police carried out a rigorous review of a number of previous investigations to consider if there were any missed opportunities or any merit in reinvestigating previous reports. Reconsideration of allegations with the Crown

⁸³Para. 57 Child sexual exploitation and the response to localised grooming House of Commons London: The Stationery Office Limited. June 2013

⁸⁴ Advice, Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. Department for Education. February 2017

⁸⁵ Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E, and F. Oxfordshire Safeguarding Children Board. 2015

Prosecution Service led to prosecution of perpetrators and facilitators. A number of issues were considered by the Force professional standards department which led to management action against individual officers.

Extensive police training has increased the rigour in establishing names, relationships and why people are together when encountered by the police. Improvements in technology allow officers easier access to intelligence through individually issued tablets.

7.5 Interagency Responses

Interagency responses focused on the victims and their attitudes and behaviour in order to try and influence them by persuasion and sometimes by control not to associate with their abusers. Very considerable energy and resources were undermined by the continuing influence of the abusers. There is no evidence that the police approach to investigation of perpetrators was challenged by other agencies through interagency procedures.

Although there were excellent examples of multi-agency working, Practitioners felt that there were also examples of professionals working in silos and without understanding the full picture. The acceptance that it was very unlikely that there would be successful prosecutions led to police attendance at interagency safeguarding meetings to be inconsistent and they did not routinely receive copies of minutes. Since 2014 this is no longer the case and the attendance at interagency meetings and circulation of minutes is monitored through audit arrangements.

7.6 Interagency Awareness and Preparedness

Effective action including resourcing to prepare for and prevent sexual exploitation relies on an understanding of the prevalence or likely prevalence in a particular area.

In 2013, the Home Affairs Committee report, citing Oxfordshire, was critical of agencies assuming that it was unlikely to happen in their area. The report of a Thematic Inspection by Ofsted in 2014⁸⁶ rhetorically questioned: “The sexual exploitation of children: it couldn’t happen here, could it?” In 2014, Professor Alexis Jay’s report into the sexual exploitation of children in Rotherham was “a wake-up call for every professional working in the field of child protection.”⁸⁷

In Section 7.1 I set out the comprehensive steps taken in Newcastle from 2000 to respond to and implement government guidance and to understand the likely prevalence of child sexual exploitation.

Although the launch of Operation Sanctuary was highlighted by all agencies and professionals as a catalyst for substantial change, the Review found no evidence prior to this of any reluctance to understand or act upon knowledge of the prevalence of sexual exploitation. Nor was there evidence of any assumption that it was unlikely

⁸⁶ The sexual exploitation of children: it couldn’t happen here, could it? Thematic Inspection Report Ofsted 2014

⁸⁷ Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013 Alexis Jay OBE Rotherham Metropolitan Borough Council. 2014

to happen in Newcastle. More recently, Ofsted⁸⁸ found that considerable emphasis has been placed on the collection and sharing of information with partner agencies “resulting in a sophisticated understanding of the extent of sexual exploitation in Newcastle and surrounding areas.”

Reports⁸⁹ in 2014 and 2015 on events in Rotherham referred to unsuccessful attempts by professionals to have sexual exploitation addressed by alerting senior figures. One was a whistle-blower who with The Times investigative reporter, Andrew Norfolk, exposed⁹⁰ failures of the authorities. In Rochdale and Oxfordshire families and professionals repeatedly attempted to alert police and social care services.⁹¹

The Review specifically and as thoroughly as possible considered whether this had occurred in Newcastle.

All local MPs, the Police and Crime Commissioner, and key community and voluntary organisations were asked whether they had raised issues or had been approached by any professionals or members of the public. Partner Agencies were asked to check whether such issues were raised through strategic interagency processes, consultation processes or chief officer and senior management meetings or correspondence. Agencies’ complaints and representation records were reviewed to ascertain whether any member of staff or service user had registered discontent. External, independent inspection reports were considered. Press and media coverage of safeguarding and contact with trade unions and professional associations were reviewed.

There was no evidence that any professional, individual, member of the public, politician or agency tried to alert the authorities or complain about any lack of proactivity or response in addressing large scale sexual exploitation.

The Safeguarding Boards’ multi-agency audits require partner agencies who deliver services to confirm whether they have effective whistle blowing policies and systems in place for professionals and service users, which are compatible with the Boards’ Policies.

In 2013, the Home Affairs Committee asserted that Rochdale public servants lacked human compassion and Rotherham Inquiry Reports identified lack of empathy by staff involved.

There was no evidence in the material considered during the Review or discussions at the Learning Events that in Newcastle the approach of the police or any other

⁸⁸ Newcastle Upon Tyne Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board. Inspection date: 24 April 2017 – 11 May 2017. Ofsted Report. 7 July 2017

⁸⁹ The Independent Inquiry into Child Sexual Exploitation in Rotherham published in 2014 and the Report of Inspection of Rotherham Metropolitan Borough Council published in 2015

⁹⁰ Broken and Betrayed: The true story of the Rotherham abuse scandal by the woman who fought to expose it. Jayne Senior. Panmacmillan 2016

⁹¹ Overview Report of the Serious Case Review in respect of Young People 1,2,3,4,5 & 6. Rochdale Borough Safeguarding Children Board 2013; Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E, and F. Oxfordshire Safeguarding Children Board 2015

agency was influenced by disregard for the victims' welfare and safety. While different responses might have been more effective, in doing what was done, staff were anxious to do their best for the children and adults who were being exploited.

Commentators on Rochdale alleged perpetrators were not pursued for fear of being accused of racism.⁹² In 2015⁹³ the Government, citing the Jay Report, declared that in Rotherham misplaced concerns about political correctness stopped any proper action being taken. There was also inappropriate interference by senior officials and political leaders to prevent inquiries being pursued effectively.

The Review considered as thoroughly as possible whether anything similar had occurred in Newcastle. There was no evidence that any action or inaction by police or any other staff or officials were motivated or affected by fears of allegations of racism and no evidence of impropriety by any person in a position of authority.

Safeguarding vulnerable adults from sexual exploitation has not attracted the national profile of child sexual exploitation and lacks central guidance and advice.

There are only passing references to vulnerable adults in the 2017 Report of the HMIC inspection of Northumbria Police⁹⁴. The HMIC website list of "Our work" highlights "Child abuse and child protection issues" but makes no reference to safeguarding vulnerable adults and no discrete inspections address this area of service.

In 2015⁹⁵ the Government warned that child sexual exploitation was not confined to one area and that "any local authority or police force that denies that it has a problem, or thinks that it is only happening elsewhere, is wrong." This Review has confirmed that this strong statement applies equally to sexual exploitation of vulnerable adults.

Some national materials for child sexual exploitation are relevant to adult sexual exploitation. There are arrangements in place in Newcastle City Council Adults Social Care and Newcastle Safeguarding Adults Board to consider and take account of relevant strategic and practice child safeguarding guidance, although the legal framework for services is very different.

The sexual exploitation tools used in Newcastle were reviewed jointly when the Safeguarding Boards launched the joint Sexual Exploitation Communication Strategy in 2015. A checklist was developed from work undertaken with victims which Practitioners identified as a very effective tool. Arrangements which include considering the factors in the cases reviewed are in place to evaluate its effectiveness.

The Practitioners identified an urgent need to increase awareness of sexual exploitation of vulnerable adults nationally, for government guidance on strategic

⁹² Times 23 May 2017

⁹³ Tackling Child Sexual Exploitation. HM Government. March 2015

⁹⁴ Report of HMIC's PEEL: police effectiveness inspection of Northumbria Police Force March 2017

⁹⁵ Tackling Child Sexual Exploitation. HM Government. March 2015

and practice implications and reform to take account of the weaknesses in the legal framework.

In 2017, the Ofsted inspection recognised the excellent interagency work by Newcastle City Council and its partners, highlighting the coordination between the Safeguarding Boards which has effectively supported and overseen the development of “outstanding multi-agency practice in responding to sexual exploitation.”

Assessing the impact of consistent responses and preventative action is difficult. More effective identification and raising awareness has led to an increase in numbers of victims. However, some cases involve historical abuse, some involve recent exploitation which indicates that despite action and publicity, perpetrators continue to target victims. In 2016, an independent report⁹⁶ explained that child sexual exploitation takes place despite a range of preventative, supportive and enforcement measures and that:

“The extent of CSE can be mitigated but not eradicated, as a result of the complex array of push factors (which are related to poverty, family relationships and education).”

7.7 Regional and National Links

The Review found that there has been a determination to share learning and to learn from increasing knowledge elsewhere. Newcastle City Council Safeguarding Adults Unit have received requests from across the country to provide training, advice and support to authorities looking to embed similar practice in relation to transition and adults at risk of sexual exploitation.

Staff at the Hub have given presentations at national conferences and workshops and contribute to national initiatives. Safeguarding Boards and local authorities from across the country visit Newcastle to observe and discuss the good practice in overcoming obstacles to closer working of adults and children's services.

Regional meetings of representatives of Local Safeguarding Boards provide opportunities to share information and develop co-operative arrangements. Newcastle representatives stress the urgent need to assume sexual exploitation of adults takes place in all areas.

National links include the National Working Group Network (a national charity offering support and advice to staff working with people affected by sexual exploitation, Parents Against Child Sexual Exploitation (a leading national charity working with parents and carers of sexually exploited children) and the Child Sexual Abuse Centre, a Home Office funded centre of expertise on child sexual abuse led by Barnardo's.

⁹⁶ Northern Rock Foundation Report on Child Sexual Exploitation in the North East and Cumbria 2016

7.8 Police and Crime Commissioner

Police and Crime Commissioners replaced police authorities in November 2012 and are broadly responsible for securing efficient and effective policing of a police area.

The Police and Crime Commissioner for Northumbria Police Area, Dame Vera Baird, QC, has a national reputation for promoting the interests of victims of domestic violence and sexual assault. She has good relationships with Newcastle City Council and partner agencies and attends and contributes to interagency safeguarding events.

She has been kept well informed of developments regarding sexual exploitation in Newcastle and the progress of Operation Sanctuary and was invited to contribute to the Review.

She was keen to speak positively of the culture in Northumbria that deals with sexual exploitation and vulnerability as a key issue and gives strong support to the development of Personal, Social, Health and Economic education in schools that addresses sexual violence. She has been a strong supporter of campaigns to ensure that victims can record their evidence for criminal proceedings and need only do so once.

The Review gave an opportunity to consider the benefits of more formal links between the interagency safeguarding frameworks and the Commissioner.

The Safeguarding Boards routinely send copies of Annual Reports to the Commissioner so that she can fully consider the contents and how she can improve her contribution to safeguarding throughout her organisation and to the joint work of the Boards.⁹⁷ Arrangements include sending copies of agendas of Safeguarding Boards' meetings in advance so that she can consider making a contribution. There is a standing invitation for her to request issues to be considered and to attend meetings if appropriate.

Representatives of the Newcastle Boards are liaising with other Boards in the region to ensure that there is consistency in this across the Northumbria Police Area.

Police and Crime Commissioners have statutory duties under the Children Act 2004⁹⁸ to co-operate with the local authority and to carry out functions having regard to the need to safeguard and promote the welfare of children. They must hold Chief Constables to account for the exercise of their duties under the same provisions.⁹⁹

As part of its statutory remit, Newcastle Safeguarding Children Board carries out audits with agencies to ascertain how Children Act duties are being met and arrangements have been made to include the Commissioner in these audits.

⁹⁷ Schedule 2 paragraph 4 (2)(b) Care Act 2014. Paragraph 14.161 Care and Support Statutory Guidance 2014

⁹⁸ ss 10; 11 Children Act 2004

⁹⁹ s 1(8)(h) Police Reform and Social Responsibility Act 2011. Para. 18 Chapter 2 Working Together to Safeguard Children. HM Government. 2015

In 2017 the Commissioner published an important and influential report¹⁰⁰ setting out the results and conclusions from observations by volunteers who attended 30 rape trials at Newcastle Crown Court. In a significant number of cases safeguards for the treatment of victims were not being met. The report included recommendations to courts and the Crown Prosecution Service and the discussions that took place as a result. It is relevant to any work undertaken by agencies supporting victims through criminal processes.

7.9 Crown Prosecution Service

The Crown Prosecution Service was requested to take part in the Review but initially declined to do so. The Acting Chief Crown Prosecutor for the CPS North East, was keen to ensure that his Team was not distracted from the job in hand and thought involvement may not have yielded proportionate value to the review. An offer was made to respond to any issues relating to the Crown Prosecution Service that arose.

The value of a Serious Case Review is that agencies review their own practice within the context of what was known and done by other agencies. As the Review progressed the failure to deal with perpetrators through the criminal justice system and otherwise was a significant feature of the Learning Events and further representations expressing disappointment that the Crown Prosecution Service was not taking part were made.

It was decided that the Crown Prosecution Service would review the cases in which it had involvement. By this time, the interagency review processes were almost complete and the Service reviewer was unable to play any part in the Learning Events or contribute to interagency discussions and it was therefore an isolated piece of work.

An Overview Report of a Serious Case Review¹⁰¹ carried out in 2010 included a recommendation, accepted by the Crown Prosecution Service, that it should develop internal arrangements to participate in Serious Case Reviews and the Crown Prosecution Service website appears to reflect a policy favouring involvement.

There did not appear to be any established internal processes to contribute to the Review and I had a number of helpful meetings with the reviewer who, although not independent of case work, did apply critical consideration to the process. The final report was the best that might have been produced in the circumstances. It highlighted good practice and included suggestions for improved arrangements, including practical arrangements for witnesses at Court.

The CPS North East covers an area within which there are a significant number of Safeguarding Boards and it is reasonable to consider the potential resources required to be involved in reviews. The Newcastle review was likely to be high profile and the action taken against perpetrators is a significant area of public interest. If

¹⁰⁰ Seeing is Believing: The Northumbria Court Observers Panel Report on 30 Rape trials 2015-16: Baird, DBE, QC, Northumbria Police and Crime Commissioner. March 2017

¹⁰¹ Overview Report Concerning Children E. Caerphilly Safeguarding Children Board. Neath Port Talbot Safeguarding Children Board. Pembrokeshire Safeguarding Children Board. 2010

efficiency of a review is not to be undermined, decisions about participation and arrangements for challenge need to happen quickly.

The statutory guidance on child sexual exploitation issued in 2000 and 2009 and safeguarding adults in 2000 and 2014 expected that the Crown Prosecution Service would have links to interagency safeguarding arrangements and with partner agencies. This was so the Service could provide advice on disruption plans, evidential requirements to support criminal offences, what evidence is reliable and can be admitted in proceedings and how non-criminal justice agencies can assist in recording and gathering information in a way that will ensure that it can be admitted as evidence.

The lack of action against and disruption of the activities of perpetrators has been a matter for comment in reports considering sexual exploitation across the country and is a feature of the historical approach in Newcastle. Whilst in some local areas the Service has had some links to Safeguarding Boards, there has been no nationally agreed approach or direction and these provisions have not had the intended impact.

In correspondence, the Service indicated that it is difficult to provide precise details of the response to the Guidance but as far as can be ascertained the Crown Prosecution Service was not consulted prior to the publication.

It was also highlighted that a joint thematic review conducted in 2005 by Inspectorates to assess the effectiveness with which authorities and agencies, including the Crown Prosecution Service, safeguarded children, made a series of recommendations, including “involvement with and attendance (where appropriate)” at Local Safeguarding Children Boards, “which were implemented by the Service”. The framework for interagency safeguarding arrangements has developed significantly since 2005.

There has been no involvement the Crown Prosecution Service with the Safeguarding Boards in Newcastle or elsewhere in the North East.

While it is not possible to conclude that, had the Service participated as the Guidance expected, action against perpetrators would have been more effective earlier, the participation would have been likely to improve knowledge and understanding across agencies and so inform practice and support for victims.

Because of the number of Boards within areas covered by the Crown Prosecution Service, the involvement with Safeguarding Boards requires consistency and national direction.

Recommendation 2.4

I recommend that:

The Crown Prosecution Service should arrange for guidelines to be developed on involvement of the Service with Safeguarding Boards and other local safeguarding frameworks.

Recommendation 2.5

I recommend that:

The Government should ensure that when national guidance or advice requires involvement of a national agency or one which is not a statutory local partner with Safeguarding Boards or other local safeguarding frameworks, the documents include confirmation that the agency is aware of and has made arrangements for the expected involvement.

In Newcastle there has been contact between staff in the Crown Prosecution Service and the legal services staff in Newcastle City Council to address issues such as disclosure of materials for criminal justice processes.

Helpful discussions during the Review identified that more formal arrangements would benefit both criminal processes and welfare focused processes and legal proceedings. The Crown Prosecution Service can provide feedback on issues arising during criminal processes, explanations for why particular events have occurred, judge's sentencing remarks, awareness of which may be relevant for Practitioners in addressing victims' needs, and updating information on developments in law and process. It can also contribute effectively to and benefit from interagency training.

The Crown Prosecution Service Review Report recommended the cultivation of working relationships with Local Authority legal teams.

In Newcastle, arrangements have been made to identify members of staff in each agency to ensure communication takes place and pending national direction concerning involvement with interagency safeguarding frameworks. Agendas for Board meetings will be sent to the Service and legal staff will also consider whether any issues arising should be communicated. Newcastle staff are arranging for these issues to be raised with colleagues in other areas across the region to ensure consistency of approach.

The Director of Public Prosecutions acknowledged, to the Home Affairs Committee in 2013 that the Crown Prosecution Service's previous approach to credibility of witnesses of sexual exploitation was inappropriately cautious and risked leaving the whole category of victims unprotected. The Committee recorded that the Service had introduced specially trained and accredited rape prosecutors and announced its intention that every Service region would have a dedicated Rape and Serious Sexual Offences Unit. A national policy and guidance for police and Crown Prosecution Service drawn up by the College of Policing were issued and a training package prepared delivering practical advice and guidance to front line police and prosecutors.

These arrangements contributed significantly to the successful outcomes of Operation Sanctuary and the associated criminal trials.

7.10 Links with the Judiciary

During the Review, in order to keep them informed of progress and issues arising, I had a number of conversations with Her Honour Judge Hudson, the Designated Family Judge for Northumbria and North Durham and Her Honour Judge Moir, who is the lead Court of Protection Judge for the region.

Whilst Statutory Guidance in 2000¹⁰² encouraged involvement with the local judiciary, there is no further national direction and links between strategic interagency processes and local judiciary have been variable across the country.

In Newcastle, there were good links with the Family Court Business Committee during the early period reviewed. In 2017, Ofsted¹⁰³ confirmed that Newcastle City Council has well-established effective relationships with the local family justice board and Cafcass. This ensures efficient and effective progression of legal proceedings, with court timescales among the best locally. Good arrangements are in place to ensure that Newcastle City Council legal services and CAFCASS promptly make Independent Reviewing Officers aware of information and material in family court proceedings.

Her Honour Judge Hudson confirmed that when appointed in October 2014, she arranged regular meetings with local authority legal services, Assistant Directors of children's social care services and with senior solicitors from the 7 local authorities in the region. This is in addition to meetings of the Family Practitioners' Forum, which involves professional court users, and the Local Family Justice Board. The Judge also corresponds by email with the local authorities, if necessary.

These arrangements have proven to work extremely well and Her Honour Judge Moir has also arranged, through Newcastle City Council Legal and Adult Social Care Services for similar meetings to take place with representatives from local authorities in the region to discuss areas of interest concerning vulnerable adults.

Arrangements have also been made for copies of agendas for meetings of Newcastle Safeguarding Boards to be sent in advance so that the judges can consider whether they might make a contribution to the issues. There is also a standing invitation for them to request for any issues to be considered and to attend a meeting if appropriate. Representatives of the Newcastle Boards are liaising with other Boards to ensure that there is consistency across the region.

7.11 Leadership from the Safeguarding Lead Agency

Newcastle City Council is the lead agency for safeguarding children and vulnerable adults.

¹⁰² Safeguarding Children Involved in Prostitution: Supplementary Guidance to Working Together to Safeguard Children: Department of Health, Home Office Department for Education and Employment, National Assembly for Wales. 2000

¹⁰³ Newcastle Upon Tyne Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board. Inspection date: 24 April 2017 – 11 May 2017. Ofsted Report. 7 July 2017

Reports concerning Rochdale and Rotherham included critical comments about lack of leadership¹⁰⁴ and press and politicians highlighted that “officials who looked the other way as young lives were all but destroyed have not been brought to account”.¹⁰⁵

The Home Affairs Committee in 2013¹⁰⁶ asserted that Directors of Children’s Social Care must also take full responsibility for failures of their department as it is their personal responsibility to find out what is taking place. Statutory guidance was issued for local authorities on the roles and responsibilities of the Directors of Children’s Services and Lead Members for Children’s Services¹⁰⁷ and in 2015 the Government¹⁰⁸ emphasised that “those who fail in their duties to protect children must be held accountable.”

The Secretaries of State for the Home Department, Health, Education, Justice, and Communities and Local Government wrote to all Chief Constables, Leaders and Lead Members of Councils, Chief Executives of local authorities and health system leaders and Directors of Children’s Services to reinforce the need for leaders to take responsibility for addressing failures identified by the Jay Report and any other inspections in their area.

The Review therefore carefully considered this issue, in relation to strategy and practice in Newcastle and found no evidence to suggest that the approach to addressing sexual exploitation was undermined or adversely affected by any lack of leadership or interest by senior officials. There is currently strong and committed leadership.

This view was supported by Ofsted in 2017 which found that the Newcastle City Council leadership, management and governance is “Good”. The senior leadership team and elected members are committed to service improvement and the Lead Member for Children is highly committed and ensures that senior leaders are held to account and can evidence improvements in children’s outcomes.

The Ofsted Report described the Council Chief Executive as having demonstrated strong leadership, with effective oversight and accountability. Since coming into post in 2015, she has brought together children’s and adult’s social care into one Directorate. The Director of People has the statutory appointment of Director of Children’s Services and is Director of Adult Social Care Services which reflects “a determination to support children through their life course.”

Most local social services authorities do not have this model. In Newcastle City Council, the changes were not driven by economic pressures but to encourage

¹⁰⁴ Overview Report of the Serious Case Review in respect of Young People 1,2,3,4,5 & 6. Rochdale Borough Safeguarding Children Board. 2013; Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013 Alexis Jay OBE Rotherham Metropolitan Borough Council 2014. Report of Inspection of Rotherham Metropolitan Borough Council. Louise Casey CB. House of Commons. 2015

¹⁰⁵ Times 23 May 2017

¹⁰⁶ Child sexual exploitation and the response to localised grooming Child Sexual Exploitation: scale and prevalence House of Commons Home Affairs Committee. June 2013

¹⁰⁷ Statutory guidance on the roles and responsibilities of the Director of Children’s Services and the Lead Member for Children’s Services For local authorities. Department for Education. April 2013

¹⁰⁸ Tackling Child Sexual Exploitation. HM Government. March 2015

effective service delivery. In 2016, a Local Government Association Peer Review commissioned by the Director¹⁰⁹ reported positively on the single directorate. Focusing on sexual exploitation it found a commitment from service providers to work together to tackle it at whatever age.

In conversations, the Assistant Directors of Children's Services and Adult Services confirmed the benefits for joint working, collaboration and understanding each other's business, encouraged by co-location with other senior managers. They have strong links with practice and chair panels and oversee decisions regarding individual children and adults.

The Review found that over the whole period reviewed there were examples of children's and adult services excellent working together. The structural arrangements embedded management and operational improvements across services and have impacted positively on partner agencies.

The Director has a strong personal commitment to safeguarding and being in touch with frontline practice. The Service Managers for Safeguarding Children and Safeguarding Adults report directly to him. He encourages support from across Council departments and recognises the need for proactive specialist legal services.

The Chief Executive is familiar with and supports the objectives of the statutory provisions and guidance under which she is accountable for the effectiveness of safeguarding arrangements. She meets regularly with the Director of People to discuss safeguarding issues and meets with the Newcastle Safeguarding Children Board Chair and holds him to account for achieving statutory objectives. Although the statutory framework does not require it, she has also made arrangements to meet with the Chair of the Newcastle Safeguarding Adults Board on the same basis.

As the issues concerning sexual exploitation have developed the Chief Executive and Chief Constable have had regular conversations and she has given frequent high-level briefings on the progress and eventual outcomes of Operation Sanctuary to chief officers of public authorities in the region who attend the Accountable Officers Group and the North East Combined Authority Chief Executives Group.

The Newcastle City Council Corporate Safeguarding Group ensures that safeguarding is considered in all aspects of the Council's business.

Good arrangements have been made to ensure elected members of Newcastle City Council have been kept informed through reports to the Scrutiny Committee, which is chaired by the Leader of the Opposition. In conversations with me, the Leader of the Council, previous and current Lead Members for Children's Services and Adult Services and the Leader of the Opposition spoke highly of the political climate of challenge and extent to which senior officers have ensured that they have been kept well informed over the whole period considered by the Review.

¹⁰⁹ Local Government Association Adult Safeguarding Peer Challenge Report. March 2016

7.12 Interagency Leadership

The Newcastle Safeguarding Boards were established and functioned in accordance with statutory guidance and regulations over the period reviewed. Collaborative arrangements between the two Boards developed early beyond expectations in guidance, and as awareness grew were well-equipped to respond to challenges of child and adult sexual exploitation.

In 2017, the Ofsted inspection found the functioning of Newcastle Safeguarding Children Board was “Good,” effectively meeting statutory requirements and supported by constructive relationships between partner managers with strong governance arrangements and board processes with political overview. It highlighted the coordination between the Newcastle Safeguarding Boards which has supported and overseen the development of “outstanding multi-agency practice in responding to sexual exploitation”.

7.13 Resources

Agencies have made available significant resources to address sexual exploitation through Operation Sanctuary, the establishment of the Hub and otherwise.

The Practitioners and Report Authors emphasised the dramatic impact of the resourcing and expressed anxiety about whether the changes can be maintained once the court cases were over and having regard to austerity measures and increasing demand. They believed that the cases identified through Operation Sanctuary reflect the “tip of the iceberg” evidenced by the lack of male victims or survivors and low numbers from Black and Minority Ethnic communities.

It is not necessary to make a recommendation concerning future resourcing.

Funding has been agreed until March 2019 from Newcastle City Council for the posts and the accommodation. Conversations with the Council Chief Executive, the Director of People and the Leader of the Council confirmed the intention to provide on-going resources. Careful consideration is being given to ensuring other essential services are not unduly affected.

Northumbria Police and the Police and Crime Commissioner are committed to continuing resources and NHS Newcastle Gateshead Clinical Commissioning Group has approved staffing resources for a member of staff to be shared between the two Hubs.

7.14 Quality Assurance and Audit

Effective audit is necessary to quality assure practice and the impact of strategic initiatives and training. The Review considered carefully what has been and is in place across children’s and adults services. There has been a history of utilising audit processes, informed by experience and increasing knowledge, to evaluate and inform planning.

Audit Groups report multi-agency practice and themed audits to relevant sub groups and the Safeguarding Boards and do not to rely on records and data only but involve practitioners to understand what has happened and why.¹¹⁰

The Risk Management Group Data Group established in 2016 strengthens how data and outcomes are used to target resources and reports to the joint Multi-Agency Sexual Exploitation and Trafficking Group and the Safeguarding Adults Boards.

Newcastle City Council Adult and Children's Social Care operate an internal audit procedure where cases are randomly selected. The arrangements are robust, identify changes or trends and influence development of training. The framework firmly ensures compliance with statutory requirements and that senior managers are well aware of the strengths and weakness of their service.¹¹¹

7.15 Public Sector Commissioning

Newcastle public authorities have a tradition of encouraging and supporting community and voluntary organisations and they provide a necessary and effective contribution to services for the vulnerable, working hard to preserve services and to minimise the impact of austerity with reduced funding streams. Good commissioning arrangements are underpinned by strong partnerships and good consultation with stakeholders, providers and voluntary organisations.¹¹²

The processes within Newcastle City Council for commissioning and grant aiding community and voluntary organisations are in accordance with statutory requirements.¹¹³ Regular and effective audits take place to monitor compliance.

7.16 Other Providers of Services

Preparedness for recognising and responding to sexual exploitation needs to include all services in which professionals might have contact with victims or potential victims, including those who may not usually be involved with safeguarding processes. The Review considered a number of these in Newcastle.

Chemists and Pharmacists provide contraceptives, morning after pills, advice, and pregnancy tests.

“I went constantly for the morning after pill – to different places.”

Professional development is monitored by NHS England. Registered pharmacists are required to undertake professional development relating to safeguarding training which includes sexual exploitation of children and vulnerable adults. If a client is under 16 years they should assess competence according to the Fraser Guidelines,

¹¹⁰ Para. 1.9. The Munro Review of Child Protection: Final Report A child-centred system. Professor Eileen Munro. Department for Education. 2011

¹¹¹ Newcastle Upon Tyne Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board. Inspection date: 24 April 2017 – 11 May 2017. Ofsted Report. 7 July 2017

¹¹² Para. 83. Ofsted Inspection Report. 7 July 2017

¹¹³ s11 Children Act 2004

but as with other health professionals, assessment relies on a conversation. If not competent the client should be referred to Contraception and Sexual Health Services. They have available a Referral for Contraceptive Support Sexual Exploitation Risk Assessment Checklist and relevant agency telephone numbers. A summary record of consultations should be kept.

In Private Health Provision, General Medical Council and Nursing and Midwifery Council codes apply. The rules of professional conduct relating to safeguarding, capacity, consent to treatment and safeguarding are the same as within public provision - professional first, employee second. Understanding principles for information sharing is particularly important since victims may be taken to private provision to avoid this. Private sector providers are inspected by the Care Quality Commission. Counselling services may be provided privately.

NHS Dental practices are responsible for ensuring that they are adequately trained and are overseen by NHS England. Newcastle Gateshead Clinical Commissioning Group has encouraged NHS England to seek assurance that sexual exploitation training is part of reviewing practices; a safeguarding assurance framework has been developed and is being proposed.

Early identification and prevention requires awareness by all those professionals who might have contact with a victim or potential victim and clarity of expectations of their responses. Awareness of the potential for vulnerable adult victims is likely to be low.

Recommendation 1.5

I recommend that:

Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should identify services in the community that are not routinely involved with local safeguarding arrangements and consider how best to engage with them on safeguarding issues.

Recommendation 2.6

I recommend that:

The Government should consider which community services not routinely involved with local safeguarding frameworks have a contribution to make to early identification and prevention of sexual exploitation and make arrangements to ensure that their contribution is made and monitored through regulatory functions or otherwise.

7.17 The Role of Schools and Education Services

The cases included victims for whom abuse began during teenage years, but one victim described how:

“A man in his twenties waited outside the primary school. We said he was our friend. I was 10/11 years old.”

“In the Park, I met R. I was in year 8. He was asking my age and about school and why I was out so late. He took us to his house. There were a huge number of people there ... R. asked me for my number to keep in touch and that was the start of the problem.”

The Home Affairs Committee in 2013 identified teachers as more likely to see victims on a regular basis than almost any other professional. Recurrent or prolonged absences and significant changes in behaviour are key in identifying children at risk at an early stage and, by raising concerns, they may be able to stop grooming before sexual exploitation has begun. The Committee recommended that all teachers are provided with a list of warning signs.¹¹⁴

Schools can be protective environments and can help to build resilience but only if children attend.

“(my parents) didn’t rate education – I didn’t do much at school – different schools and didn’t go much.”

But regular attendance and good performance does not mean exploitation is not taking place. Some victims continued to attend school and exploitation was not recognised. One victim aged 12 years met a man at the Park and they:

“... got real close. It was good at first. He bought me stuff – he was making up for my parents. Phones, clothes, food. I still went to school.”

She had very high attendance and achieved excellent examination results, continuing to higher education. Another said:

“At school, I was not naughty and passed all the exams except maths. I did not have any involvement with social services.”

The cases also included examples of severely disrupted early school history, a lack of chasing absence or responding to bullying and inadequate responses to bereavement and loss.

Staff from schools contributed positively to the Review. With hindsight, they felt that there were early warning signs in the backgrounds of pupils, whom it was later learnt were victims, but schools did not at the time have a sound understanding.

¹¹⁴ Para. 104. Child sexual exploitation and the response to localised grooming Child Sexual Exploitation: scale and prevalence House of Commons Home Affairs Committee June 2013

Training and work with the school staff, reinforced by involvement in the Review, has led to a greater understanding and better insight into multi-agency work, especially understanding thresholds. They reported a greater sense of trust, more collaborative work and sharing information with agencies and pastoral staff. Welfare referrals to other agencies have increased as a safety-first approach has been adopted and better monitoring of progress takes place by Deputy Head Teachers when a child is accessing or is referred by staff to specialist agencies or the school nurse.

The Safeguarding Boards' sexual exploitation checklist is available in all Newcastle schools in order to promote more effective practice.

The Home Affairs Committee asked the Minister to look, once again, at the relationship between schools and local authorities highlighting concerns about missing children. This is a reference to increasing independence of schools from local authorities, which includes responsibility for safeguarding arrangements and the management of budgets for training and development of data systems. Safeguarding training might be commissioned by governing bodies from local authority specialist staff or from other sources. Statutory safeguarding guidance for schools requires governing bodies to quality assure training and recommends that it is consistent with policies, procedures and priorities of Safeguarding Boards.

There has been a proliferation of different types of school within the public sector. Draft statutory interagency guidance¹¹⁵ would expect all local safeguarding arrangements to contain explicit reference to how safeguarding partners plan to involve, and give a voice to all local schools and academies in their work.

Newcastle City Council education safeguarding lead officer for schools has worked hard to preserve good working relationships with Newcastle schools and provide safeguarding advice. There is a schools sub-group of the Newcastle Safeguarding Children Board and head teacher representation from primary, secondary and special schools. Schools contribute to the Boards safeguarding audits. In all Ofsted inspections of schools safeguarding arrangements are considered.

Schools can also access safeguarding training and advice from partnership agencies in Newcastle including The Children's Society, Barnardo's, Streetwise, Brighter Futures and specialist staff from Newcastle Safeguarding Children Board partner agencies.

7.18 Children Missing School Education

The cases included children whose attendance was erratic, where the victim was said to be registered as receiving education at home or whose expected transfer to another school did not occur or where there was a significant delay because the family moved out of the area, leading to absence from education.

¹¹⁵ Consultation draft Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children April 2018.HM Government. October 2017

Newcastle City Council has a statutory responsibility to offer all children, except those registered as being educated at home, a full time offer of education when requested by parents. The Education Service attendance team has developed robust monitoring procedures concerning alternative provision, partial timetables, permanent exclusion and transfers to help state schools to fulfil their statutory duties. There is now greater support and challenge to schools around attendance.

In January 2017, the monitoring of children who are electively home educated was brought back in-house within Newcastle City Council, into the same team responsible for children missing education. This ensures information about potentially vulnerable children is recorded consistently and can be cross referenced with other information sources including social care. The monitoring officer works closely with other agencies to assess and address safeguarding concerns.

The legislative framework for children not being educated in a school over the period considered by the Review was not helpful. Local Authorities had, and continue to have, no mandate for intervention or monitoring of pupils around safeguarding, despite increased vulnerability. It was suggested at the time of the review that clearer guidelines from the Department for Education and increased powers are required.

However, in October 2017, the Department for Education confirmed that there are no government plans to change legislation despite the report of a review in 2009 having made twenty recommendations for reform including improved safeguarding arrangements.¹¹⁶ There is no data kept centrally on children allegedly being home educated for whom there are safeguarding concerns.

A Private Members Bill¹¹⁷ introduced into the House of Lords in June 2017 to make provision for local authorities to monitor the educational, physical and emotional development of children receiving elective home education might improve the arrangements, if it successfully passes all Parliamentary stages.

Proposed changes for statutory guidance on interagency safeguarding¹¹⁸ would require the Child Safeguarding Practice Review Panel to have regard to significant harm or death of a child educated otherwise than at school when deciding whether a national review should be carried out but there is no indication why this is particularly important.

Recommendation 2.7

I recommend that:

The Government should arrange for a review of the safeguarding implications for children educated otherwise than at school having regard particularly to the body of knowledge about sexual exploitation, issue guidance on safeguarding children

¹¹⁶ Report to the Secretary of State on the Review of Elective Home Education in England Graham Badman. 2009

¹¹⁷ Home Education (Duty of Local Authorities) Bill (HL) 2017-19

¹¹⁸ Para. 37 Chapter 4: Consultation draft Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children April 2018.HM Government. October 2017

educated otherwise than at school and consider the need for legislation to more effectively regulate this provision.

7.19 Children who Change Schools

The cases highlighted that vulnerability can be compounded if the child is at risk of exclusion, is excluded or changes school. It was apparent that there was a need for schools and other agencies to be vigilant so that welfare oversight and continuity of educational opportunities are not disrupted.

Educational history and assessments were not readily available to the Review without approaching individual past schools despite statutory duties on governors to ensure transfer of records. Current school staff did not have access to information about whether there had been previous concerns to inform their judgments.

There are now improved arrangements to manage a move from one school to another to prevent permanent exclusion. Fair Access procedures in Newcastle should ensure that no situation arises when a pupil is not on roll of a school.

The schools involved in the Review felt that, whatever the reason, a move must be managed and all appropriate paperwork completed by the referring schools prior to referrals to the Local Authority and all students should be monitored appropriately.

Recommendation 1.6

I recommend that:

Newcastle Safeguarding Children Board should arrange to carry out an audit of a sufficient number of cases to form a judgment about whether regulatory and guidance expectations concerning pupils who change educational settings are consistently followed.

In 2016, the Education service introduced a new service area, Vulnerable Learners, to monitor the safeguarding and attainment of pupils susceptible to a range of vulnerabilities including attendance, disrupted or missed education. This service is developing a robust data set and systems through which to support and challenge school performance and meet local authority and school statutory responsibilities.

The school staff reported improved information sharing between schools, including previous concerns, particularly safeguarding. Changes of responsible staff are kept to a minimum and a peer support network of pastoral leads in secondary schools has developed. This provides peer challenge and support around managed moves which fall outside statutory admissions processes.

7.20 Arrangements to Consider Missing Children and Young People

The Missing and Sexual Exploitation and Trafficking Group was established as a sub-group of the Newcastle Safeguarding Children Board as early as 2006 and became a sub-group of the Safeguarding Adults Board in 2015.

The Risk Management Group considers monthly children facing serious risks, including those who go missing and are at risk of sexual exploitation, considers and interrogates data, monitors patterns and reports to the Boards. It ensures robust planning, allocation of resources and identifies connections between individual children and young people and the potential risks within their networks.

This Group includes representatives from Newcastle City Council Children's and Adults Social Care, Northumbria Police, Your Homes Newcastle (which provides council housing on behalf of Newcastle City Council), Aspire Housing Association, the Youth Offending Team, the Screening and Intervention Programme for Sensible Drinking, the Child and Young Peoples Service, and Newcastle upon Tyne Hospitals NHS Foundation Trust, which also represents General Practitioners.

Practitioners identified that the system for carrying out interviews with children who have returned or been found after being reported missing is now more robust. SCARPA undertakes return home interviews with children not receiving a service from Children's Social Care and, with a specialist City Council social worker, those who are looked after by the Council or otherwise receiving a service.

The vast majority of children going missing receive return home interviews. However, learning from the Review and the Ofsted Inspection in 2017 has led the Group to review and update procedures to ensure consistency in individual planning and wider prevention strategies. A designated social worker has been appointed to the Multi-Agency Safeguarding Hub to coordinate missing children and young people issues.

In March 2017, HMIC found that a robust review and checking process ensures that all cases are always checked for links to child sexual exploitation.¹¹⁹

The processes are kept under review by monitoring through audit, reported to the Missing and Sexual Exploitation and Trafficking Group.

This is more complicated for adults, who, unless known to have a vulnerability, can choose where they will be and if elsewhere than expected this will not necessarily give rise to concerns. Adult safeguarding staff adopt a proactive approach to determine on a case by case basis whether return interviews should take place. When an individual is subject to known or suspected safeguarding concerns, contact between agencies takes place and protection plans address the concerns. All residential and domiciliary care staff caring for someone at risk of sexual exploitation are provided training and guidance on how to respond to missing episodes.

Recommendation 1.7

I recommend that:

Newcastle Safeguarding Adults Board should carry out an audit of a sufficient number of cases to form a judgment about the effectiveness of arrangements to interview vulnerable adults following a period of missing.

¹¹⁹ PEEL: Police effectiveness 2016 The report of HMIC's inspection of Northumbria Police. March 2017

7.21 Raising awareness among potential victims

The Newcastle experience illustrates that potential future victims include children and adults with vulnerabilities. Age is not the determining vulnerability.

A joint communications strategy has been developed by the Safeguarding Boards and Northumbria Police have invested significantly to raise awareness in communities.

The Newcastle Safeguarding Adults Board has produced a series of generic adult abuse leaflets made available at points across the City. Work is undertaken with Boards in North Tyneside and Northumberland to promote Safeguarding Adults for Everyone; a weeklong series of events and publicity drives to raise awareness amongst victims and the public. Bespoke training and awareness raising sessions are provided for community and service user groups.

Positive links with children and young people across Newcastle are provided by a large number of charitable, community and voluntary, faith and public-sector organisations. They deliver a diverse range of activities and support services including assistance with accessing education, employment and training. Newcastle City Council commissions and grant aids services. The Play and Youth Support Team publishes a Directory of Services and provides co-ordination and assistance on safeguarding, identifying additional funding, training, and signposting professionals to services to meet the needs of a particular young person.

The 2017 Ofsted inspection found the Voices for choices and Care Leavers Group for Children in Care Council to be strong and visibly actively promoting the voice and experiences of children looked after by Newcastle City Council. Established following the publication of the Care Matters White Paper in 2007, the Group organises events, makes films and DVDs, comments on services locally and regionally, works with Councillors and MPs, advises government on regulation and policy and is involved in staff recruitment.

A quarterly newsletter is sent to children looked after by the Council across the City and is published on-line. The Group has direct access to senior managers and members of the corporate parenting advisory committee and provides good communication, consultation and advice on a range of issues including risks to safety and welfare and the likely effectiveness of proposed arrangements.

In April 2017, legislation¹²⁰ required relationships education to be taught in schools in England and relationships and sex education taught in secondary schools from September 2019. Governors and proprietors will be responsible for content and delivery. Newcastle City Council Personal, Social, Health and Economic lead and Healthy Schools team will lead responses to consultation on relationships and sex education and provide support and training to develop the programme.

¹²⁰ Children and Social Work Act 2017

During the time considered by the Review, all state schools in Newcastle delivered Personal, Social, Health and Economic in accordance with non-statutory guidance. Schools taking part reported that awareness of child sexual exploitation is included.

Education of children about sexual activity can be controversial in relation to content and age at which it should be delivered, particularly among parents and faith groups.

This is a difficult area. Sophisticated grooming by perpetrators is calculated to persuade victims that they are in intimate relationships; interest or excitement may encourage them to try it out. Researchers recently suggested that teaching adolescents about sex and making access to contraceptives easier may have encouraged risky behaviour.¹²¹

Other researchers monitoring changing sexual practices of young people since 1990, have commented that sex education programmes need to keep up with experiences of young people. Easy access to internet pornography contributes to moving away from traditional sexual activity and updating sex and relationships education to keep pace with current trends in sexual practices is crucial.¹²²

Newcastle Safeguarding Boards' Sexual Exploitation Strategy includes reviewing and monitoring the impact of raising awareness.

Recommendation 2.8

I recommend that:

The Government should arrange for national research to be carried out on the impact on sexual exploitation of Personal, Social, Health and Economic education programmes.

¹²¹ Paton and Wright. The Effect of Spending Cuts on Teen Pregnancy. *Journal of Health Economics* 23 May 2017
ISSN 0167-6296

¹²² Lewis et al, London School of Hygiene and Tropical Medicine and University College London. *Journal of Adolescent Health*. November 2017

8. Consultation with Children and Adults

There have been determined efforts in Newcastle to engage with young people to inform services and the issues arising are being taken forward by agencies and the Safeguarding Boards.

Victims who contributed to the Review were asked what might have helped them to avoid becoming involved with exploitation.

“I should have been taken away from my family before I was born. For neglect. It took until I was 14 years old.”

“I’m not sure anything really. I don’t think anything would have stopped me at the beginning. Except maybe information about it. People are familiar with it now – Coronation Street.”

“I needed someone to sit down with me and ask who do you think would do this “

(Who should have sat down with you?)

“Trust is a real issue. I didn’t trust anyone at first. I needed one person for me not a big team.

If I had had someone to talk to sooner it might have helped but I did not have the words.”

“If I had been alerted to sexual exploitation it would have made a difference.”

(How could you have been alerted?)

“Probably only by Social Media.”

“I went to a community support service and they sent me to sexual health services for contraception. There was no mention of sexual exploitation.”

“The teachers could not have done anything – they were brilliant teachers. Nobody could have known – I was a bright kid. I knew when someone wanted to know something and I would not have helped them.

Some kids from the High School came to help out – that could help. I had a good relationship with one. Some kids do not talk to adults.”

“If I had had someone to talk to it might have made a difference. I used to tell them to f-off – but they shouldn’t give up.”

“Parents - if the kids are out with friends, check up and see they are ok – put a tracker on the phone. Check their phone bill. Make sure the kids are with who they say they are. Tell them not to get in a car.

But I wouldn't have taken that at the time."

"When you are young and told not to do something you are more likely to do it – it's tempting. So, it's important that the police take action when they can.

I didn't have a relationship with anyone."

"It would not have helped if I had been told about grooming. I didn't have enough school to hear about it."

"The only thing that would have stopped it happening would have been if I was taken into care at birth. It would also have been good if I had been taken away when a teenager or later."

8.1 The SCARPA Squad

The Children's Society Safeguarding Children At Risk – Prevention and Action Programme (SCARPA) set up the SCARPA Squad, a group of young people, to comment on and inform agencies. The Squad has developed training, produced a DVD highlighting risks of child sexual exploitation and raises awareness in schools and locations where young people are likely to meet.

During the Review, a conversation took place with Squad members. They were unaware of sexual exploitation before attending SCARPA and felt it would not be stopped without listening to what young people suggest about tackling it - young people are more likely to listen to other young people than to professionals. They were realistic about expecting too much and thought "friends might not want to betray friends" and would be unlikely to "grass on mates"

Young people need to learn how to keep safe and should get the help before it happens Teams need to spot the signs and look beyond the behaviour and ask why? There is a reason behind everything. Young people need to take it seriously. Schools should teach healthy and unhealthy relationships. There should be more films; DVD's: programs, like Whitney off East Enders, Coronation Street; documentaries; cards and Apps rather than leaflets. The best places are schools, cinema adverts, buses and metros, and public toilets and hotspots where young people congregate, day and night. Staff should be educated. There should be more information in schools.

Where are the risks?

"Online is massive."

The Squad had good support and information from SCARPA, but were less complimentary about other professionals.

They did not feel well treated by the police, and thought social services want to split families up. Most doctors haven't a clue. Nurses at sexual health services are quite good and ask the right questions and return home interviews

are useful because they come to you, and speak to you alone. More mental health services during transition are needed.

8.2 Children and Young People Staying Safe in the City Event

In 2017, Newcastle Safeguarding Children Board hosted an event to canvass young peoples' views about staying safe in Newcastle and to share learning from the Boards.

There were presentations from young people, including the SCARPA Squad and Young Carers, activities on themes including Sexual Exploitation and questions and answers with a panel of decision makers from across partner agencies.

The issues that arose included:

- Mental health services - accessible and responsive to need – waiting lists are unacceptable
- Schools - education about sex and sexual exploitation to be compulsory
- Awareness – messages about services available for sexual health or sexual exploitation are not getting out to young people - more should be done to raise awareness

8.3 Young People in Newcastle and the risk of sexual exploitation: Unicef U-Report August 2017

Newcastle Safeguarding Children Board rolled out the Unicef U-Report app as part of a consultation exercise with young people about sexual exploitation. The findings included:

- 49% had received information on sexual exploitation
- School and social media are most significant to help to know when at risk
- 76% knew where to go or what to do if they were concerned
- 65% thought young people and parents should be involved in strategic and operational work; 31% of whom thought that education and awareness important

As a result of these contributions, the Missing Sexually Exploited and Trafficked Group is co-ordinating a more strategic approach to awareness in schools, the community and social media.

9. Identifying Sexual Exploitation; Protecting Victims

9.1 Identifying

Recognising that grooming is taking place or an individual or individuals are suffering sexual exploitation is the most difficult and most important area in which to make an impact. The skill and sophistication employed by perpetrators and the influence they have on the behaviour and attitude of potential and actual victims inhibits identification.

The cases included sexual exploitation of child victims not known about until it had ceased when as adults the victims came forward or were approached by police because other victims identified them. They were “not known to services at significant junctures”.

One victim gave a chilling account of what contributed to her decision to go to the police:

“I started seeing younger girls there being raped and not realising it. School girls in uniform with their school bags coming from school.”

In 2017, the Government stressed that early sharing of information is critical to providing effective help when there are emerging problems¹²³ and repeatedly publishes guidance to encourage more effective sharing but it is not surprising that practitioners remain confused about the principles to apply.

Wherever possible practitioners should share confidential personal information with consent but:

“where there are concerns that a child is suffering, or is likely to suffer, significant harm, practitioners should be willing to disclose information without consent where the public interest served by protecting the child from harm outweighs the duty of confidentiality.”¹²⁴

If suspected, these are the criteria that should trigger child or adult protection referrals. But because of its hidden nature, if the level of concern regarding sexual exploitation satisfies the significant harm test, it is likely that considerable harm will already have been suffered.

Guidance issued by the Government in 2006¹²⁵ and since indicates that multi and interagency work starts as soon as there are:

“concerns about a child's welfare, not just when there are questions about possible harm.”

¹²³ Advice: Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. Department for Education February 2017

¹²⁴ Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers

¹²⁵ Para. 8.14 Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children. HM Government 2006

Effective safeguarding systems are those where all professionals share appropriate information in a timely way and can discuss “any concerns about” an individual child with colleagues and local authority children’s social care.”¹²⁶

Safeguarding is everyone’s responsibility and:

“Any professionals with concerns about a child’s welfare should make a referral to local authority children’s social care.”

In 2017 the Government indicated that any practitioner working with a child who:

“They think may be at risk of child sexual exploitation should ... share this information with local authority children’s social care.”

On 25 October 2017, the Department for Education published consultation documents for proposed revisions to Working Together to Safeguard Children.¹²⁷ The first page of the dedicated website is headed:

“CHILD ABUSE. IF YOU THINK IT, REPORT IT.”

What is sufficient to indicate “problems” or “concerns” or that sexual exploitation is “likely” or an individual “may be at risk” or to “think” abuse all of which appear to require a lower standard than suspicion of significant harm?

Nor is the public interest restricted to safety of an individual child or adult. There is a strong public interest in ensuring that other victims and potential victims are safeguarded.

Check lists of potential vulnerability are helpful but not all children and young people with vulnerabilities will experience child sexual exploitation and as the cases considered illustrated, sexual exploitation can also occur without any of these vulnerabilities being present.¹²⁸ Thorough consideration and assessment of checklist criteria would require sharing and acquiring information.

The Practitioners felt that where better sharing of information may have helped form judgments, it did not occur because of lack of triggers. Sharing information was necessary to decide whether information should be shared.

9.2 Sexual Health Services

Children and adults attend sexual health service clinics where advice, contraceptive treatment and treatment for sexually transmitted diseases are

¹²⁶ Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children. March 2015 updated in 2017

¹²⁷ <https://consult.education.gov.uk/child-protection-safeguarding-and-family-law/working-together-to-safeguard-children-revisions-t/>

¹²⁸ Advice: Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. Department for Education. February 2017

provided confidentially. Terminations of pregnancy may be arranged. The same services might be provided by a GP and some by a pharmacist.

Children and adults may be referred to sexual health services by public sector agencies or a community and voluntary organisation, such as Streetwise. Pupils may be referred by a school nurse. Individuals can access sexual health services and Streetwise services without referral and without an appointment.

Delivering a health service otherwise than for an emergency to an individual without capacity to consent is unlawful. The professional delivering the service must form a judgment about whether a person under 16 years or a person with cognitive impairments has capacity. If not, whoever has parental responsibility or authority to act for an impaired adult should be involved or a referral made to safeguarding agencies.

In a majority decision in the House of Lords in 1985¹²⁹ it was decided that contraceptive advice and treatment could be given to children under 16 years without parents' consent or knowledge provided strict principles were applied. The Fraser Guidelines/Principles are now referred to and referenced throughout health service literature, materials and guidance and often stated or used as prompts to inform an evidential basis for the formation of the judgment. They are widely applied to circumstances unrelated to contraception. The review identified that the judgment is rarely read by professionals applying the Guidelines.

The concern of professionals, which still dominates these issues, was that denying contraceptive advice to girls under 16 might cause some not to seek professional advice at all and expose them to risks of pregnancy and sexually-transmitted diseases. The professional should decide whether a particular patient can reasonably be expected to act upon advice to abstain.

A professional must be satisfied that the patient will understand advice, cannot be persuaded to inform her parents or allow them to be informed, is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment, is likely to suffer physical and/or mental ill-health unless she receives contraceptive advice or treatment and her best interests require contraceptive advice, treatment or both without parental consent.

In the "overwhelming majority of cases", the best judges of a child's welfare are the parents and it should be "most unusual" to advise a child without their knowledge and consent. There should be no question of giving advice to a "very young girl."

How can a judgment be reliably formed? Can it be formed on the basis of a conversation without accessing information held by other agencies which might include safeguarding concerns?

This is an old case that made no reference to child protection or children in public care. It includes as an example of when advice or treatment would be permitted

¹²⁹ West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security v Gillick (1985) UKHL 7

circumstances in which abstinence from intercourse could not reasonably be expected “because the girl is under the influence of her sexual partner”. There is no reference to the age of any partner. The public interest in safeguarding other children received no consideration.

A study by the sexual health service in Newcastle after the launch of Operation Sanctuary, found that approximately 85% of victims of sexual exploitation had received services from sexual health services.

“R. and I were in a sexual relationship. It got really bad when I got pregnant. I was 12 years old. He was at university in his early twenties. I went to have an abortion. I did it by myself. I went to a Walk in Centre.”

Another victim aged 13 or 14 years received contraceptive advice and treatment and termination of pregnancy at 15 years. A 16-year-old victim who attended the service was found during a criminal trial to have had impaired capacity to consent to sexual acts sufficient to sustain a conviction and long prison sentence.

“I went to (a voluntary community service) and they sent me to (sexual health) for contraception. There was no mention of sexual exploitation.”

They asked about partners and I ... gave them a list of names. They said I was high risk for infections. They were aware there were lots of men.”

“I used to go to sexual health. I told them my name and age and when I had sex. They could have picked up what was happening.”

The Newcastle upon Tyne Hospitals NHS Foundation Trust’s review of the cases found it was not consistently and clearly evidenced that sexual exploitation or the Fraser Principles were considered. This was addressed by the development and introduction of an Under-16 proforma which in 2017 was amended to Under-18, completed when a patient attends. The form addresses the Fraser Principles and “incorporates an assessment of sexual exploitation” using a tool with trigger questions developed in conjunction with NHS Newcastle Gateshead Clinical Commissioning Group for use in emergency departments, Walk in Centres and by General Practitioners.

This assessment is confined to considering answers on the form and conversations and is not an assessment as it is understood in any other area of safeguarding practice.

An audit involving 150 sets of records has been carried out to consider the use of the Under-18 proforma in clinical practice and an audit tool has been devised to collect data for the number of Young people under 18 years attending for termination of pregnancies. The results were reported to the Trust Safeguarding Committee in January 2017.

Patients are told by General Practitioners, school nurses, Streetwise, sexual health services and early pregnancy clinics that information will not be shared with other

agencies unless they consent or it is suspected that they are suffering or are likely to suffer significant harm, the referral criteria for safeguarding referrals.

“Likely” in this context should not be understood to mean more likely than not, but attracts a lower standard of proof – “a real possibility ... that cannot sensibly be ignored having regard to the nature and gravity of the feared harm.”¹³⁰

It was suggested that current practice is that a child seeking a contraceptive implant (or removal) would be referred to safeguarding agencies if under 13 years old, as sexual intercourse is classed as statutory rape under criminal law, but there have been examples of children aged 12 receiving contraception without a referral being made. A referral on a child of 13 or over would in any event still be dependent on other factors.

The Principles applied are similar for adults except that there is a presumption under the Mental Capacity Act 2005 that an adult has the capacity to consent unless it is established otherwise. The proforma is used when it is suspected that an adult has vulnerabilities affecting cognitive functioning but the form currently makes no reference to this.

The Review involved helpful discussions with very experienced and committed staff from the sexual health services. They try to persuade young persons that they should not feel compelled to have sex and refer to data suggesting 70% people do not have sex under 16 years and a high proportion of those that did, wish they had not. They see patients alone and question them about their circumstances and relationships. If a patient is judged competent to consent to contraceptive advice and treatment they are assumed to have the capacity to prohibit sharing of information not only with parents but also other professionals.

The professional practice was and is consistent with what is expected generally in applying the Fraser Guidelines and acknowledging that it should be the fundamental, working assumption of all frontline staff working with children and young people that sexual relations between an adult and a child under the legal age of consent are non-consensual, unlawful and wrong.¹³¹

The staff are not as familiar with an individual and their family as a school nurse or General Practitioner. Sexual health services and Streetwise rely on patient honesty and accurate disclosure of information. They make no inquiries of other agencies to verify information about age and identity or ascertain whether there are any concerns, unless they have consent from the patient or they suspect significant harm.

Unless patients volunteer information, it is not known whether they are looked after by the local authority or they or people close to them have been subject to child protection or adult protection plans or concerns.

¹³⁰ In re H (Minors) (Sexual Abuse: Standard of Proof) [1996] AC 563; In the Matter of J (Children) [2013] UKSC 9

¹³¹ Child sexual exploitation and the response to localised grooming Child Sexual Exploitation: scale and prevalence House of Commons Home Affairs Committee. June 2013

General Practitioners are not always aware of other health interventions. One of the cases concerned a victim who had undergone a termination of pregnancy and her General Practitioner was only informed when complications arose. During the Review, it was suggested that sexual health service staff should routinely ask patients for consent to share information with their General Practitioners, who operate under the same principles of confidentiality.

Discussion of these issues has led to arrangements for a representative from The Newcastle upon Tyne Hospitals NHS Foundation Trust to attend meetings of the Risk Management Group at which individual cases involving sexual exploitation are considered. The representative shares the information with Health Visitors, General Practitioners, Public Health School Nurses and sexual health staff. The NHS Newcastle Gateshead Clinical Commissioning Group also has a member of staff working in the Hub.

Should sexual health professionals have access to information about which children are looked after by the local authority or be told when a child becomes looked after and have a data system that allows information about young people or adults at risk, dangerous individuals and addresses or locations to be kept for reference? Is consent to medical treatment being confused with capacity to consent to sexual acts and consent to share information?

The Home Affairs Committee in 2013 was concerned that children might be taken successively to different sexual health clinics in a region without this being recognised and recommended that:

“sexual health services give consideration as to how such information might be shared across the region in order to better identify children at risk.”

There are no such arrangements in the North East.

Recommendation 2.9

I recommend that:

National Health Service England should consider establishing a risk information sharing system for sexual health settings.

In March 2015, the Government set out the intention to create a culture where the health service and medical professionals are spotting the signs of child sexual exploitation early and are supported in sharing information with others.¹³²

NHS England has set up The Child Protection - Information Sharing Project which is connecting IT systems so that local authorities and the NHS can share child protection information securely and health and social care staff have a more complete picture of a child's interactions with health and social care services.¹³³ In Newcastle a Trust Task & Finish Group is to be established to

¹³² Para. 20 Tackling Child Sexual Exploitation. HM Government. March 2015

¹³³ <https://digital.nhs.uk/child-protection-information-sharing>

identify the processes and what is needed to support this initiative and recommendations will be made to the Newcastle Safeguarding Children Board which will include the arrangements in procedures.

It does not appear to address similar concerns about vulnerable adults.

Recommendation 2.10

I recommend that:

The Government should consider whether The Child Protection - Information Sharing Project arrangements should also apply to safeguarding adults systems and procedures.

Practitioners questioned what would trigger contact with other professionals?

A significant number felt that a 12 or 13-year-old seeking contraception and clearly involved in sexual acts was sufficient in itself to satisfy concerns to generate sharing information – accessing as well as giving information. They felt that most parents would expect that serious operative treatment of a 13, 14 or 15-year-old would require parental consent or local authority consent if the child is in care.

There was unease at encouraging children to deceive their parents which did not sit well with parental responsibility. Young teenagers are not considered mature enough to enter into binding legal contracts, to vote, or to marry. Government Advice on Risk and adolescent development emphasises the turmoil of adolescent years.¹³⁴

An unintended consequence is that if a patient is under the influence and control of a perpetrator, who may have brought or encouraged the patient to access the service, unless the processes persuade a patient to disclose this information, the service is unwittingly assisting perpetrators to abuse without risk of pregnancies and disease.

The Bristol Review found that:

“A confused and confusing stance in national policy about adolescent sexual activity, leaves professionals and managers struggling to recognise and distinguish between sexual abuse, sexual exploitation and/or underage sexual activity; this risks leaving some children at continued risk of exploitation in the mistaken belief they are involved in consensual activity.”¹³⁵

The Oxfordshire Review recommended that:

“Relevant government departments should consider the impact of current guidance on consent to ensure what seems to be the ever-lower age at

¹³⁴ Annex A: Adolescent Development. Advice, Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. Department for Education February. 2017

¹³⁵ The Brooke Serious Case Review into Child Sexual Exploitation. Bristol Safeguarding Children Board 2016

which a child can be deemed to consent (for example to treatment) and attitudes to underage sex are not making it easier for perpetrators to succeed.”¹³⁶

Should sexual exploitation be treated differently procedurally from other forms of abuse?

There has always been a reluctance to approve arrangements outside established procedures because of the risk of inconsistencies and inappropriate tolerance of abuse.

Practitioners thought lower thresholds were now generally being applied for sharing information and contacting other professionals. Waiting until concern met normal thresholds risked the influence of perpetrators, sexual exploitation and serious harm continuing. “Unless you know what others know, it is not possible to know the importance of what you know.”

The launch of Operation Sanctuary, the start of the Review and introducing arrangements to improve awareness of sexual exploitation have led to an increase in safeguarding referrals across agencies, although referrals from sexual health and school nursing services have declined.

Victims of sexual exploitation are very likely to attend sexual health services or walk-in community support services while being groomed and when they are being exploited. The current approach to and principles applied to confidentiality and assessment of capacity, to consent to treatment and sexual acts means identifying victims or potential victims is extremely difficult and is unlikely to occur.

Discussions during the Review have not led to any suggestions about how this might be overcome. Unless there is a change, which appears to require a national debate, sexual exploitation is not likely to be prevented and early identification will remain difficult.

Recommendations 1.8 – 1.10

I recommend that:

- 1.8** The outcome of audits carried out in Newcastle to review the processes of assessment of capacity of patients to receive sexual health services should be reported to Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board.
- 1.9** Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults’ Board should consider what arrangements can be made to monitor the numbers of patients who are identified as sexual exploitation victims and have received sexual health services.

¹³⁶ Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E, and F. Oxfordshire Safeguarding Children Board 2015

1.10 NHS Newcastle Gateshead Clinical Commissioning Group should arrange a forum for discussion about how potential and actual victims of grooming and sexual exploitation might be more likely to be identified in health settings and report to the Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board.

Recommendation 2.11

I recommend that:

The Government should urgently arrange for the principles applied to confidentiality and safeguarding in sexual health settings to be reviewed having regard to the body of knowledge about sexual exploitation.

9.3 School Nursing

School nurses, located in schools, are not part schools' staffing establishments.

The Review considered circumstances in which a school nurse gave a 13-year-old girl pupil contraceptive advice and referred her to sexual health services without informing her parent. There was good liaison and exchange of information between the sexual health service and the school nurse who gave support within the school. But the General Practitioner and teaching staff were unaware that the pupil was sexually active and were not informed when later, aged just 15 years, she had a termination of pregnancy. Nor was her parent informed.

Discussions confirmed that this is not an area in which practice has changed in the light of increasing knowledge about sexual exploitation. School nurses will not without consent pass on information to teaching staff unless significant harm is suspected, in which case interagency processes would be followed.

Teachers were concerned that, despite strong pastoral support systems, including full-time counsellors and chaplains, there was no system in place for methodical oversight by a senior staff member of involvement with school nurses or with specialist drug and alcohol services also operating on school premises. They felt school nurses have a role in preparing a child for adult life and safeguarding and promoting welfare rather than just medical responses to a health issues.

Recommendation 1.11

I recommend that:

Newcastle Safeguarding Children Board should arrange a forum for discussion about collaborative working between the school nursing service and teaching staff.

9.4 Information Sharing and Recording

The cases highlighted excellent examples of information sharing within agencies and between staff working in different agencies and also some areas for attention for a number of agencies.

Practitioners at Learning Events were provided with an overview of the history of the individual victims, the agency responses and family genograms. Consistently they commented that most valuable was seeing the whole picture. Despite considerable professional and interagency activity, responses to events had taken place without the full background and family context being understood. Some were shocked by what victims had experienced and by information known to others.

Discussions emphasised that good practice includes:

- Proactively considering who needs to know what - making sure the right people have the right information in a timely manner; not assuming other agencies will have shared the information
- Acquiring relevant information as well sharing it with others
- Good arrangements within an agency as well as for external communication
- Acknowledging that case transfer is a critical period and updating information should happen prior to agreed transfer
- Providing context and history as well as presenting issues
- Providing an indication of the significance of information, particularly when shared outside professional groups
- Ensuring early and continuing multi-agency review and information sharing in order to put together a full picture
- Being clear about information that should be shared or sought

Greater understanding of sexual exploitation has led generally to lower thresholds being applied for sharing information and carrying out checks or enquiries and earlier multi-agency working. All safeguarding children's referrals are now considered through the Multi-Agency Safeguarding Hub and immediate information sharing by agencies and collection of data helps to identify emerging trends. The effectiveness is monitored through audit processes.

The Ofsted inspection in 2017 highlighted the impact of the considerable emphasis now placed on the collection and sharing of information with partner agencies.

A consistent frustration felt by Practitioners was the lack of integrated systems to pull together information held by different agencies. This applied particularly to health agency systems which do not operate as a single service. However, safeguarding information should be effectively dealt with for children referred in to the MASH, where the health representative contacts appropriate health providers for example mental health and General Practitioners.

The agency reviews and the discussions led to improvements in consistency of recording which should be reviewed during supervision of staff.

The cases confirmed the importance of ensuring that arrangements are in place in Children's Social Care and Adult Social Care to receive and accurately record legal advice and the basis on which it is given.

The Council Legal Services have an experienced team of lawyers who provide a specialist service. During the Review discussions took place between legal and social care staff to ensure that the most suitable and effective arrangements are in place. Advice is uploaded onto the social care data system, is easily identifiable and available to social care and legal staff. Periodic reviews take place to ensure these arrangements are operating effectively.

9.5 Children and Adults Who Move Area

The cases illustrated the problems that arise when a family giving rise to concerns moves from one local authority area to another, particularly when this is motivated by an intention to undermine or avoid efforts to address safeguarding issues. This issue has arisen in many serious case reviews.

Practitioners highlighted the "start again syndrome", the danger that local authorities and partners re-start involvement, without sufficient account of work undertaken during previous interventions. In the cases, appropriate notices were given to the local authority to whose area a family moved but difficulties and delays occurred in transferring relevant historical information to the new authority and preparations for legal action ceased.

"My Mum kept moving to get away – to different authorities. So new social workers that didn't know it."

Local authority administrative boundaries are intended to encourage more efficient delivery of local services. Statutory duties of local authorities are identical. However, social care information is not routinely transferred. Differing data systems complicate sharing of information.

The issue is as relevant for continuity of services for adults as for children, but legislation does allow local authorities to provide services for adults ordinarily resident in another area.¹³⁷

Newcastle Safeguarding Children Board has raised the issues at regional meetings of representatives of Safeguarding Children Boards and a cross boundary protocol is being developed for the North-East Region to overcome the problems. Where legal staff are preparing to issue proceedings at the time a family moves, they will continue to act until such time as legal staff in the receiving authority have been properly instructed.

Newcastle City Council Director of People holds the statutory appointments as Director of Children's Services and Director of Adult Social Care Services and is a member of the Association of Directors of Children's Services and the Association of Directors of Adult Social Services. He has made arrangements to raise with the

¹³⁷ s19 (2) (3) Care Act 2014

Associations, nationally and regionally, the need to agree effective arrangements for the transfer of social care records between local authorities. He has also arranged for this to be considered by the Regional Chairs of Safeguarding Boards and Directors.

Recommendation 1.12

I recommend that:

There should be reports made to Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board on the outcomes of the actions taken to improve information sharing in the region when vulnerable children or adults move administrative areas.

While health information should follow an individual, the Review identified difficulties when a child looked after by the Council experiences multiple placements, particularly if some are out of authority, or if an adult with safeguarding needs has a series of different area addresses. One victim had been registered with 16 General Practices. NHS Newcastle Gateshead Clinical Commissioning Group has raised this issue with NHS England to ascertain whether this can be addressed more effectively.

Similar problems were identified in relation to the transfer of school records and continuing education for children who move either with their family or as a result of placement changes. During the review The Pupil Referral Unit in Newcastle was reviewing arrangements to try and ensure for pupils who have attended the Unit there is better and more effective sharing of information with neighbouring Local Authorities. Newcastle School Attendance Service has reviewed arrangements to encourage early identification of children moving into the City to ensure a school placement is found in a timely way.

Barnardo's have also reviewed their approach to delivering services when victims' families frequently move between areas to minimise the disruption that occurs.

Recommendation 2.12

I recommend that:

The Government should address the need to improve national arrangements for facilitating transfer of data between social care authorities.

9.6 Professional Culture

Practitioners commented that "there was a different culture in 2007" and since there has been a huge amount of learning and change. Professional cultures can impact on the response and consideration of child and adult welfare issues.

There was a strong emphasis on showing greater respect for children's views and give greater responsibility to older children and adults with cognitive impairments to make choices about their lives, which impacted on responses.

While there is no evidence in Newcastle of an approach identified in Rochdale where girls as young as ten years old were recorded as engaging in consensual sexual activity, there was historically an acceptance that teenage girls would be involved in sexual acts and made life-style choices. This was encouraged by victims who under the influence and control of perpetrators, insisted that they were making choices which they were entitled to make, avoided contact and expressed resentment and opposition to attempts to intervene.

In 2011, drawing on lessons from serious case reviews across England, Ofsted highlighted¹³⁸ that agencies had focused on challenging behaviour, seeing children as hard to reach or rebellious, rather than trying to understand the causes of the behaviour and the need for sustained support. Young people under 18 were treated as adults rather than children, because of confusion about age and legal status. Practitioners did not fully understand the calculated erosion and removal of the ability to choose by perpetrators through grooming, alcohol and drugs, coercion and threats and offering food and shelter.

At the Learning Events Practitioners identified the significance of accepting that agreeing did not necessarily satisfy the need for consent and continued contact should not be misinterpreted as informed choice or an indication of absence of harm.¹³⁹

In Newcastle, while these issues affected the perception of what might be achieved and particularly what action could be taken against perpetrators and complicated the approach, it did not lead to inactivity or lack of effort to influence victims. On the contrary, there were examples of persistent efforts to persuade and offer services as the impact of abuse led to mental health and emotional problems. Better understanding also led to recognition that effective work with victims requires a long-term commitment to support and previous encouragement to carry out time limited interventions was not helpful.

9.7 Professional Curiosity

The Government Advice in February 2017 emphasised that responding to sexual exploitation requires knowledge and skills and:

“Professional curiosity and an assessment which analyses the risk factors and personal circumstances of individual children to ensure that the signs and symptoms are interpreted correctly and appropriate support is given.”

¹³⁸ Ages of concern: learning lessons from serious case reviews. A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011. Ofsted. October 2011

¹³⁹ Advice. Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. Department for Education. February 2017

The Climbié Report in 2003 and subsequent reviews¹⁴⁰ including of sexual exploitation have emphasised the need for practitioners and supervisors to think beyond the presenting issue and consider the bigger picture.

Practitioners highlighted areas that with greater understanding of sexual exploitation would have benefited from exercising curiosity and should inform practice - challenging denials or explanations of victims and perpetrators without assuming victims lack insight into the harm they experience; exploring why victims are with older unrelated men or in particular places; considering ages of men to be significant; taking into account that victims will be unlikely to answer truthfully; following victims; always considering the level of understanding and the influence of drugs and alcohol, inducements, coercion and abuse.

The need to exercise professional curiosity supported by examples is included in the Safeguarding Boards' interagency training and practice guidance and reflection of it in practice is subject to audit.

9.8 Assessments

The thoroughness of assessments impacts on developing effective plans and the quality of outcomes for children and vulnerable adults. There are fewer published materials and tools to aid assessments involving adults.

The Review found that pressure of persistent crises and constantly changing circumstances led to superficial approaches which tended to focus on single issues, rather than employing a systematic, holistic approach. Delays in collating, assessing and analysing evidence of emerging concerns over an extended period contributed to this. Better understanding of the significance of individual events and the context would have assisted the working of the cases and informed assessments.

A recurring weakness identified in research and serious case reviews has been that histories are not researched sufficiently and consequently over-estimating families' abilities to understand and respond to professional concerns is common.¹⁴¹ An early principle established in the field of child abuse and neglect, also applicable to adults, was that "if you don't understand someone's behaviour, you don't have enough history".¹⁴²

If parents are experiencing difficulties in parenting, then knowing the parents' own family history, assessing their understanding of the impact of what is happening to them and how they parent children, and their capacity to adapt and change

¹⁴⁰ See for example Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E, and F. Oxfordshire Safeguarding Children Board. 2015

¹⁴¹ Assessing Parental capacity to Change when Children are on the Edge of Care: an overview of current research evidence. Research Report. Ward and Hyde-Dryden, Centre for Child and Family Research, Loughborough University. Department for Education. June 2014

¹⁴² Quoting Brandt F Steele; C. Henry Kempe, University of Colorado School of Medicine in 1980s; The APSAC Handbook on Child Maltreatment, Fourth Edition, Klika and Conte; The American Professional Society on the Abuse of Children. 2017

becomes crucial.¹⁴³ Understanding life experiences informs what might impair or support interventions.

A systematic approach to enquiries using a conceptual model is the best way to deliver a comprehensive assessment¹⁴⁴ which should include “Family history and functioning.” This requires a forensic approach, identifying what needs to be known, how to acquire necessary information and consideration of the impact of what is known and what is not known.

In the cases, weaknesses in researching family histories led to over-optimistic assessments of parenting capacity and repeated reliance on parents to provide a safe environment despite evidence to the contrary. General Practitioners were not consistently involved which led to important patterns and impaired cognition in parents not being sufficiently understood. Learning included that minutes of children’s and adults’ safeguarding meetings must demonstrate fully the risk analyses, risk management requirements, the rationale for decisions and the status of the victim.

Local authorities’ children’s and adults’ services are responsible for carrying out safeguarding assessments, but consideration of the quality and analysis and making an appropriate contribution is an interagency responsibility. This requires persistent monitoring because of the pressures of daily work and time constraints for decision making. The Ofsted inspection in 2017 identified continuing weaknesses which are being addressed through an Action Plan, monitoring and auditing.

In 2015, the Government wrote to Directors of Children’s Services to ensure that the decision-making tools used to support assessments are properly evidence-based, and used to help thinking, discussion and decision making during supervision.¹⁴⁵ Newcastle City Council Children’s and Adults Social Care promptly reviewed the sexual exploitation tool in use, taking account of learning from Operation Sanctuary and practice experience in the Hub.

Within adult safeguarding, nationally accredited tools are not available. The Safeguarding Boards therefore worked together to produce materials relevant for safeguarding vulnerable adults and children.

9.9 Chronologies and Genograms

Practitioners commented that the Timelines and Genograms prepared for the Review and the analyses improved understanding of the whole picture and context of their involvement. Well prepared, up to date chronologies highlight persistency of concerns and the cyclical nature of interventions. Genograms help understand relationships and highlight areas for further enquiry and understanding.

¹⁴³ Analysing child deaths and serious injury through abuse and neglect: what can we learn? Department of Children, Schools and Families. 2008

¹⁴⁴ Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children. March 2015

¹⁴⁵ Tackling Child Sexual Exploitation. 2015

Newcastle City Council Children's Social Care have introduced processes for preparing genograms and recording analytical chronologies and life events which can be updated in live terms to provide a full picture of each case to underpin and inform case planning. Compliance and effectiveness is monitored through reports made to the Senior Management Team.

The arrangements for interagency children's and adult's safeguarding meetings and processes undertaken at other points of the systems include considering whether the preparation of chronologies and genograms are necessary to assist a full understanding.

The Safeguarding Boards have arrangements in place to encourage and review the preparation of chronologies and genograms across agencies.

9.10 Neglect

During the early period of the cases, there was less awareness of the impact of long term, persistent neglect and the possible link to sexual exploitation identified in research more recently.¹⁴⁶ Disengagement with health agencies and education is significant,¹⁴⁷ particularly when victims came from large families. Practitioners' observations that vulnerable individuals were "lost in the wider family" reflected the research. They confirmed the importance of considering the needs and identities of siblings in large families and the impact on the lives of each child¹⁴⁸.

During the period reviewed, neglect was addressed more effectively. In 2017, Ofsted confirmed that action taken by senior managers in Newcastle Children's Social Care in 2015 "led directly to innovation and investment in evidence-based practice". Practice and services to children and families improved as a result.¹⁴⁹

In 2016, there was an ambitious redesign of long-term social work services through the introduction of the Family Insights systemic practice model, funded through the Department for Education Innovation Programme. Independent monitoring and evaluation is being undertaken to explore the impact of this innovation¹⁵⁰ on permanent positive change for families.

9.11 Understanding and Responding to Diversity, Language and Culture

Culture - the ideas, customs, attitudes and behaviour characteristics of a particular social group or people or society,¹⁵¹ has a significant impact in safeguarding.

Within families or communities, cultural attitudes may be determined or encouraged by religion or might develop despite principles under-pinning religion.

¹⁴⁶ Hanson, E Exploring the Relationship between Neglect and Child Sexual Exploitation: Evidence Scope 1. Research in Practice: Dartington. 2016

¹⁴⁷ Failure to ensure access to health care is feature of statutory definition of neglect and should alert professionals to safeguarding needs. HM Government. 2015

¹⁴⁸ Child Visibility in Cases of Chronic Neglect: Implications for Social Work Practice, Howarth, J. and Tarr, S. BJSW 45 (5), 1379-1394. 2015

¹⁴⁹ Newcastle Upon Tyne Inspection of services. Ofsted Report. 7 July 2017

¹⁵⁰ Newcastle City Council's Family Insights Innovation Programme: Research Evaluation Report 31 July 2017

¹⁵¹ Oxford English Dictionary

It might lead to differences of approach to men and women and to girls and boys and may affect how a child or vulnerable adult feels about themselves and what they can expect from others. It might vary across a geographical area, be strongly influenced by family traditions or affect an individual's or group's attitude towards authority, whether advice or stronger expectations will be adhered to and whether departure from what is expected will be acknowledged. It may influence whether concerns are reported.

In 2015, the Government asserted that:

*"There is no culture in which sexual abuse is not a serious crime."*¹⁵²

However, what is considered to be abusive might be affected by cultural and legal issues.

In any assessment, it is therefore important to ensure that as much relevant information as possible is obtained concerning the attitudes and approach of carers and of perpetrators to child rearing and the care of vulnerable adults. In cases involving people from abroad these issues may be prominent but need to be considered whatever the background.

Two of the victims in the cases had family backgrounds from different African States. No enquiries were made about their experiences before they came to the United Kingdom or about the likely cultural attitudes towards the issues that were causing concern. In both, immigration status had affected the families including severely restricting income but no links had been made with the Home Office.

One victim discussed cultural issues that she thought had not been understood:

"... one night I was late and petrified of going home I called the police and they took me to a foster home. When you are black my parents said they assume you have problems and they want to put you in jail. When they took me, I thought they were right."

Later when she was a victim of rape:

"They were going to kick me out."

"My parents blamed me. It was a matter of pride It is cultural."

"In ... there are (very many) ethnic groupings and almost as many languages. Two main languages. But there is no single ... culture. It is important to understand what individuals think and believe. My parents believe that children can misbehave because of evil spirits that can be beaten out of them and got support from the church. But not all ... believe that. Nobody understood."

¹⁵² Tackling Child Sexual Exploitation.HM Government. March 2015

It is difficult if conversations with family members take place in a language no professionals understand.

“No one could understand what he was saying. He told me to say I wanted to go home.”

The Practitioners accepted that the parents’ deeply ingrained cultural values were not fully understood. They also identified the need to consider the background of the workforce and volunteers, whether they will understand the important issues, or have access to competent advice, whether language inhibits engaging with and understanding communities and perpetrators’ values. It was emphasised that these issues are relevant for other communities including learning disabled and deaf and blind communities.

In Newcastle, resources are available to practitioners to assist understanding cultural issues. A section on Abuse Linked to Spiritual and Religious Beliefs is published in the Procedures Manual by the Newcastle Safeguarding Children Board¹⁵³, and reflects and has links to non-statutory government guidance from 2007, the National Action Plan 2012 and a research report on Possession and Witchcraft 2006.

These were not referenced in the Agency Review reports and awareness in practice appeared limited.

The involvement of a Home Office representative at Learning Events was described by other participants as “welcome and helpful”. As a result, the Home Office had a better understanding of the potential risks for other children and young people and of a return to the country of origin and how immigration status and inability to work might contribute to vulnerability to sexual exploitation.

Arrangements have been made in Newcastle for Home Office representatives to establish links with local authority social care services, attend Safeguarding Conferences to encourage networking and sharing information and contact children’s services regularly for update, to better understand safeguarding issues to feed into immigration decisions.

In the cases which had foreign links, no attempt had been made to obtain information from the countries of origin.

In 2014, the Government published Advice¹⁵⁴ for local authorities, social workers, service managers and children’s services lawyers on working with foreign authorities including Embassies’ contact details to inform judgments about children and families with foreign links and inform courts of the steps taken if proceedings

¹⁵³ Abuse Linked to Spiritual and Religious Beliefs <http://newcastlescb.proceduresonline.com>; Safeguarding Children from Abuse Linked to a Belief in Spirit Possession. Department for Education and Skills 2007; Child Abuse linked to Faith or Belief: National Action Plan, Department for Education 2012; Child Abuse Linked to Accusations of “Possession” and “Witchcraft”. Stobart research Report No. 750 Department for Education and Skills. 2006

¹⁵⁴ Working with foreign authorities: child protection cases and care orders Departmental advice for local authorities, social workers, service managers and children’s services lawyers Department for Education. July 2014

were initiated. A copy of the Advice is on the Newcastle Safeguarding Children Board Website.

The need to have regard to and apply the Advice was raised by their manager with Independent Reviewing Officers and Children's Services Teams in Newcastle City Council and there is evidence of it being used by staff. Further work is being undertaken to embed this in practice.

Newcastle City Council legal services specialist staff routinely contact relevant Embassies and report outcomes in court proceedings. Only few responses have been received, even after sending a reminder. In the cases with no response, with agreement of the court, further delay was considered detrimental to the children.

There is no national guidance relating to adult safeguarding and contacting Embassies and Foreign Authorities. Newcastle City Council Adult Social Care staff apply the principles in the children's Advice when working with an adult. Staff have linked with foreign authorities for cases involving forced marriage of people with a learning disability and when working with asylum seekers. A designated staff member who works with asylum seekers and people with no recourse to public funds helps build expertise and knowledge of appropriate contact points for Foreign Authorities.

Recommendation 1.13

I recommend that:

Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should consider how access for practitioners to advice on cultural attitudes when assessing and managing risks might be improved.

9.12 Plans

A survey of over 500 professionals in 2017 found that developing plans related to Harmful Sexual Behaviour was the work area with the lowest level of confidence.¹⁵⁵

Safeguarding plans that deliver good outcomes depend on good assessments and analysis. They are more than strategic intentions and should set out measurable operational objectives and how they will be achieved, the "how, who, what and when" to enable the plan to be used as a means of checking whether or not those objectives are being met¹⁵⁶. To avoid effecting changes in a crisis, there must be a contingency plan.¹⁵⁷

In the cases, the plans focused on the behaviour of the victims and how to persuade or prevent them associating with perpetrators. They did not address the cause of the concern, which was the activities of the perpetrators, and as a result,

¹⁵⁵ Workforce perspectives on harmful sexual behaviour: findings from the Local Authorities Research Consortium 7. National Children's Bureau. 2017

¹⁵⁶ Richards J.: R (AB and SB) v Nottingham CC (2001) EWHC Admin. 235

¹⁵⁷ Munby J.: R v Caerphilly County Borough Council (2005) EWHC 586

although they engaged the interagency framework and significant resources and commitment, they did not ensure consistent safety of the victims.

Circulating widely actions to be taken against perpetrators is not appropriate but the need to address the issue and who will be involved should be clearly addressed so that effectiveness and impact on other areas of practice can be reviewed.

The pressure of repeated crises, victims being missing or frequent changes of placement, inhibited carrying through actions identified as necessary.

“Why don’t they do the plans? I was meant to have psychological treatment and so on. Never done. I was told I would not accept support but they said I needed longer for treatment but it didn’t happen. Why don’t they listen to advice? Unclear plans.”

The Agency Reports robustly identified persistence with plans that were failing, supported by misguided optimism, uncertainty about how to manage the risks and insufficient overview, so lack of progress was not identified. The cases included victims looked after by the Council and so subject to oversight by Independent Reviewing Officers, and whose welfare was considered by courts and Children’s Guardians.

One of the most common, problematic tendencies in human cognition is the failure to review judgements and plans. Once a view is formed, evidence that challenges that picture is often unnoticed or dismissed.¹⁵⁸

“Nothing changed.”

Before the Review began, overuse of multiple “contracts of expectation” had been identified in multi-agency audits and highlighted in a serious case review. These statements, sometimes repeatedly insisted upon by courts, signed by carers, set out detailed lists of actions for carers and were repeated from one meeting to the next with limited attention to outcomes for individual children.

Reference to them has been removed from Newcastle City Council Children’s Social Care Practice Guidance which encourages instead working collaboratively to achieve tightly planned goals and positive outcomes with clear timescales, monitored through audits reported to the Senior Management Team and Newcastle Safeguarding Children Board.

Where court proceedings are contemplated, the development of the Public Law Outline includes a requirement that local authorities clearly set out concerns and what is needed to address them and provides an alternative to agreements.

Where there was anxiety about lack of progress, legal advice about what options might be available was not always sought promptly. There have been discussions between staff in the respective departments and work undertaken to maximise access to legal expertise. Weekly meetings ensure a consistent effective early

¹⁵⁸ SCIE Report 19: Learning together to safeguard children: developing a multi-agency systems approach for case reviews. Fish, Munro and Bairstow. 2008

contribution and consideration of the soundness of judgments and quality of assessments which reflects court expectations.¹⁵⁹

Decisions about accommodating children and initiating proceedings are now considered by the fortnightly Care and Resources Panel, chaired by the Assistant Director of Children's Social Care and attended by Legal Services to provide robust oversight and up to date legal advice. A fortnightly Legal Proceedings Panel considers and monitors the progress of all cases involving proceedings.

The effectiveness of the processes is monitored through performance data and review.

That the development of plans was an area in need of improvement was identified by audit and inspection and an Action Plan to address this, including training, was in place before the Review began.

It is impossible to know whether, if early plans had included the need to address the perpetrators and failure to achieve better outcomes had been highlighted, the focus on investigating, disrupting and prosecuting perpetrators might have occurred earlier.

Newcastle City Council social care services are responsible for ensuring safeguarding plans are in place but the development of and effectiveness of plans is an inter-agency issue. There was no evidence that any other agency commented or complained about the ineffectiveness of or criticised the adequacy of the implementation of plans. In Section 11, I discuss the need for robust collective responsibility and interagency challenge.

Taking part in the Review encouraged agencies to consider carefully their internal planning arrangements. Right-Trak Ltd, which manages care homes, developed a model for Missing from Home Safety Plan. This is a robust document setting out boundaries and expectations of residents, curfew times, when and where they should be when attending education, guidance on locating residents should they go missing, known associates that pose a risk and areas of concern and addresses where they could be at risk of harm.

The Risk Management Group, set up in 2012 to consider children who were considered to be at high risk of harm, now has a multi-agency membership which includes adult social care. Chaired by a Newcastle City Council Children's Social Care senior manager, the Group ensures earlier identification and access to multi-agency support and scrutiny at senior level. All children and young people considered medium or high risk following a sexual exploitation risk assessment are referred to the Group. If plans are not achieving objectives this is identified and addressed.

¹⁵⁹ Munby P. *Darlington Borough Council v M, F, GM, GF and A* [2015] EWFC 11

9.13 Working with Families

The Agency Reports and Practitioners identified that the pressure of recurring crises generated a reactive approach and the persistent and determined efforts to impact on and influence the behaviour of victims detracted from constructive and systemic work with families. The lack of engagement with or involvement of family members was not identified or challenged. It was assumed that sexual exploitation was an issue external to the family and lack of knowledge about family backgrounds led to both inappropriate reliance on the ability or interest to protect and overlooking potential for positive contributions.

A mother of a victim commented that she felt that if she had had help with problems in the family, which wore her down physically and emotionally, sexual exploitation might not have happened. She also thought that, although she had been able to express her concerns about her daughter's placements they were not acted upon.

In September 2017, the Centre of Expertise on Child Sexual Abuse published an evidence review¹⁶⁰ examining "Supporting parents of sexually exploited young people". The key messages included are as relevant to cases involving adults:

"There is a wealth of evidence pointing to the significance of parents in the lives of young people and the importance of parenting to outcomes, even where parent-child relationships are on the verge of breaking down. It is vital that services support the role of parents in supporting their children."

Many parents will be encountering services and systems for the first time or, if not, the focus is likely to have been quite different. One of the biggest sources of distress for parents is their child not receiving the help they need.

Before the Review began the intention to address this area of practice contributed to the decision to introduce the Family Insights Systemic Practice Model of social work into Newcastle City Council Children's Social Care.

Child sexual exploitation cases have been allocated to a specific Unit, the effectiveness of which is closely scrutinised. Outcomes are measured and monthly meetings involving leaders and operational managers explore data, examine the quality of casework and identify lessons which can be shared. A Multisystem Therapy Team provides intensive family and community based collaborative intervention for children aged 11-17 at risk of being removed from home.

Service User Satisfaction Surveys were fed into an evaluation through Oxford University. Consultation and support has been provided by Morning Lane, a social enterprise organisation with a proven track record of assisting local authorities improve the skill set within their workforce. Reporting arrangements to oversee ongoing implementation are through a Strategic Board chaired by the Newcastle City Council Director of People.

¹⁶⁰ Exploratory study on the use of tools and checklists to assess risk of CSE. Centre of Expertise on Child Sexual Abuse. 2017

9.14 Safeguarding Procedures: Children Looked After by the Local Authority and Adults subject to Adult Protection Plans

Children may become looked after by the Local Authority because they are known or suspected to be suffering sexual exploitation. The local authority can decide where the child lives and other resources are available, but the behaviour or attitude of the victim is unlikely to immediately change or the risk of abuse diminish by reason only of the change of status. Victims may meet others for whom there are similar concerns. The local authority powers to control or restrain are very restricted unless statutory criteria are satisfied and the child is placed in registered secure accommodation, which involves placement away from agencies who have been working with the child and family.

The cases included circumstances in which an agency other than Newcastle City Council was aware that a looked after child was suffering or likely to suffer significant harm but a referral under the interagency Child Protection Procedures was not made and there were therefore no child protection enquiries or conference to consider whether a child protection plan related specifically to safety should be developed. The Procedures do not include any provision excepting their application to children looked after by the local authority; nor are statutory provisions requiring child protection enquiries so limited.

A number of the cases included circumstances in which children were not subject to any child protection processes as they approached adulthood despite being victims of unresolved sexual exploitation. Newcastle City Council Adult Social Care while involved during the transition period did invoke adult safeguarding procedures.

Statutory regulations and guidance¹⁶¹ address circumstances in which a child subject to a child protection plan becomes a looked after child and provides that the child protection plan should continue unless and until the child is protected from significant harm. Meetings held to review a looked after child's case have a different function and children mostly want as few people as possible at a review meeting when they are present, whereas a child protection conference is a multi-agency meeting.

The regulations and guidance do not address specifically circumstances in which a looked after child suffers significant harm but the argument for child safety focussed processes are strong.

There were similar examples when concerns were not shared when a vulnerable adult was subject to an adult protection plan or Newcastle City Council Adult Social Care were already actively involved.

It is likely that there was an assumption that the welfare of the victim would be safeguarded by arrangements in place arising from status, including, for looked

¹⁶¹ Paras 2.11 to 2.13 The Children Act 1989 guidance and regulations Volume 2: care planning, placement and review. Department for Education. 2010 updated 2015. The Care Planning, Placement and Case Review (England) Regulations 2010 amended 2013

after children, the requirement for a care plan and oversight by an Independent Reviewing Officer.

Reports of reviews elsewhere¹⁶² and Ofsted¹⁶³ drawing on reviews across the country have highlighted dangers when professionals do not consistently refer to procedures and assume other agencies will be aware or are responsible for addressing concerns and so make no referral.

This issue has been addressed within Newcastle Social Care guidance. Safeguarding Procedures require agencies to make safeguarding referrals or notifications whatever the victims' status, wherever they live and whatever arrangements are in place, so that full information is collected and consideration given to whether safeguarding enquiries and interagency meetings should take place. When the victim is a looked after child, the Independent Reviewing Officer will consider whether involvement of expertise and independence that arise from convening safeguarding meetings can be achieved through the statutory review of the child's case or a safeguarding conference should be convened.

These arrangements are subject to audits reported to the Safeguarding Boards.

9.15 Listening to Victims

In 2015, the Government published¹⁶⁴ an intention to generate a culture in which all professionals listen to victims and those at risk and respond to allegations. The cases demonstrated how difficult it is to take account of what victims want to happen, when the perpetrators' calculated and malign influences ensure that they will be deceitful, misleading and contradictory. Practitioners also commented that:

“Often we just go in and expect them to disclose straight away when in fact they need to build trust in people before they can even consider disclosure.”

Listening may include challenging and clarifying, being available and waiting until a victim is ready and confident to talk. Victims gave much fuller accounts of their experiences than previously when giving evidence in court.

One victim felt strongly that what she had to say about who was responsible for her going missing and being exploited was insufficiently listened to. She thought that she did not have anyone she could trust and talk to and that unavoidable changes of social workers contributed to this. She worried that what had happened to her was not fully understood and despite many conversations never really understood the risks.

“People kept saying I was at risk but I didn't understand. What was CSE?”

¹⁶² The Review of Multi-Agency Responses to the Sexual Exploitation of Children in Rochdale; Rochdale Borough Council. 2012

¹⁶³ Ages of concern: learning lessons from serious case reviews: A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011. Ofsted. 2011

¹⁶⁴ Tackling Child Sexual Exploitation HM Government March 2015

She and her mother regularly attended meetings and voiced their concerns about where she was placed and the contact she was allowed to have with another victim with whom she was placed.

“I told the social worker. The staff ... should’ve known that there were restrictions ...”.

The Review looked carefully at the background to this. What they were saying was clearly understood, considered and recorded but the contributions from victims have helped agencies and practitioners learn, reflect and change practice.

While the focus of the extensive work was on protecting the victim from exploitation, the case illustrates how important it is to clearly communicate to the victim and family with explanations for what was happening and why, including any difficulties arising from limited placement options and problems planning when responding to frequent crises. If agreement on proposals cannot be reached, there should be consideration given to how nevertheless victims might be helped not to feel they have been excluded.

These contributions illustrate how important it is not just to listen. Listening must be accompanied by clarity over what has been understood and communication of the likely implications, including ensuring all relevant professionals are fully aware.

This victim is being helped to access advice and raise concerns about her time in residential care and is being encouraged to work with staff to look at practice. She is very keen to support other children at risk and is helped to do so.

Work has been undertaken to encourage focussing on continuity, consistency and communication. In 2017, the Ofsted inspection found that in Newcastle children do have meaningful and consistent relationships with social workers, who know them well and Inspectors saw good examples of direct work helping children understand their histories and experiences.

All the other victims maintained that when sexual exploitation began they would not have co-operated with any attempts at persuading them to talk about it, which appeared to be due to lack of understanding about the true nature of the abuse, fear, and threats and coercion they faced.

Arrangements to carry out return interviews of individuals who have been missing have been improved and allow that not even partial disclosures might occur without further work being undertaken. Support includes accepting that victims will frequently require time before talking about experiences. All the victims stressed how important continuing support and patience of staff working in the Hub was in gaining their confidence.

Newcastle Safeguarding Boards’ interagency training, practice guidance and review and audit processes include care taken to listen to victims.

9.16 Lack of Engagement with Services

In the cases, there were examples of victims and victims' families not engaging with services available or offered. This concerned particularly mental health or specialist community services.

Agency Reports and Practitioners noted that records often described this as a client's difficulty in engaging with services or failing to attend or to keep appointments. It was suggested that it is preferable to record that the service was failing to engage with the client as this is more likely to encourage consideration of how the problem could be addressed. The victims' lives were chaotic, they lacked awareness of their abuse and their priorities were at odds with the professionals whose involvement was resented.

"I pushed the help away. I knew professionals were trying to see me and I cancelled appointments. I was scared of being judged."

"I was not eating properly - I was anorexic. The social workers were worried about me. It was difficult to contact me. They did not know why. I was scared to tell anyone – ashamed."

Inevitably, pressure on resources leads to discharges or closure of cases and there may be no benefit from an open case if there is no attendance.

There were good examples, including SCARPA, and Newcastle City Council services where files were kept open even though a client was not attending, in case the situation changed. With other agencies repeated failure to attend appointments led to discharge from the service with no or insufficient enquiry to ascertain the reason and without follow up or action. There were examples of correspondence notifying appointments being sent to a recipient who had difficulty reading or sent to an out of date address.

"With letters people need to be more understanding about what I can understand."

Practitioners emphasised that discharge should not occur without a family member or local authority employee responsible for ensuring appointments were kept being informed. A child in the care of a local authority should not be considered for discharge from a service without reference to the responsible social worker and consideration by the managers of the authority and the Independent Reviewing Officer. Where attendance is a feature of a safeguarding plan for a child or adult, the issue should be considered within interagency arrangements.

"When my mother died. I was offered counselling in school but did not go back. They did not ask why."

"It was fear of the perpetrators and their associates. Also, everyone would know – the embarrassment, humiliation and I was a grass"

“I didn’t tell people about the voices – I don’t know why. I was drinking heavily. there was a lot of chaos.”

“I was struggling to get to appointments – it was put down to the drink.”

There were no examples of agencies “giving up”, but plans to address this problem were often weak.

In 2015, the Government¹⁶⁵ commented that it is unacceptable that children who need treatment from Child and Adolescent Mental Health Services cannot access services or should be dropped from services where they are unable to attend an appointment. It undertook to set out in a Child and Young People’s Mental Health Taskforce report an ambition to support and inform the design and delivery of local services to all children and young people, including those sexually exploited. Delivering that ambition “will require local leadership and ownership”.

“Mental health support has been a joke. Loads of assessments but nothing comes out from them – what is to be done about it?”

“I have been detained under the Mental Health Act on 3 occasions. But nothing happened afterwards.”

“That is until now. I am involved with the Personality Disorder hub – psychologists.”

In February 2016 the Department of Health and Department for Education commissioned the Social Care Institute for Excellence to establish an Expert Working Group. In November 2017, the Group published its final report including recommendations on improving mental health support for children and young people.¹⁶⁶

Non-engagement with victims was reflected in the Review Learning Logs as requiring immediate attention. The expectation now is that when interagency safeguarding arrangements are in place, availability of provision should not be withdrawn without the issue being considered and a solution agreed or the development of alternative plans.

General Practitioners and Newcastle upon Tyne Hospitals NHS Foundation Trust have a protocol to address non-attendance of children at appointments which involves referral to the Trust safeguarding team, which has a monthly operational safeguarding meeting with a social worker in attendance. These arrangements are subject to audits that confirm such referrals are made.

Agencies have also reviewed how their service models might include a broader range of methods for engaging children and young people who may be hard to reach or at risk including how to mitigate loss of contact through being placed on a waiting list.

¹⁶⁵ Para. 54 Tackling Child Sexual Exploitation HM Government. March 2015

¹⁶⁶ Improving mental health support for our children and young people: Expert Working Group. SCIE. November 2017

Recommendation 1.14

I recommend that:

Northumberland Tyne and Wear NHS Foundation Trust should report to Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board on the arrangements being made for local delivery of the Governments ambition to improve access to Mental Health Services for all children and young people, including those sexually exploited.

9.17 Team Around the Worker

The Review included cases in which multiple needs of victims led to involvement of large numbers of agencies which ironically increased the likelihood of non-attendance. For one case 25 agencies provided timelines and reports. The Learning Events highlighted that this was likely to be overwhelming for the service user.

It was suggested that a co-ordinator should be appointed through interagency processes to ensure continuity, flexibility and wrap around services and to identify the professionals or services with which a victim feels most comfortable. This would be a challenging role requiring considerable support, hence the reference to a “Team Around the Worker”.

These principles have been reflected in the development in children’s services of Early Help and the Team Around the Family which includes an expectation that an appropriate Lead Practitioner will act to co-ordinate services. The framework developed by Newcastle Safeguarding Children Board expects that the co-ordination will identify specific support for members of the Team and is subject to review and monitoring.

In Adult Safeguarding arrangements are in place to try and keep the number of professionals involved to a minimum by identifying a single point of contact through the professional who has the best relationship with a victim.

9.18 Capacity and Choice

A persistent feature of the cases was uncertainty about whether a suspected victim had the mental capacity to consent to sexual acts and to reject attempts by agencies to prevent abuse and to choose to continue to be involved with perpetrators.

In 2011, Ofsted found that in serious case reviews across the country that during 2007 to 2011, there was a failure to understand the impact of coercion by abusers on behaviour and to assess capacity to make informed choices or truly consent to

go with their abusers.¹⁶⁷ The issue has consistently arisen since, including in Rochdale, Rotherham, Oxfordshire and, in 2017, Somerset.¹⁶⁸

As children approach adulthood the impact of the statutory ability to consent to sexual acts after the age of 16 years complicates the issue.

In Newcastle, similar uncertainties and the extent to which vulnerabilities undermined capacity also arose in relation to adult victims. Practitioners felt there had not been a clear understanding of the application of Mental Capacity Act principles and the impact of the assumption of capacity. Risky behaviour was interpreted as making unwise decisions by competent individuals rather than possible result of abuse.

However, there was no evidence that assumptions were applied to all cases systematically or that having concluded victims had capacity, attempts to influence victims and the choices they made ceased, as appears to have occurred elsewhere.

On the contrary, the encouragement to allow children and adults with vulnerabilities autonomy, responsibility and the right to choose influenced judgments about what could be done rather than whether something should be done.

As the prevalence and impact of sexual exploitation has become better understood, the criminal courts have been more accepting that the ability to consent and make choices in best interests can be eroded by grooming, coercion, drugs and alcohol. National safeguarding children guidance now stresses the importance of considering these factors. The experience in Newcastle illustrates that the same care must be applied to adults who are vulnerable and targeted.

These issues have been robustly addressed by the Safeguarding Boards through interagency training programmes, the joint sexual exploitation strategy and by partner agencies through internal training. Problems are considered by the Multi-Agency Sexual Exploitation Group and individual cases at the Risk Management Group. The effectiveness of arrangements is monitored through audit and reported to the Boards.

9.19 Mental Health and Learning Disability

The cases included victims whose cognitive impairment had been identified previously and others in which no impairment had been identified but was suspected by professionals involved in addressing the exploitation. There were also circumstances in which cognitive difficulties of parents and the impact on their ability to protect had not been considered.

During the Learning Events discussions identified uncertainty about:

¹⁶⁷ Ages of concern: learning lessons from serious case reviews: A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011. Ofsted 2011

¹⁶⁸ The Fenestra Serious Case Review into Child Sexual Exploitation: Somerset Safeguarding Children Board November 2017

- Differences between learning disability and learning difficulty and relevance
- The extent to which either is susceptible to formal diagnosis
- Whose responsibility it is to assess
- Education services responsibilities
- What is the relationship with mental ill-health
- The meaning and impact of mild, moderate or severe categories
- Skills to work with impaired victims and when victims are unwilling to engage
- Handling and distinguishing capacity to decide some things but not others
- Impact on capacity of drugs and alcohol, abuse and mild cognitive impairment
- When to expect that impairment will have been identified during childhood
- Sources of expertise, advice and consultation for practitioners and availability from mental health services or the Community Learning Disability Team

This is unsurprising. Uncertainty is widespread. NHS Choices explains that learning disability is not the same as learning difficulty or mental illness but “it can be very confusing as the term "learning difficulties" is used by some to cover the whole range of learning disabilities.”¹⁶⁹

There is a difference in the language used in the education, health and social care services. Learning disability is assessed taking account of a combination of IQ and intellectual and social functioning rather than an absolute diagnosis. Terminology might determine eligibility for services and for benefits.

Recommendation 1.15

I recommend that:

Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should arrange for guidance to be issued to practitioners on the differences between learning disability and learning difficulties and the relevance for safeguarding judgments and services.

In one case, practitioners in Children’s and Adults Social Care working with a victim approaching adulthood, who had no history of assessment of cognitive impairment, suspected her ability to make appropriate choices was undermined by cognitive problems. This issue had an impact on the ability to intervene once she became an adult.

After seven months of negotiations it was concluded by the provider of mental health services, Northumberland Tyne and Wear NHS Foundation Trust, it would require the victim’s consent to assess capacity and if she was not for any other reason eligible for services, the Trust would not become involved. The same principles would be applied if an assessment of a parent or carer was required.

Even if a victim refuses to consent and is not eligible for mental health services, safeguarding practitioners still need advice on the approach to the case and to

¹⁶⁹www.nhs.uk/livewell/childrenwithlearningdisability/

support court applications. Newcastle City Council paid privately for an assessment and advice.

In some cases, such difficulties have been overcome by the willingness of individual professionals to become involved rather than clarity about the appropriate source for these services. NHS Trusts have statutory duties¹⁷⁰ to cooperate with the local authority to safeguard and promote the welfare of children and vulnerable adults and carry out all their functions having regard to the need to safeguard and promote the welfare of children. But the services are commissioned and funded by NHS Clinical Commissioning Groups.

There is a determination in Newcastle to address and clarify this issue. NHS Newcastle Gateshead Clinical Commissioning Group is taking the lead in bringing interested parties together to discuss and clarify the need for services and from where they should be accessed. A report will be made to the Safeguarding Boards on the outcome of this initiative.

The Review confirmed that there is now a greater awareness of the need for timely recognition that victims may lack capacity, the impact of learning disability on capacity to make decisions and that children and adults with special needs may be at increased risk.

Responding to Agency Reports and the Learning Events discussions, training has been delivered and attended by the Council Legal Services, to improve understanding of the Mental Capacity Act 2005, the application to individuals aged 16-18 years, the Deprivation of Liberty Safeguards, the relationship with the Care Act 2014 and other legislation, the jurisdictions of the Court of Protection and High Court and the impact of case law.

Northumberland Tyne and Wear NHS Foundation Trust has made improved the organisation of safeguarding arrangements and guidance and training to increase awareness and improve practice in identifying children and young adults who may be at risk. Policies have been updated to encourage a multi-agency approach and include clear criteria and referral processes and the consideration to be given to vulnerability wider than mental health. Staff attend Multi-Agency Risk Management Group meetings and take part in the Huddle, which provides a fast track process for mental health services for victims considered within the Hub.

NHS Newcastle Gateshead Clinical Commissioning Group has commissioned, through The Newcastle upon Tyne Hospitals NHS Foundation Trust, Specialist Learning Disability Liaison Nurses within the Safeguarding Adults team, who work across the Trust and provide support to ward staff and community staff. The records of patients with a learning disability are flagged so all services are aware and make reasonable adjustments.

The under-18 proforma in Sexual Health Services has been amended to demonstrate consideration of mental capacity and assessment and a specialist learning disability nurse has been appointed. Mental Capacity Act training is

¹⁷⁰ Children Act 2004. Care Act 2014

provided and there is a Mental Capacity Act Steering Group within the Trust, and Lead member of staff in post. There has been investment in a learning disability service in maternity services and in improving recognition, response and recording in the emergency department.

Your Homes Newcastle has arranged training to raise awareness of working with clients with learning difficulties and a specialist mental health social worker advises the Housing Advice Centre.

The Missing, Sexually Exploited and Trafficked Group has developed an Action Plan and established a working group to ensure that the learning and recommendations in a report¹⁷¹ on the needs of children with learning disabilities who experience, or are at risk of, sexual exploitation are incorporated on a multi-agency basis into documents, policies and procedures.

The Ofsted inspection in 2017 identified that some children in Newcastle are waiting too long for timely access to specialist emotional and mental health support services. Children also criticised delays.

Action is being taken to address this and multi-agency policy and procedures are being updated.

9.20 Education Services and Learning Disability

The cases included an adult who was at continuing risk of financial and sexual exploitation. There was no record of any assessment of learning disability during childhood but as part of the safeguarding adult's processes, she was assessed as having a significant learning disability, sufficient to support an application to the Court of Protection for authority to deprive her of her liberty.

Practitioners at the Learning Events highlighted an apparent discrepancy between school reports of her doing well and evidence of learning disability and limited capacity as an adult. However, review of her school file indicated that although this was not available to adult practitioners, she had been identified as having special educational needs and undergone continued assessment while at school. With this support, she was able to make satisfactory progress against attainment targets.

To place this in context, during the Review a contribution from the Manager of the Educational Psychology Service provided helpful clarification:

- Assessments of special educational needs and disabilities operate with a statutory Codes of Practice¹⁷² revised from time to time. During the period reviewed, they consistently emphasised the need for a graduated response, with schools being expected to assess and meet needs before involving outside specialists or requesting additional support from the Local Authority.

¹⁷¹ Unprotected, overprotected: meeting the needs of young people with learning disabilities who experience, or are at risk of, sexual exploitation; Franklin et al, Barnardo's. 2015

¹⁷² Special Educational Needs and Disabilities Code of Practice; latest version issued 2015

- Education staff refer to learning difficulties - learning takes place within a context and learning difficulties will vary according to environment, teaching methods and a range of social and emotional factors as well as underlying cognitive skills. Access to provision or level of support within Newcastle's education systems is never determined by an IQ score.
- Whether a child has a defined learning disability is not typically a focus for school assessment or intervention. Schools and Educational Psychologists focus on the child within context, investigating possible reasons for any Special Educational Need, planning appropriate interventions and reviewing progress.
- From an education perspective, a young person's adaptive behaviour and the protective factors are as important in predicting vulnerability as their IQ. A young person with a low IQ might be less vulnerable than one with a higher IQ depending on their life experiences and environment.
- Newcastle City Council funds Educational Psychologists to carry out statutory assessments for the Education, Health and Care Plan process. All other work is funded by schools or other services. The majority of work in schools is planned through priority setting meetings with school staff.
- School staff are unlikely to refer children to the Educational Psychology Service if they are settled and happy and making progress at their own level, with or without support.

It is therefore not unusual that even though an adult may be assessed as having a severe learning disability, there will not have been and need not have been any cognitive assessment during childhood. Therefore, no assumptions should be made about cognitive impairment and in safeguarding processes appropriate assessments always need to be considered.

It was suggested that there is a need to develop protocols between education and social care services to provide for what action social workers should take if concerned a child may have cognitive impairments or a learning disability.

While discussions that include consideration of children over school leaving age have been taking place, guidance has been issued by Newcastle Children's Social Care to social workers clarifying the issues and emphasising the need where assessments are necessary to inform judgments to privately commission them from appropriate services.

A report will be made to Newcastle Safeguarding Children Board when a protocol for access by children's social care services to educational psychological services to inform welfare judgements has been agreed.

9.21 Placements

Placing children looked after by the local authority is complex. When for reasons linked to their vulnerability and perhaps coercion, they are determined to leave

accommodation and not co-operate with arrangements, the complexity is significantly increased.

Resources for children with complex needs are scarce. Victims of sexual exploitation are likely to be placed with other children who have complex needs. In her contribution, one victim illustrated this problem.

Providers of accommodation decide who will be admitted and local authorities compete for provision. Residential placements are often at considerable distance from home areas and the professionals working with them. Residents may include victims from their own area and from different parts of the country.

“I wanted to get away. P was placed there. We ran away and were picked up by L and a man. The abuse went on.”

Another case included a victim who experienced 13 different care placements and 16 moves and, another, 15 placements involving two foster placements, seven residential placements, two independent living placements and four periods in secure accommodation.

In these circumstances it is difficult to plan and ensure continuity of health and education provision. Arrangements have since been made to try and ensure health information promptly follows the child and is shared with relevant personnel.

Within the constraints, the cases reflected a strong and ongoing commitment by Newcastle City Council Children’s Social Care to identify appropriate placements to protect the victims. This included secure accommodation when it was necessary to restrict the ability of a victim to leave a placement, continued unusually in one case until the victim was 18 years of age to maximise opportunities to influence her behaviour.

During the Learning Events the Practitioners expressed unease at the placement of a victim in a secure placement while the perpetrators remained free. All the victims had high regard for the staff who work in secure units but resented having been placed.

“I was put in a secure placement with kids with a criminal background. I was a victim – why was I there, I had done nothing wrong.”

“I was in a care home – but those men were walking about free.”

“The risk assessments also meant that my phone and internet were removed which made me feel isolated. I had no contact with friends who were no risk to me.”

One victim spent 10% of her childhood in secure accommodation.

Secure placements for children are authorised and kept under review by the Family Court and must end when the statutory criteria allowing the placement are no

longer satisfied. Residents can be skilled at complying with requirements and securing release before there has been an opportunity for therapeutic intervention.

“It didn’t change me”.

The Oxfordshire Review concluded that secure accommodation may solve the problem temporarily but is ineffective beyond, unless groomers are disrupted or removed.¹⁷³

The Practitioners commented that the placements had two objectives, to save victims from themselves and to save victims from perpetrators. Mostly the first was met but the second was not always met in secure settings, since contact from perpetrators continued and there were no effective measures to deal with them.

An evaluation report of a secure unit published in 2016¹⁷⁴ commented that for a secure placement to do more than care for a young person for the length of the order, it needs to be part of an integrated long-term plan by the placing authority, incorporating:

- Thorough appraisal of needs and assessment
- An ongoing relationship with a worker – preferably prior to, during and after
- Transition planning from the start of the order
- Appropriate residential, foster care and independent living options being available
- The start of therapeutic relationships to continue in the community
- Transitional support to parents and carers

“... this is far more difficult if young people are placed a long distance away.”

The circumstances in which this is achievable must be very rare.

The impact of current legislation is that a child may either be placed where there is no ability to physically control or in a registered secure placement.

There is more flexibility for placements of adults and Newcastle Adults Social Care has effectively used the court to gain authority for making variable arrangements, short of total deprivation of liberty. These still require judicial overview to satisfy Article 5 European Convention on Human Rights and Fundamental Freedoms.

“I am in a bungalow for people with disabilities. I am there under a court order. I am to learning to manage. I am not ready to leave yet.”

It would be helpful to consider introducing similar flexibility for the placement of children.

Article 5 and the courts’ interpretation require the ability to appeal against and continuing judicial review of deprivation of liberty. The current arrangements are

¹⁷³ Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E, and F. Oxfordshire Safeguarding Children Board 2015

¹⁷⁴ Scott, S Aycliffe CSE Innovation Project: Evaluation Report, Department for Education. 2016

unwieldy and costly and would benefit from consideration of whether arrangements more suitable for the task might be introduced and be compliant with Article 5 requirements.

Recommendation 2.13

I recommend that:

The Government should review the arrangements for obtaining authority to control or restrict the liberty of children and vulnerable adults at risk of sexual exploitation with a view to improving flexibility of provision and reducing costs and complexity of judicial overview.

In Newcastle, arrangements for planning and commissioning placements have been reviewed. Only 5% of children looked after by Newcastle City Council are in residential care. Decisions about accommodating children and initiating proceedings are considered by the Care and Resources Panel which is attended by Legal Services. Admissions to care are approved by the Assistant Director and consistent with legislation and guidance, decisions to place out of authority and at a distance are taken personally by the Director of People.

Local authorities in the region work together to assure quality of placements and, when it is necessary to go outside the local framework, checks are made of relevant Ofsted reports, consultations take place with area local authorities and the social worker visits prospective placements prior to and during placement. Police may be asked to undertake checks to help identify potential risks.

As part of an overall strategy, Newcastle City Council is to build a new children's home for young people who may be harder to place.

All the agencies providing residential care that took part in the Review have introduced changes that reflect careful consideration of the issues. These include:

- More effective planning of sharing information with residents
- Identifying a sexual exploitation champion staff member to lead with the Home Manager on sexual exploitation
- Improved arrangements for notifying social workers of safeguarding concerns
- Improved partnership working with police
- More care considering referrals of previously placed young people and victims who become perpetrators
- More focus on multi agency work
- Clarity about work to be completed before the end of placement
- Prioritising an Impact Risk Assessment and information gathering prior to admission
- Child Sexual Exploitation Risk Assessment
- Locality Risk Assessment, identifying crime rates and local area hotspots
- Developing a Missing from Home Safety Plan
- Risk Management Panels
- Online safety training; devices to jam Wi-Fi signals

9.22 General Practice

A feature of serious case reviews is often that General Practitioners have been insufficiently engaging with or contributing to safeguarding. In this Review, however, General Practitioners supported victims and, in the context of what they knew, responded to their needs and acted appropriately in relation to interagency processes.

The cases revealed that an assumption by other agencies that General Practitioners are the repository for most health records and details of health engagements was wrong. They may not be informed of involvement by other health agencies, including sexual health services, and safeguarding enquiry processes need to have regard to this. This has been addressed in Newcastle within procedures and practice guidance.

Practitioners argued that if confidential relationships extended across the health service rather than with a professional or a unit, a General Practitioner may treat a patient with an understanding of the bigger picture.

General Practitioners were not consistently informed about the status of a patient, in particular if they were looked after by the local authority or subject to child protection or adult protection concerns, strategy meetings or conferences. Action has been taken to address this and compliance is included in audit arrangements.

NHS Newcastle Gateshead Clinical Commissioning Group has drawn on experience elsewhere and developed a tool to assist General Practitioners to better identify sexual exploitation and flag records.

9.23 Boys and Men

There were no boys or young men among the cases considered in the scope of this Review and only one victim suggested their involvement.

“There were a lot of girls and boys. Some were beaten up. It was sort of normal.”

Although the consensus of opinions is that males are likely to be sexually exploited, they have not been significantly represented in investigations and responses. In the cases that have arisen, different and complex models of exploitation have been involved. It is suggested they have been largely overlooked.¹⁷⁵ In 2015, Research on Child Sexual Exploitation in the North East and Cumbria identified a total of 310 female and 41 male victims.¹⁷⁶ In 2017 the Government asserted¹⁷⁷ that boys are also at risk and during the Review the SCARPA Squad suggested that boys need to be educated in healthy relationships, as they get exploited also.

¹⁷⁵ Summary of findings Research on the sexual exploitation of boys and young men: A UK scoping study. Nicholls et al. Barnardo's. August 2014

¹⁷⁶ Child Sexual Exploitation in the North East and Cumbria. Hartworth Northern Rock Foundation November 2015

¹⁷⁷ Advice: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation". Department for Education. February 2017

The Newcastle Safeguarding Boards Joint Sexual Exploitation Strategy relates to female and male victims. Tools and the training highlight the importance of proactively engaging with male victims and the barriers to male victims making disclosures and how they may present differently. The local understanding of the prevalence of sexual exploitation of boys and young men is a priority area in the Strategy.

The BLAST Project is the UK's leading male only sexual exploitation service. In June 2017 staff from the Hub, Northumbria Police and the Newcastle Safeguarding Boards attended the BLAST training programme on promoting awareness of sexual exploitation of young men and boys.

10. Professional Awareness, Training and Staff Development

Up to date training programmes and a knowledgeable and skilled workforce are preconditions to competent responses to sexual exploitation.¹⁷⁸ Managers and practitioners need to have confidence in a level of understanding across agencies.

10.1 Interagency Training

Training delivered in response to Government Guidance from 2000 was developed in the context of the understanding of the prevalence and nature of sexual exploitation.

The staff who attended the Learning Events felt that, during the early period reviewed, training was “patchy” and the general level of awareness was low. There was a lack of experience and expertise to draw upon. Some professionals, particularly General Practitioners, had difficulty committing time. They confirmed that there is now a significantly greater awareness of sexual exploitation encouraged by inter- and intra-agency training over recent years, informed by national and local reviews.

The Newcastle Safeguarding Children’s Board has provided face to face training on child sexual exploitation carried out by the Children’s Society since 2009 and online training commissioned through the Virtual College with an increase year on year.

In 2014 the Audit Group established a set of minimum standards of knowledge for practitioners within a Sexual Exploitation Capability Framework. Newcastle Safeguarding Children’s Board with the NSPCC provided a seminar to key professionals across agencies on partnership working to protect from child sexual abuse and exploitation.

The Safeguarding Boards identified common features of sexual exploitation of children and vulnerable adults and collaborated on strategy, procedural and practice development, but found a lack of national resources and training relating to adults. As a consequence, the Boards developed training materials from scratch, based on local experience and knowledge and a joint training work plan with pathways for all agencies.

The Boards have also worked with the Virtual College to develop an e-Learning package which covers both adults and children, the first of its kind available nationally. In 2016, the Boards introduced a joint training programme.

Briefings and training events have addressed General Practitioners, Practice Nurses, Paediatricians, Adults Safeguarding Team and Independent Schools and

¹⁷⁸ Advice, Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. Department for Education. February 2017

Newcastle City Council Senior Education Advisor Safeguarding and SCARPA Project Manager have trained Designated Teachers. In February 2016, Newcastle Safeguarding Children's Board commissioned the drama production of Chelsea's Choice for schools, linked to the Personal Social, Health and Economic healthy relationship curriculum. Ten schools were involved in this, reaching 1093 pupils.

Consideration of the cases and discussions at Learning Events identified a number of areas for training which included:

- A need to improve awareness and "legal literacy" amongst professionals of the provisions Mental Capacity Act and the impact of case law.

This has been addressed through training which Newcastle City Council Legal Services has delivered, improving the level of knowledge within its own service.

- Working with different cultures and faiths.

The Practitioners' Events indicated a need for further training on distinguishing between differences in child rearing and practice skills to address the shame families might feel at having professionals involved. Newcastle City Council Children's Social Care have included these issues in training provision reflecting the importance of including culture and faith issues as an integral part of all safeguarding.

- Managing cases of neglect

The cases confirmed research¹⁷⁹ that neglected children are vulnerable to sexual exploitation. A background of child neglect also gives rise to risk for adults with vulnerabilities. Neglect training measured through evaluation, feedback and surveys, was launched as a priority by Newcastle Safeguarding Children Board in January 2016. The Ofsted Inspection in 2017 found the identification of neglect as a Board priority has ensured a consistent focus and practice development.

- Wider education across agencies on the importance of considering the impact and need for care across the whole life course.

The Safeguarding Boards joint training programme on sexual exploitation addresses need for understanding the impact of sexual exploitation throughout life.

- Training should be through a variety of methods accommodating for different professional groups.

The Review found that there is a range of well-planned training across agencies which includes face to face and on line, taking account of different learning preferences. The Boards' multi-agency joint training programme is delivered in line with priorities and informed by a range of audits of practice, evaluations and

¹⁷⁹ Exploring the Relationship between Neglect and Child Sexual Exploitation: Evidence Scope. Research in Practice: Dartington. Hanson, E. (2016); Howarth, J. and Tarr, S. 2015 Child Visibility in Cases of Chronic Neglect: Implications for Social Work Practice, BJSW 45 (5), 1379-1394

research and a Training Evaluation Strategy. Attendance and frontline practitioner's views and suggestions are reported to the Board.

Community and voluntary organisations attend Newcastle Safeguarding Boards' training and deliver training to other agencies and to the community and to schools. Barnardo's and the Children's Society have brought learning from their agencies' national perspectives. The Angelou Centre provides a link with ethnic minority communities.

The Newcastle Council for Voluntary Service disseminates up to date information to the voluntary and community organisations and contributes to training by the Boards and SCARPA. An annual safeguarding check-up about safeguarding for voluntary and community sector organisations is undertaken.

Because of Operation Sanctuary, Newcastle has become a centre of excellence and a source of expertise. Success breeds success and attracts and retains staff and has an immeasurable beneficial impact on morale and availability of expertise for training.

The Ofsted inspection in 2017 confirmed this positive view of the training arrangements.

Recommendation 1.16

I recommend that:

When reviewing the training strategy Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should have regard to the issues raised at the Learning Events.

10.2 Agency Training

The Safeguarding Boards audit agency training to establish what is provided and by whom and have set minimum standards to ensure consistent learning outcomes. All agencies and Practitioners have reported increased training, including refresher and induction training, for staff on recognising, working with and the impact of sexual exploitation. The expertise and specialism within the Sexual Exploitation Hub has supported practitioners across the workforce.

Reviewing the cases, the Newcastle upon Tyne Hospitals NHS Foundation Trust found it was not consistently evidenced that sexual exploitation was considered when individuals attended services, including emergency departments, Walk in Centres, sexual health services and early pregnancy clinics. Action has been taken to raise awareness and the Review reports reflected a confidence that learning has been embedded through training, safeguarding forums and a sexual exploitation awareness day. A package reflects learning from the Review and includes children and young adults.

Northumberland Tyne and Wear NHS Foundation Trust identified weaknesses in understanding and recognition during case management and in multi-agency

approaches to referrals, assessments, care planning, treatment and support for victims. Every team member now covers all aspects of safeguarding and has received additional training to encourage comprehensive and holistic approaches. Sexual exploitation training has been updated and includes referral processes. All clinical staff undertake Mental Capacity Act, Mental Health Act and deprivation of liberty safeguards training every three years.

Extensive training in Northumbria Police meets College of Policing expectations.¹⁸⁰ It has been identified through Northumbria Police's Sexual Exploitation Strategy and Action Plan, the Multi-Agency Sexual Exploitation and Trafficking Groups and business managers. A CSE APP provides guidance on relevant legislation and orders.

Operation Sanctuary increased understanding of possible responses. A training package was delivered to all operational staff within four months of the launch and refresher training to all officers throughout 2015. In October 2015, a joint conference was attended by 500 professionals from all safeguarding partners in the region. Dealing with victims with complex needs has been addressed and a psychotherapist has improved understanding by all officers, including the Chief Officer Team.

Northumbria Police has delivered joint training for leads in primary and secondary schools, for all General Practitioners, health visitors, midwives, Newcastle City Council Elected Members and Adult and Children's social care. They have worked with the licensing staff in local authorities to train taxi drivers and all taxi drivers now have to attend safeguarding training as a condition of license application and renewal.

In order to improve awareness, Your Homes Newcastle has arranged additional training and a lecture from a national expert for support staff, extending an invitation to attend to Board partners and some voluntary organisations. All support staff have had training in Mental Health needs and discussions with Newcastle Safeguarding Children Board have been held to include front line Young Persons Service staff in learning disability training as this has been identified as a multi-agency need.

Training for all staff and induction in the Housing Advice Centre Team includes awareness.

In Newcastle Children's Social Care and Adult Social Care sexual exploitation training, underpinned by learning from local and national reviews, is included in all safeguarding children and adults training including induction. Training has been carried out by Barnardo's for all Children's Social Care staff and mandatory training is provided for all residential staff and foster parents. Staff have access to a Cultural Competence departmental training course provided by the Coram BAAF Academy.

¹⁸⁰ College of Policing CSE Action Plan 2014 to 2016

Joint training developed for children's and adult social care staff covers a range of topics including the Mental Capacity Act, Transitional Arrangements, The Care Act 2014 and responding to sexual exploitation.

Newcastle City Council Legal Services has ensured that all legal staff are aware of the range of legal options available to address sexual exploitation and the Mental Capacity Act implications for children and adults. Legal staff have contributed to training including court skills for Adult and Children's Social Care staff.

The Home Affairs Committee¹⁸¹ highlighted the need for awareness of sexual exploitation across Council departments. Newcastle City Council has a Corporate Safeguarding Group chaired by the Director of Operations that brings together senior staff from across departments to address wider training and education within services other than social care and education.

Community and voluntary organisations have comprehensive training programmes including awareness and addressing sexual exploitation, taking account of learning from the Newcastle experience.

The Safeguarding Boards' routine audits ask agencies about training on sexual exploitation within the organisation and providers of services they commission.

10.3 Personal Professional Responsibility

The government has emphasised that practitioners need to be aware of their personal responsibility to ensure they have the knowledge and skills to competently practice.

During consideration of the cases and at the Learning Events, there was extensive evidence that staff worked hard to safeguard and support victims. The Agency Reports included reference to research and national guidance when commenting on practice, but there was little evidence of consideration of these in the working of the cases.

National published materials address strategic arrangements but often also include detailed practice guidance. Working Together to Safeguard Children 2015, includes in the answer to "Who is this guidance for?"

"All relevant professionals should read and follow this guidance so that they can respond to individual children's needs appropriately."

A version of the guidance for young people and a separate version suitable for younger children are also available for practitioners to share. Unless aware of the content they clearly cannot decide which children or young people should have a copy.

Paragraph 49 of Working Together 2015 provides that:

¹⁸¹ House of Commons Home Affairs Committee Report: Child sexual exploitation and the response to localised grooming House of Commons London: The Stationery Office Limited. June 2013

“Social workers and managers should always reflect the latest research on the impact of neglect and abuse and relevant findings from serious case reviews when analysing the level of need and risk faced by the child. This should be reflected in the case recording.”

The Government Advice in February 2017, emphasised that practitioners across agencies are responsible for ensuring they fulfil their role and responsibilities in a manner consistent with the statutory duties of their employer. Detailed practice expectations were set out in Annexes. Departmental Advice published in 2014 on Working with foreign authorities, was “primarily for local authority staff working with children and families, frontline social workers, their team managers, service managers, and children’s services lawyers.”¹⁸²

This issue is as important for safeguarding adults as for safeguarding children.

Newcastle partner agencies and the Safeguarding Boards have good arrangements in place to consider new guidance and paraphrase or reflect the content in local guidance and procedures. Links are provided to substantive documents and briefings or additions to training programmes promptly arranged. There will be a delay before local interpretation and dissemination can take place and practitioners need to be able to put the local materials within a national context and be aware of what they can expect of other agencies and professionals.

Newcastle Children’s Social Care staff have access to Community Care and Research in Practice which provides up to date guidance on and legislation as well as evidence and learning of best practice across the country. Adult Social Care staff are provided with updates on guidance and legislation through “Community Care Inform”.

Audit arrangements and reports to the Safeguarding Boards address whether agencies have in place arrangements to make clear to staff that they have a personal responsibility to be familiar with legislation and guidance that relates to their area of function.

10.4 Staff Welfare

Sexual exploitation and the work involved is distressing. The inability often to have a positive impact and addressing the long-term damage is likely to be stressful. Staff may be exposed to violence. The emotional impact may include negative feelings such as anxiety, worry and upset even by those reporting higher levels of knowledge, skills and experience.¹⁸³

Newcastle City Council Adult Social Care and Children’s Social Care have arranged for external expert support on an ongoing basis for staff in the Hub from a psychotherapist who has provides group and individual sessions for staff, case discussion sessions and oversight of policies and procedures

¹⁸² Working with foreign authorities: child protection cases and care orders Departmental advice for local authorities, social workers, service managers and children’s services lawyers Department for Education July 2014

¹⁸³ Workforce perspectives on harmful sexual behaviour: findings from the Local Authorities Research Consortium 7. National Children's Bureau. 2017

New Key Support Ltd have a staff friendly rota system and a staff retention and welfare policy to provide early recognition and intervention of personal and team staff issues.

Northumbria Police Force arrangements reflect the College of Policing Action Plan which expects effective welfare procedures for staff investigating child sexual exploitation.

The Children and Family Court Advisory and Support Service has a confidential counselling helpline service for staff welfare.

Audit arrangements and reports to the Safeguarding Boards address whether agencies have in place arrangements to consider the welfare of staff in the context of carrying out safeguarding responsibilities.

11. Challenge, Support and Escalation

11.1 Challenge

There was no evidence that any agency challenged the police over their approach to investigations or lack of action against perpetrators prior to 2014 or raised concerns about the adequacy of safeguarding assessments and plans that did not address the perpetrators. There were examples of agencies having anxieties about responses by other agencies but this was not addressed in interagency meetings or escalated to senior managers or through any other processes.

The effectiveness of safeguarding arrangements is a collective interagency responsibility and a culture in which challenge is expected, encouraged and welcomed is necessary.¹⁸⁴ The tendency of groups to avoid dissension needs to be countered by professionals challenging themselves and encouraging challenge as the most effective corrective to biases, misjudgements or clinging to erroneous beliefs.¹⁸⁵

The members of Safeguarding Boards have an individual and shared responsibility for the effective discharge of the Boards' functions, to contribute to the work of the Boards, to make the assessment of performance as objective as possible and to recommending or decide upon action necessary to put right any problems:

“This should take precedence, if necessary, over their role as a representative of their organisation.”¹⁸⁶

The Learning Events highlighted lack of familiarity with Newcastle Safeguarding Children Board's inter-agency Resolving Professional Differences Protocol and it has been relaunched and widely circulated. Audits show that pathways for resolving issues without formal processes are well established. The use of and circumstances leading to the use of the Protocol are monitored and reported to the Board.

Practitioners identified the establishment of the Hub and co-location of staff as encouraging collective responsibility, challenge and contribution to judgments made by other professionals, extending beyond the Hub. There is a new openness to critical reflection and challenge which they found supportive.

Schools reported that collaborative work was taking place with staff in Children's Social Care and they have no hesitation in taking up concerns about responses

¹⁸⁴ Ages of concern: learning lessons from serious case reviews: A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011. Ofsted .2011

¹⁸⁵ Munro: Improving reasoning in supervision. Social Work Now. August 2008. Groupthink: psychological studies of policy decisions and fiascos, Boston, MA: Houghton Mifflin Janis 1982, Reder and Duncan Lost innocents: a follow-up study of fatal child abuse, London: Routledge 1999. Working with child abuse, Corby 1987; Birchall and Hallett; Farmer and Owen. Milton Keynes: Open University Press. 1995

¹⁸⁶ Paras. 3.58; 3.65 Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. HM Government. 2006; Paras. 3.70; 3.85 Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. Department for Schools, Children and Families. 2010

with senior managers and would if necessary escalate the issues through the Protocol.

Checks and balances to provide for challenge include the role of Independent Reviewing Officers and, during family court proceedings, the Children's Guardians appointed by the Children and Family Court Advisory and Support Service. In the cases, there were examples of Independent Reviewing Officers acting positively to challenge drift, but others where it was insufficient. Neither service challenged the inadequacy of plans that did not disrupt perpetrators' activities.

In 2017 Ofsted¹⁸⁷ commented that Independent Reviewing Officers' scrutiny of children's plans and evidence of their challenge and impact is not well recorded and could be stronger. Action has been taken by Newcastle City Council to strengthen the remit and authority of Independent Reviewing Officers and the effectiveness of this role will be subject to continuing review and audit.

Audit arrangements and reports to the Safeguarding Boards address whether there is evidence in practice that healthy challenge is a feature of safeguarding work in Newcastle.

11.2 Supervision

A recent survey of over 500 professionals working across agencies in six local authority areas found high quality reflective supervision is key to practitioners' ability to work safely, but access to this is patchy. All those working in this area should have access to one-to-one support enabling reflection on and processing the emotional impact of work. Agencies should share practice on effective supervision, to minimise variability.¹⁸⁸

Materials available to support supervision in adult safeguarding are limited. The issues that arose are relevant for safeguarding children and vulnerable adults.

In reviewing the cases, Newcastle Social Care found there was limited evidence of supervision or reflection on case records. Since, the Social Work supervision policy has been updated and rewritten, providing for greater reflection and challenge. Managers have been trained in the use of reflective supervision. In addition, the process for ensuring supervision is recorded on the child's record has been reviewed and compliance is subject to overview through regular reporting and audit.

The Ofsted inspection confirmed that regular supervision takes place at all levels but recommended that the quality should be improved and case records better demonstrate how staff are supported and able to reflect on practice. An Action Plan to address this includes addressing the skill mix within teams and the importance of supervision and support to unqualified staff.

¹⁸⁷ Newcastle Upon Tyne Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board Inspection date: 24 April 2017 – 11 May 2017 Report published: 7 July 2017

¹⁸⁸ Workforce perspectives on harmful sexual behaviour: findings from the Local Authorities Research Consortium 7. National Children's Bureau. 2017

There were no significant references to supervision in other agencies' reports or comment on why it did not identify weaknesses in plans and lack of action against perpetrators.

Newcastle Safeguarding Children Board's audits require agencies to confirm whether staff receive regular supervision and appraisals but not the detail and the practice effectiveness - what part experience has in the allocation of cases, how is challenge ensured and the continuity of involvement of professionals.¹⁸⁹

"The support I have had has been exceptional. Except mental health support has not been as good. It took a long time to get a CPN. I've had 4 and the latest is about to change."

"I had mental health problems. As the trial came up I had CPNs – there were constant changes when the trials were on – a different one every month - no-one for 3 months. I had to rely on the police. They were a good support."

"I never had anyone I could trust and talk to.... workers kept changing."

"... workers not going on long term sick when they have complex cases. They need more support as it's obviously having an impact on them."

Recommendation 1.17

I recommend that:

Partner agencies should report to Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board on the arrangements for supervision of staff and how they measure the effectiveness and impact on outcomes.

¹⁸⁹ The Munro Review of Child Protection: Final Report A child-centred system. Professor Eileen Munro Department for Education. May 2011

12. The Criminal Court Experience and Criminal Justice Processes

In 2013, The Home Affairs Committee¹⁹⁰ highlighted widespread acknowledgement that the criminal justice system has failed to adequately protect and support victims. It criticised reluctance to prosecute and the damaging experience in court which has a detrimental impact on the administration of justice. The court process can compound the damage to victims who suffer with feelings of trauma, betrayal and stigmatisation and blame themselves. The Committee referred¹⁹¹ to a victim who spent 15 days in the witness box, 12 of them under cross-examination by a succession of defence lawyers.

In 1989, the Report of the Advisory Group on Video Evidence¹⁹² recommended that witnesses eligible for special measures should be allowed to give evidence by video recording. Ten years later, section 28 Criminal Evidence Act 1999 allowed video recorded cross-examination or re-examination but this was not implemented. The Home Affairs Committee and the Lord Chief Justice criticised the Ministry of Justice for failing, after fourteen years, to implement this measure.

A pilot scheme at three court centres was then introduced and in summer 2016 the Justice Minister reported that s28 would be rolled out nationally but this depends on whether Courts have facilities available.

This was not available for the victims giving evidence in the Sanctuary Trials in Newcastle in 2017.

The Crown Prosecution Service Review Report highlighted problems at Newcastle Crown Court with the ability of witnesses to give evidence through a link and not be seen in court. The Service has been proactive in raising this with the Court but the practicalities of arranging this include taping cardboard around the TV monitor.

The Home Affairs Committee recommended that each court should have a named individual with the responsibility for ensuring that special measures are being implemented appropriately.

Recommendation 1.18

I recommend that:

Newcastle Safeguarding Boards, involving the Northumbria Police, the Police and Crime Commissioner and the Crown Prosecution Service, should arrange for discussions to take place with Newcastle Crown Court to consider how practical arrangements at court can be improved to ensure protection of the interests of victims giving evidence.

¹⁹⁰ Para. 85 House of Commons Home Affairs Committee Report: Child sexual exploitation and the response to localised grooming House of Commons London: The Stationery Office Limited. June 2013

¹⁹¹ Evidence of Andrew Norfolk, Times. House of Commons Home Affairs Committee Report: Child sexual exploitation and the response to localised grooming House of Commons London: The Stationery Office 2013

¹⁹² Report of the Advisory Group on Video Evidence. Judge Thomas Pigot. Home Office. 1989

The Home Affairs Committee identified “Myths” that are commonly canvassed in sexual assault trials to undermine victims’ accounts. These are listed on the Crown Prosecution Service Website.¹⁹³ Returning to abusers is routinely represented as evidence victims consented to and enjoyed the experiences.

The Crown Prosecution Service and Trial Judges are expected to correct the myths but defence lawyers continue to exploit them. Cross-examination about sexual history should not take place without permission of the judge who should determine relevance and prevent harassment or bullying of a witness.

A Government Report¹⁹⁴ in 2014 included eight recommendations on how distress to victims in trials of sexual violence might be reduced.

In early 2017, Northumbria Police and Crime Commissioner published a Report¹⁹⁵ highlighting that in 30 rape cases heard in Newcastle Crown Court over 12 months the expected protections were not consistently enforced.

None of the Sanctuary Trials were included in the work carried out for this survey. A dedicated trial judge was appointed to preside over all the trials and she took care to ensure that proper process was followed and there was no cross examination that went beyond what should be permitted.

The Crown Prosecution Service arranged for teams to identify how complainants were coping with the prosecution and other issues in their lives and assist in fast tracking referrals to support agencies. Each complainant was allocated a contact officer. Liaison with social care and mental healthcare professionals assisted in assessing ability to give evidence. All witnesses had comprehensive support through the Hub.

The Crown Prosecution Service Report highlighted that the Crown Court has responded positively to requests for early dialogue about forthcoming cases including expediting timetabling of cases to avoid delay and joinder of cases.

Nevertheless, despite this care and the support victims received, all victims who gave evidence and contributed to the Review complained about the delays that increased the likelihood of witness intimidation, about how they were treated in cross-examination, the pressure, aggressive questions about their backgrounds and motives and about personal details in records of which they were previously unaware.

Court Professionals are familiar with the rules – strangers’ inexperience, anxiety and vulnerability can be easily exploited. It is not difficult to confuse and distress a vulnerable witness. For some it led to lasting serious mental health problems.

¹⁹³ Rape and Sexual Offences - Chapter 21: Societal Myths. www.cps.gov.uk

¹⁹⁴ Report on review of ways to reduce distress of victims in trials of sexual violence. Ministry of Justice March 2014

¹⁹⁵ Seeing is Believing: The Northumbria Court Observers Panel Report on 30 Rape trials 2015-16: Baird, DBE, QC, Northumbria Police and Crime Commissioner. March 2017

"I waited a long time for a trial date. There were video interviews, statements, identity parades. I gave full evidence at the trial and was cross examined.

Court was awful, the worst experience ever – spoken down to – felt I was on trial – the defence. The judge intervened a lot to stop it but it still went on.

I was commended for my strength by the police and prosecution. Shortly afterwards, thinking it was over, I was told there was a legal problem with a part of the case, not to do with me or my and evidence. The trial was stopped.

A year later I was asked to give evidence again. I couldn't face reliving it. To stand up in front of all those people -and then told I had to do it again – I had already made statements. If I only had to tell it once that would be brilliant.

The Police understood and asked the CPS to consider using evidence from the original trial because of the impact on my mental health. The CPS requested a mental health assessment, which resulted in a brief meeting. I was asked first off to take Diazepam to go through with the trial.

The allegations referred to drugs being used for the purposes of rape and I was now being asked to take a drug to help relive it and put up with another full trial. I couldn't do it and refused.

Two days later I was sectioned under the mental health act for risks to my own life, whilst the men despite all the evidence were set free.

Why couldn't that jury have seen my evidence like they saw my original video evidence? They record everything anyway. If this had been allowed I might've got justice for what happened to me. They walked free.

The impact of the crimes and failed court process to the victim and close family is intolerable."

Material concerning victims in agency records is considered for disclosure to the defence and may be referred to in cross-examination. The Crown Prosecution Service Report stressed the care and planning by the prosecution team to ensure the process maintained the confidence of the Trial Judge and of the defence lawyers. Material was also used positively to highlight patterns of vulnerability. The Report reinforces the importance of considering the material and its likely impact before a decision is taken to charge.

The disclosure process is costly. Records are not kept expecting they might be disclosed. Victims are unlikely to be aware of much of the content and are not informed in advance of appearing as a witness for fear of allegations that they have been coached and prepared.

The consequence of this is that damaged and vulnerable individuals are knowingly exposed to distressing material without notice and to an experience calculated to confuse, intimidate and cause them further damage and distress. There is a strong argument that this is inhuman and degrading treatment prohibited by the European Convention on Human Rights and Fundamental Freedoms and does not lead to fair administration of justice.¹⁹⁶

“I received compensation. I was cross examined about it.

In the last trial, I was asked about the compensation – I was startled. I applied after the first trial – I didn’t know anything about it until I was told then. They accused me of knowing and doing it all for the money and lying – including in the case already decided.”

“The second time in court the defence lawyer hated me. It was suggested that the previous case was all lies. That I had planned everything – the self-harming was done because I enjoyed self-harming. He said I made it up to get compensation.”

“When cross-examined I was called a liar – that it was all untrue. It was hard to put up a fight. I knew the police believed me.”

“You should not be questioned about stuff outside the time zone for the case. For me, some of it was years ago. For some it’s new and fresh. You can put it at the back of your mind. I was questioned about a note for school asking for absence when I forged my mother’s signature years before.

Afterwards I cried. I was in a catatonic state for a day.

I felt that I was on trial. He hated me. Said I preyed on older men (I was 15/16). Said I had done something like this before – i.e. made complaints that were lies.

There were not guilty verdicts.

It put me off ever giving evidence again. I would not do it.”

“It was 3 years and nine months after I went to the police that final sentencing took place.

I was prepared for court. But the police did not tell me what they would ask. I was not prepared for that. I was frightened of the perpetrators.

Court was horrific. I knew the men there. I was talking about them. I thought I could hear them – sighing and grunting as if I was lying.

¹⁹⁶ Article 3; Article 6; European Convention on Human Rights and Fundamental Freedoms

It would have been better if I could have talked when they were not in the room. I was told I could not do video. I would have preferred if there was someone else. If someone was sitting with me it might have helped.”

“I should not have gone – I was so distressed in my head. They questioned me one after the other for 2/3 days.

I was talking about horrible stuff. It was intimidating. I was asked about a very intimate thing which was extremely distressing. It has caused me a lot of stress. I don’t know why they had to ask such a personal question.

They brought up personal issues – made me feel unclean.

There were screens. I could see the jury. The perpetrators and their family members were there.

I had to see the doctor – who said I was not well enough. Then the trial was stopped - I don’t know why. I was told it was politics and to do with the jury.

I went back to heavy drinking. Lost control. The perpetrators were continually in my head. I was sectioned and detained.”

“I had good support for the criminal court. Good preparation. But it made me angry. I was made out to be a liar and it made me feel low.

That came as a surprise – it was dreadful. I wasn’t expecting it. Afterwards I was very upset and couldn’t control myself. I started having dreams and flash backs.

I was asked about things in my records that I knew nothing about – my past and I didn’t know why.”

Bad experiences are shared and deter other victims coming forward. Only one victim despite her experiences stated that:

“I do not regret going to court. I would say to someone else don’t feel ashamed – do it”.

At the end of the trials, Newcastle City Council Leader Councillor Nick Forbes praised the victims who had to relive their ordeals in giving evidence and face their perpetrators. Some suffered the trauma of doing it more than once:

“I can’t begin to imagine how difficult that must be, but I would like to pay tribute to each and every one of them. They have been brave beyond belief and undoubtedly have made our city safer.”

The Crown Prosecution Service Review Report highlighted the difficulties in identifying appropriate criminal offences that address obviously abusive activities. A proactive and imaginative approach was taken to address evidential difficulties

including those arising from issues of consent with victims over 16 years old. A range of charges included criminal conspiracies.

Victims were surprised by and complained about charges that included incitement to prostitution, fearing this labelled them as prostitutes. Similar inappropriate terminology has been removed from national safeguarding guidance. Staff supporting victims during and after the trials suggested that there should be an updating review of the law relating to sexual exploitation which is informed about the importance of language, the nature and impact of grooming and addresses the growing knowledge of activities of perpetrators.

The Sanctuary Trials were a considerable success. Prosecutions have been taking place across the country but defendants represent a fraction of total numbers of perpetrators. Those convicted know who else is involved. A separate offence of having been convicted when it is clear others were involved and failing to identify them might encourage co-operation.

It might be known a person was present when abuse took place but there is no direct evidence of involvement in offences because of reluctance or fear or confusion in the victims. In some jurisdictions it is an offence to fail to disclose an arrestable offence to the police¹⁹⁷. In England, recent legislation requires some professionals to report abuse.

An offence of being present during abuse and not preventing or reporting it, would address this issue. Careful drafting could ensure victims present at abuse of others are appropriately protected.

Recommendation 2.14

I recommend that:

The Government should arrange for a review of the criminal law to ensure that it provides a range of criminal offences that reflect the body of knowledge about sexual exploitation, more effectively address the behaviour and involvement of perpetrators and does not through terminology cause distress to victims.

Recommendation 2.15

I recommend that:

In the light of the body of knowledge about sexual exploitation and continuing concerns about the treatment of victims when giving evidence in criminal proceedings and the impact on the fair administration of justice, the Government should arrange for a review of the rules relating to the treatment of victims when giving evidence and the disclosure of records and their use in proceedings, including whether data subjects should be made aware of material disclosed.

¹⁹⁷ Criminal Law Act (Northern Ireland) 1967. An examination of local, national and international arrangements for the mandatory reporting of child abuse: the implications for Northern Ireland: Wallace and Bunting. NSPCC. August 2007

13. Supporting Victims and Survivors of Sexual Exploitation

A guiding philosophy underpinning the establishment of the Hub was that suspected victims should have available continuous, reliable, comprehensive support, whether or not they were able or willing to give evidence in criminal proceedings or able to accept support. Practitioners emphasised that experience shows that additional or targeted resources are likely to be required for care and support over a long period.

13.1 Advocates

Victims may find it difficult to engage and articulate or argue on their own behalf.

In the cases, there were examples of timely arrangements for appointments of independent advocates funded by Newcastle City Council Children's and Adults Social Care to help suspected victims to contribute to processes and ensure their opinions were considered. The service is provided for children and adults aged up to 25 by the National Youth Advocacy Service and specifically for adults by Your Voice Counts. In the early period reviewed Advocacy Centre North provided a service for adults.

Involvement included advocating wishes and feeling of victims and considering positive male role models during placements in secure accommodation, at reviews of children looked after by the local authority, and at safeguarding adult's meetings. Support was available during criminal justice and Court of Protection processes. The service brought experience of good practice in cases involving learning disability and impaired mental capacity.

Even when processes require independent involvement to assist victims and family members, they may still feel that their views have had little impact and expect more.

"I had a solicitor when I was put in secure but they didn't talk to me about anything except this is what they are saying and did I agree or not."

It may be what a victim wants to say is not relevant to the decision being taken and this is difficult to accept. An Independent person is appointed to assist children at all reviews of secure placements but this victim could not recall this. Nor could she clearly recall the role played by the Children's Guardian and Independent Reviewing Officer - *"no-one listened to me."*

Advocacy services and formal representation and complaints processes have been addressed in procedures and written material for children looked after by the Council. The Ofsted inspection report in 2017 suggested this was an area for more attention. There were circumstances in which appointing an advocate was not routinely considered during reviews of children's cases.

Action has been taken to improve support by social workers and Independent Reviewing Officers to access the advocacy service and ensure children are aware

of its availability and formal representation and complaints processes. This is being monitored through practice audits.

The appointment of an advocate is considered during adult safeguarding processes and if appointed they attend all adult safeguarding meetings. Practice audits include reviewing compliance with this expectation.

13.2 Support of Victims during Trials and Beyond

A report¹⁹⁸ on Rochdale recommended that Criminal justice organisations should work together to ensure support is provided from reporting the crime, making a statement, preparing for trial and after the trial.

In Newcastle, the victim focus of the Hub has included intense support by the whole multi-agency framework to ensure that practical, housing, emotional and health needs are addressed. In one case, when a victim was admitted in a catatonic state, a social worker stayed in the hospital with her.

All the victims, while criticising the court process, have consistently commented that the support from the Hub and colleagues in the agencies was excellent and was always there. They continue to be supported since on the same basis with an expectation that for some it may be lifelong support.

“The support from the Hub is brilliant.”

“I know support will always be there for me.”

The Ofsted inspection in 2017 found that:

“Wrap-around services provided by a high number of agencies to assist children to recover and move forward with their lives are outstanding. At the core of this practice is targeted work to promote children’s self-esteem and self-confidence in order to reduce future risk and support recovery.”

Throughout the trials a confidential helpline was put in place which allowed other victims to make contact, to report abuse or seek advice as a result of publicity about convictions and sentencing.

13.3 Compensation and Personal Injury Claims

The Review considered the support provided for victims to pursue applications for compensation under the Criminal Injuries Compensation Scheme¹⁹⁹ under which a person may be eligible for an award if they sustain a criminal injury directly attributable to being a direct victim of a crime of violence. Payment can never fully compensate for the injuries suffered, but it is recognition of public sympathy.²⁰⁰ A

¹⁹⁸ Review of Multi-Agency Responses to the Sexual Exploitation of Children: Rochdale Borough Safeguarding Children Board. 2012

¹⁹⁹ The Criminal Injuries Compensation Scheme Ministry of Justice 2012; Criminal injuries compensation: a guide to applying for compensation under the Criminal Injuries Compensation Scheme Ministry of Justice. March 2014 updated November 2016

²⁰⁰ A guide to the Criminal Injuries Compensation Scheme 2012. Criminal Injuries Compensation Authority. 2013

person may be eligible for an award whether or not the incident has resulted in a conviction.

Encouragement and help provided by an adult care social worker resulted in a significant payment in one case. Others clearly entitled to apply had not made applications and were unaware of the scheme. In some circumstances the issue was not identified even though the victim was a child looked after by the local authority and had been subject to family court proceedings when Children's Guardians and advocates were acting.

This is a difficult area because of the common practice of defence counsel in criminal trials cross examining victims alleging they are motivated by the possibility of compensation. Understandably, this has led to the issue not being addressed until after a trial is completed which can involve considerable delay. This can give rise to problems because of time limits on applications which can only be extended for exceptional reasons.

Also:

"The Criminal Injuries Compensation Scheme is a government funded scheme to compensate blameless victims of violent crime."

Awards will be withheld if the applicant has unspent convictions, whether or not related to the crimes and abuse committed against, or where the conduct of the applicant or the applicant's character makes it inappropriate to make an award.²⁰¹

One victim gave evidence in a Sanctuary Trial which resulted in the defendant receiving a sentence of 29 years. She had been convicted of an offence and sentenced to a community order for 12 months which attracted a further 12 months rehabilitation period before being spent. Her application for compensation was made before the rehabilitation period expired and she was refused compensation. A delay in applying would have put her application outside time limits.

It was irrelevant that the impact of the abuse and exploitation led her into the offending behaviour. The decision letter explained:

"I have no discretion to waive this irrespective of the personal circumstances you were in which led to your conviction."

It is not likely that decisions regarding prosecution and sentencing would have considered the likely detrimental impact on her ability to claim compensation for serious abuse.

A further difficulty recently highlighted by Barnardo's and Victim Support²⁰² drew attention to awards being refused on the basis of victims of sexual exploitation having consented to the abuse.

²⁰¹ A guide to the Criminal Injuries Compensation Scheme 2012. Criminal Injuries Compensation Authority. 2013

²⁰² The Times 18 July 2017

These provisions have particularly impact on victims of sexual exploitation. It is not likely that the draftsmen of the Scheme intended that these victims would be so disadvantaged.

These issues illustrate the importance of victims receiving good advice and support that takes account of the detail of the Scheme.

The Scheme is also:

“intended to be one of last resort. We expect you to try to claim compensation from the person, or persons, who caused your injury or loss. You may also be able to claim from someone who was indirectly responsible for your injury.”²⁰³

Victims may be able to obtain payment of damages directly from an abuser who has assets by pursuing a civil personal injury claim. This is subject to time limits²⁰⁴ and the amount of the amount of damages will depend on how well the case is prepared and argued.

Arrangements are now in place for compensation and damages to be considered as a standing item within the statutory review of every case of children looked after by Newcastle City Council and at Safeguarding Adults Meetings. Legal services staff are available to assist with the preparation of applications under the statutory scheme or arrange for victims to be advised and represented by experienced personal injury lawyers.

The Council is arranging to work with the police, the Police and Crime Commissioner, the Youth Offending Team, sentencing courts and other relevant partners to raise awareness of the impact of prosecution of victims on their ability to claim compensation. Information will be collected in order to draw the attention of government to the unfairness of these arrangements.

Payments made to children or to adults with impaired capacity will need to be managed and a process for accessing the fund established. Some victims may in any event need advice on managing an award or it may be important to delay payment if a victim is subject to inappropriate influence.

Although arrangements are in place to identify cases as they arise, there are likely to be some individuals who have been entitled to claim but have not done so. They need to be identified and assisted.

Regular reports will be made to the Safeguarding Boards informing members of the effectiveness of these arrangements.

²⁰³ A guide to the Criminal Injuries Compensation Scheme 2012. Criminal Injuries Compensation Authority. 2013

²⁰⁴ The Limitation (Childhood Abuse) (Scotland) Act 2017; in Scotland survivors of child abuse no longer face the ‘time-bar’ that requires personal injury actions for civil damages to be made within three years of the related incident

14. Concluding Remarks

This Joint Serious Case Review into Sexual Exploitation in Newcastle was commissioned in October 2015 by the Newcastle Children and Adult Safeguarding Boards.

In 2014, a picture emerged in Newcastle of hundreds of victims of sexual exploitation. There was a proactive approach to protecting victims and dealing with perpetrators and quickly over 30 men were arrested.

Despite the length of the Report, it has been difficult to do justice to the large amount of material and the energy and effort that has characterised this ambitious Review which has been carried out in a proportionate and open manner.

The large scale of the exploitation is reflected in the thematic methodology used to undertake the Review. It looked beyond individuals and focused on identifying and examining themes to fully understand the circumstances and issues arising from sexual exploitation in Newcastle and provide evidence for findings, conclusions and lessons for future practice.

It was agreed that a sufficient number of individual cases should be considered to facilitate consideration of the themes. The eight cases identified fully reflected insofar as possible the different characteristics of the wider cohort of individuals who had been identified as victims. The Review also considered what has been known and understood about sexual exploitation within agencies and by the Safeguarding Boards and the response to this knowledge, other published reviews and relevant research.

The contributions from victims have improved significantly understanding of vulnerability, the impact of sexual exploitation and the long-term nature of the support that is required.

It is significant that Newcastle is different to other areas where there has been large scale Child Sexual Exploitation. In Newcastle, the exploitation has also involved vulnerable adults. In addition, there is no evidence in Newcastle that decisions about taking action were affected by lack of concern or interest, misplaced fears about political correctness or fear of being seen as racist, ineffective leadership or inappropriate interference by senior official or political leaders to prevent action being taken that have been features of reviews carried out elsewhere.

The Review has highlighted the complex nature of Sexual Exploitation - the extreme and long-lasting impact it has on victims; the difficulties in identifying and preventing the exploitation; the intense and lengthy support that is required to gain the trust of victims to help them understand that what they have experienced is exploitation and enable them to talk about their experiences.

The primary aim must be to protect victims, prevent further exploitation and help them so far as possible to rebuild positive lives, whether or not prosecutions and

convictions are achievable. This approach that has proven to be successful in Newcastle.

The material illustrates the calculated and persistent determination of perpetrators over a long period to exploit women and girls through horrific acts of abuse, violence and manipulation, targeting and grooming the most vulnerable with a dismissive disregard for the criminal justice system.

The learning from this Review and from Operation Sanctuary has been embedded in Newcastle through enhanced service provision, particularly the development of the Multiagency Sexual Exploitation Hub. But it has also raised awareness and developed understanding of the nature and impact of sexual exploitation. This has impacted positively not only on identification and prevention, but also on how best to support victims and has led to exceptional victim led practice recognised independently and nationally.

Tackling sexual exploitation must address the perpetrators – not only preventing their activities but understanding their motivation. A common experience of reviews of this kind has been the lack of meaningful engagement of perpetrators. Often when they do participate it is in order to protest their innocence and derogate the victims. This should not prevent attempting to develop an understanding of what has led them to be involved and what might have helped prevent their offending – this was the strongest message from practitioners at the Learning Events.

The learning from this Review does not only apply to Newcastle. It is hoped that it will be used to influence and shape services in other areas of the country and inform the need for national reform. The review has reinforced the message to agencies that if they do not recognise sexual exploitation of children and vulnerable adults in their area, it is because they are not looking hard enough.

Developments in Newcastle illustrate that determination and multi-agency victim focused services can make a significant difference.

“The future – I take each day as it comes.... I have proved everyone wrong. I am learning to manage. There are people I can get in touch with. I know support will always be there for me.”

“I would really like to help other people who get abused. I have been involved with the National Working Group.”

15. Recommendations

15.1 Local

Number	Recommendation	Section	Page
1.1	Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should make arrangements to review the progress and impact of the actions taken and intended to be taken as a result of carrying out the Joint Serious Case Review.	2.6	19
1.2	A report should be made to Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board on the arrangements to take forward the initiative to establish a process for discussion with communities about the issues that have arisen from the Joint Serious Case Review.	5.11	49
1.3	Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should continue to work with relevant partners to try and encourage conversations with perpetrators to better understand the Newcastle context of their offending.	6	52
1.4	When considering national guidance or advice Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should ensure that expectations for engagement with a national agency that is not a local partner are addressed and kept under review.	7.1	59
1.5	Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should identify services in the community that are not routinely involved with local safeguarding arrangements and consider how best to engage with them on safeguarding issues.	7.16	76
1.6	Newcastle Safeguarding Children Board should arrange to carry out an audit of a sufficient number of cases to form a judgment about whether regulatory and guidance expectations concerning pupils who change educational settings are consistently followed.	7.19	80
1.7	Newcastle Safeguarding Adults Board should carry out an audit of a sufficient number of cases to form a judgment about the effectiveness of arrangements to interview vulnerable adults following a period of missing.	7.20	81
1.8	The outcome of audits carried out in Newcastle to review the processes of assessment of capacity of patients to receive sexual health services should be reported to Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board.	9.2	94

1.9	Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults' Board should consider what arrangements can be made to monitor the numbers of patients who are identified as sexual exploitation victims and have received sexual health services.	9.2	94
1.10	NHS Newcastle Gateshead Clinical Commissioning Group should arrange a forum for discussion about how potential and actual victims of grooming and sexual exploitation might be more likely to be identified in health settings and report to the Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board.	9.2	95
1.11	Newcastle Safeguarding Children Board should arrange a forum for discussion about collaborative working between the school nursing service and teaching staff.	9.3	95
1.12	There should be reports made to Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board on the outcomes of the actions taken to improve information sharing in the region when vulnerable children or adults move administrative areas.	9.5	98
1.13	Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should consider how access for practitioners to advice on cultural attitudes when assessing and managing risks might be improved.	9.11	105
1.14	Northumberland Tyne and Wear NHS Foundation Trust should report to Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board on the arrangements being made for local delivery of the Government's ambition to improve access to Mental Health Services for all children and young people, including those sexually exploited.	9.16	114
1.15	Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should arrange for guidance to be issued to practitioners on the differences between learning disability and learning difficulties and the relevance for safeguarding judgments and services.	9.19	116
1.16	When reviewing the training strategy Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board should have regard to the issues raised at the Learning Events.	10.1	127
1.17	Partner agencies should report to Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board on the arrangements for supervision of staff and how they measure the effectiveness and impact on outcomes.	11.2	134

1.18	Newcastle Safeguarding Boards, involving the Northumbria Police, the Police and Crime Commissioner and the Crown Prosecution Service, should arrange for discussions to take place with Newcastle Crown Court to consider how practical arrangements at court can be improved to ensure protection of the interests of victims giving evidence.	12	135
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15.2 National

Number	Recommendation	Section	Page
2.1	The Government should carry out a review of vehicle licensing for driving vehicles that transport members of the public, to include arrangements for private operators of larger vehicles, and taking account of the body of knowledge about sexual exploitation.	5.4	35
2.2	The Government should urgently issue guidance or advice on addressing sexual exploitation of vulnerable adults.	5.9	44
2.3	The Government should arrange for research to be undertaken concerning profiles, motivations and cultural and background influences of perpetrators of sexual exploitation of children and vulnerable adults and publish guidance for strategists and practitioners on the most effective way to reduce offending.	6	53
2.4	The Crown Prosecution Service should arrange for guidelines to be developed on involvement of the Service with Safeguarding Boards and other local safeguarding frameworks.	7.9	69
2.5	The Government should ensure that when national guidance or advice requires involvement of a national agency or one which is not a statutory local partner with Safeguarding Boards or other local safeguarding frameworks, the documents include confirmation that the agency is aware of and has made arrangements for the expected involvement.	7.9	70
2.6	The Government should consider which community services not routinely involved with local safeguarding frameworks have a contribution to make to early identification and prevention of sexual exploitation and make arrangements to ensure that their contribution is made and monitored through regulatory functions or otherwise.	7.16	76
2.7	The Government should arrange for a review of the safeguarding implications for children educated otherwise than at school having regard particularly to the body of knowledge about sexual exploitation, issue	7.18	79

	guidance on safeguarding children educated otherwise than at school and consider the need for legislation to more effectively regulate this provision.		
2.8	The Government should arrange for national research to be carried out on the impact on sexual exploitation of Personal, Social, Health and Economic education programmes.	7.21	83
2.9	National Health Service England should consider establishing a risk information sharing system for sexual health settings.	9.2	92
2.10	The Government should consider whether The Child Protection - Information Sharing Project arrangements should also apply to safeguarding adults systems and procedures.	9.2	93
2.11	The Government should urgently arrange for the principles applied to confidentiality and safeguarding in sexual health settings to be reviewed having regard to the body of knowledge about sexual exploitation.	9.2	95
2.12	The Government should address the need to improve national arrangements for facilitating transfer of data between social care authorities.	9.5	98
2.13	The Government should review the arrangements for obtaining authority to control or restrict the liberty of children and vulnerable adults at risk of sexual exploitation with a view to improving flexibility of provision and reducing costs and complexity of judicial overview.	9.21	122
2.14	The Government should arrange for a review of the criminal law to ensure that it provides a range of criminal offences that reflect the body of knowledge about sexual exploitation, more effectively address the behaviour and involvement of perpetrators and does not through terminology cause distress to victims.	12	140
2.15	In the light of the body of knowledge about sexual exploitation and continuing concerns about the treatment of victims when giving evidence in criminal proceedings and the impact on the fair administration of justice, the Government should arrange for a review of the rules relating to the treatment of victims when giving evidence and the disclosure of records and their use in proceedings, including whether data subjects should be made aware of material disclosed.	12	140