



**Coventry Safeguarding Children Board**

**SERIOUS CASE REVIEW**  
**Child G, Child H, Child I, Child J, Child K**

## CONTENTS

<b>1. Introduction</b>	<b>Page 2</b>
1.1 The circumstances that led to this Review	Page 2
1.2 Methodology	Page 3
1.3 Contributions from the children concerned	Page 7
<b>2. Summary of the individual children's experience</b>	<b>Page 7</b>
<b>3. The links between the children and those abusing them</b>	<b>Page 9</b>
<b>4. Appraisal of practice</b>	<b>Page 11</b>
4.1 Introduction and Context	Page 11
4.2 January 2010-May 2012	Page 12
4.3 June 2012: Identification of CSE & Multi-agency response	Page 20
4.4 The longer term approach to working with victims of CSE	Page 26
4.5 How the children's voices were heard and how they engaged with professionals	Page 28
4.6 Summary	Page 32
<b>5. Current practice and the implications for future work</b>	<b>Page 33</b>
5.1 Introduction	Page 33
5.2 Changes in practice	Page 35
<b>6. Concluding Comments</b>	<b>Page 38</b>
<b>7. Recommendations for the Boards</b>	<b>Page 39</b>
<b>References</b>	<b>Page 40</b>

## 1. INTRODUCTION

### 1.1 The circumstances that led to this Review

- 1.1.1 In the autumn of 2012 West Midlands Police initiated a major investigation, as a result of information that several teenage girls were victims of Child Sexual Exploitation perpetrated by a group of men in Coventry. Five men were subsequently convicted of a number of criminal offences, including physical assault, witness intimidation and the supply of drugs and were given custodial sentences. The men had also been charged with a number of sexual offences, but these charges did not result in any convictions.
- 1.1.2 Following the investigation the Police provided a briefing to the Safeguarding Children Board regarding the investigation. The Coventry City Police Commander referred the cases of these five young people, who previously or at the time of the abuse had been in receipt of services from agencies in Coventry, to the Board's Serious Case Review Sub Group for consideration. The Independent Chair of Coventry Safeguarding Children Board formally made a decision to undertake a Serious Case Review on 2<sup>nd</sup> March 2015, as this case had met the criteria for a Serious Case Review as identified in Working Together to Safeguard Children 2015<sup>1</sup> in that there was information that:
- (a) abuse or neglect of a child is known or suspected; and*
  - (b) either (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.*
- 1.1.3 Irrespective of the outcome of the criminal proceedings, what is absolutely evident to this Review is that the five children under consideration have experienced appalling violence, intimidation and sexual exploitation over a considerable period of time.
- 1.1.4 The 5 children subject to this Review were between 13 and 15 years old at the start of the time period under consideration and were from different racial and ethnic backgrounds. Information about the individual children within this Review is limited in order to minimise the risk that they could be identified.
- 1.1.5 A conscious decision has been to refer to the individuals subject to this report as **children**, in clear recognition of their age, legal status and vulnerability at the time of these events. It should however be acknowledged that at times and in some settings the use of the term young people is quite appropriate for this age group, indeed referring to teenagers as children in direct work with them can be actively unhelpful. This will be referenced further in the body of the report. As all five are now over the age of 18, references to them in the present will use the term 'young people'.

---

<sup>1</sup> Working Together: HM Govt 2015

- 1.1.6 An Independent Chair and Author were appointed in June 2015. The Independent Chair is David Peplow. Mr Peplow is the Independent Chair of two Local Safeguarding Children Boards and also has experience of chairing and authoring SCRs. The Independent Author is Sian Griffiths. Ms Griffiths has significant experience of authoring Serious Case Reviews including a previous high profile SCR regarding Child Sexual Exploitation. Ms Griffiths has no previous involvement with any of the agencies involved with these children. As Chair of a neighbouring LSCB Mr Peplow has contact with some of the Health Trusts concerned in this context, but has no involvement with any of the agencies which would impact on his independence.
- 1.1.7 The date for completion of the Review was initially hoped to be in six months' time, with the intention of the Report being presented to the Board in January 2016. However, an extension was subsequently agreed due to the complexity of obtaining adequate information relating to the identified timescale and the report was actually presented to the Board in June 2016.

## 1.2 Methodology

- 1.2.1. Statutory guidance within Working Together requires Local Safeguarding Children Boards to have in place a framework for learning and improvement, which includes the completion of Serious Case Reviews. The guidance establishes the purpose as follows:

*'Reviews are not ends in themselves. The purpose of these reviews is to identify improvements that are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.'* (Working Together, 2015:73)

Statutory guidance further requires SCRs to be conducted in a way which:

- *recognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;*
- *is transparent about the way data is collected and analysed; and makes use of relevant research and case evidence to inform the findings.* (2015:74)

- 1.2.2. The methodology used for this Review was underpinned by the principles outlined in Working Together, including the need to use a systems approach. The author of this report is familiar with a systems based methodology. In particular this approach recognises the limitations inherent in simply

identifying what may have gone wrong and who might be 'to blame'. Instead it is intended to identify the work context and systems that supports good practice, as well as the work context in which poor safeguarding practice is more likely to take place. This allows us to achieve a focus on the underlying reasons as to why there may be problems with practice when we look back and examine it in detail.

- 1.2.3. A proportionate methodology focussed on future learning was designed to take into account the historical nature of the events under consideration; the importance of not identifying the young people concerned; the body of learning about CSE already identified as a result of a number of recent reviews and reports; and the significant changes to policy and practice that have taken place in Coventry since these events.

The primary focus for this Review was to consider the response of agencies in Coventry to the Child Sexual Exploitation of five children. Child Sexual Exploitation (CSE) can be defined as follows:

*Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities.*

*Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability<sup>2</sup>*

- 1.2.4. The Review was not required to work to prescriptive Terms of Reference, instead 3 Core questions were posed:

- i) What can we learn specifically about these cases, as well as more widely around responses to troubled young people?**
- ii) Why did it happen and could it have been prevented?**
- iii) Could it happen now? If yes, what do we need to change?**

The Review was also specifically asked to consider:

---

<sup>2</sup> National Working Group 2015

- **the voice of the children, their understanding of their own situations and the implications for what disclosures they make**
- **Professionals’ relationships to the children**

1.2.5. The starting point for the Review’s time frame was determined by the Safeguarding Children Board to capture adequate information about the children’s involvement with services prior to the point at which it was recognised that they were experiencing CSE. The time frame ends at the point that the police investigation was identified as a major incident and a multi-agency response was initiated. That is:

**January 2010 to end September 2012.**

1.2.6. The Chair and Author worked with a core Review Team made up of Senior Safeguarding representatives from the key relevant agencies as follows:

Children’s Society ( responsible for the projects known as Reunite and Streetwise)	Programme Manager Birmingham, Coventry and Solihull
COMPASS (drug and alcohol service)	Assistant Director Young Peoples Services
Coventry City Council Children’s Services	Children’s Social Care Lead
Coventry and Warwickshire Partnership NHS Trust	Safeguarding Lead
Coventry City Council (Education)	Head of Student Services
Coventry & Rugby CCG	Designated Nurse Child Protection & Lead GP
University Hospitals Coventry and Warwickshire NHS Trust	Named Doctor for Safeguarding
West Midlands Police	Detective Chief Inspector, Coventry and Solihull Domestic and Child Abuse Lead
YMCA Coventry and Warwickshire	Chief Executive
Youth Offending Service, Coventry City Council	Service Manager

1.2.7. The review process included:

- Consideration of chronologies and learning summaries produced by 10 key agencies.
- 5 meetings of the Review team.
- Meetings with a range of key professionals

1.2.8. The following agencies provided chronologies and Agency Reflection and Learning Reports - focussed reports identifying the key lessons from each agency:

- **West Midlands Police**
- **Coventry Children's Services (CSC)**, including Adoption Support, Looked after Children<sup>3</sup> (LAC), Referral and Assessment (RAS), After Care team.
- **Streetwise** – a project run by the Children's Society (previously known as Reunite) which initially worked with young people who had been missing from home, but later focussed on work with children experiencing CSE
- **Compass** - Charity commissioned by the Local Authority to provide Drug and Alcohol services for young people
- **Education**
- **GPs**
- **Coventry and Warwickshire Partnership NHS Trust** (including CAMHS, School & LAC Nurses, sexual health.
- **University Hospital Coventry and Warwickshire, NHS Trust**
- **YMCA Coventry and Warwickshire**
- **Youth Offending Service**

1.2.9. Individual meetings took place with 17 practitioners who had been involved with the children at the time, including 3 who no longer worked in Coventry but who had significant involvement with the children. The author also had conversations with some key managers and professionals currently involved in CSE work in the multi-agency partnership.

1.2.10. Towards the end of the Review a meeting of practitioners who had either been involved with the children or were currently working with those at risk of Child Sexual Exploitation across services took place. A total of 28 front line staff and managers attended the meeting and contributed to the information gathering and the analysis aspects of this Review. The Independent Author and Chair, supported by members of the Review team facilitated the event.

1.2.11. The Independent Author also attended meetings of the following groups to learn more about the way in which CSE was understood and responded to in Coventry:

- Young People's CSE participation group
- Supported Housing accommodation Providers group

---

<sup>3</sup> Looked After Children (LAC). A child is described as 'looked after' by a Local Authority if provided with accommodation under the Children Act 1989.

### **1.3 Contributions from the children concerned**

- 1.3.1. All the young people concerned were informed that the Serious Case Review was taking place and asked if they would wish to contribute to the Review. Only one of the young people said that she would like to contribute, but a change in her circumstances meant that she was not able to do so before the report was completed.
- 1.3.2. As a result it was not possible to gain a first-hand understanding of the experience of those who were subject to the Review and it was not felt to be appropriate to attempt to identify and meet with other young people who had been subject to CSE. In the absence of such direct feedback, the perspectives provided by the young people from the CSE consultation group regarding the general experience and understanding of young people within the city, were of particular value.
- 1.3.3. All the young people were provided with the opportunity to read the report prior to publication and make any contributions at that time. The young people were overwhelmingly concerned that their privacy was not compromised as a result of this Review and this was a significant factor in the level of detail about individuals contained within the final report.

## **2. SUMMARY OF THE CHILDREN'S EXPERIENCE**

- 2.1. This section provides a brief combined summary of what is known about the 5 children and their involvement with agencies. The level of detail about the children's lives has been carefully considered during the Review, but has not been included here in order to minimise the risk of identifying the individuals concerned. The decision not to describe full details of each child's individual experience is purely for their protection.
- 2.2. The five children were from different racial and ethnic backgrounds, with three identified as White British and two dual heritage (Asian/White and White/Black African Caribbean). No information has been provided to this review regarding issues such as disability, faith or religion in relation to the children. The Review recognises that this means there may be gaps in our understanding of their experience.
- 2.3. All of the children had experienced contact with a range of statutory and voluntary services during their lifetimes, including health, children's services and the police. All had experienced some form of disruption or difficulties within their birth families, for example allegations of domestic abuse or parental mental health problems. Two of the children, who had been adopted, experienced family breakdowns during their teenage years which led to the involvement of the Local Authority Post Adoption Support Team. However for neither family was it possible to prevent the breakdown and the child left the home to move into foster care or semi-independent accommodation. By the time at which it became understood that the children were experiencing



abuse, they were all living away from their homes, one in a Local Authority residential home, the others in semi-independent accommodation. All of the children had very limited personal support.

- 2.4. Whilst each child's story is unique to them, they all had a number of needs and problems which led them and their families either to seek help or to be referred for help and assessment. There was evidence of significant neglect with one of the children which did not at an early stage lead to her being identified as a child in need or at risk, although she did later become looked after by the Local Authority. The children at times showed very clear signs of distress at their situations, with substance abuse identified as a concern as well as self-harm and in one case involvement in a serious offence. Often the children or families did not take up services that were offered to them, and as a result their cases were closed to health and social care services.
- 2.5. With all of the children there were identified concerns about sexual activity. This included being sexually active at a young age, allegations about possible sexual abuse in the home and direct referrals to the police regarding possible sexual offences against them outside of the home. One of the young people was subject to a Strategy Meeting<sup>4</sup> as a result. Other allegations were also investigated by the police but none resulted in criminal charges prior to the autumn of 2012.
- 2.6. Despite their difficulties there was also positive information about the children. Individual workers spoke with warmth about them and, for example, one of the children achieved good academic grades despite her highly disrupted personal circumstances and absence from school.
- 2.7. By early summer 2012 four of the children were living in a housing unit run by the YMCA which provided semi-independent accommodation. In the first half of 2012 it was being specifically recognised by the Voluntary Sector organisation, Streetwise, and by the Looked After Children Nurse that there was a pattern of sexual exploitation taking place, with some of these children involved. It was also becoming increasingly apparent to the police and staff at the YMCA, that a group of men at a house close to the YMCA were involved in anti-social behaviour, with both drug use and '*inappropriate sexual activity*' being reported. Some of the children living at the YMCA were involved with this group and concerns were growing about them as they often returned distressed, intoxicated or with injuries.
- 2.8. In June 2012 a neighbourhood police officer began to investigate the activities at the house. Initially some children made allegations but were reluctant to make statements due, not least, to concerns about repercussions against them by the men. However, ultimately the children were supported to make statements leading to the eventual prosecutions.

---

<sup>4</sup> A Strategy Meeting/discussion is required whenever there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm. This should include Children's Services, the police, health and any other appropriate body.

### 3. THE LINKS BETWEEN CHILDREN AND THOSE ABUSING THEM

3.1 A significant difficulty in Coventry, as has been the case with other Local Authorities is that initially the agencies struggled to understand the links both between the children and with the network of men in which CSE was taking place. The following is a summary of the key events which agencies (singly or collectively) were aware of at this time.

#### Key dates table

January 2010	<b>Child H:</b> Allegation of sexual abuse by older males. No prosecution deemed viable as she withdrew allegations.
March 2011	<b>Child K:</b> Moved into YMCA.
Dec 2011	<b>Child G:</b> CAMHS records noted she was at risk of sexual exploitation
August 2011	<b>Child J:</b> Social Worker for Child J's younger sibling concerned that both were at risk of CSE. <b>Child J</b> became Child in Need and Streetwise involved to discuss CSE with her.
Sept 2011	<b>Child J:</b> CSC recorded concerns about possible CSE/grooming (not specific).
Oct 2011	<b>Child G</b> admitted to hospital due to self-harm. Referred to CAMHS and CSC, allegations of abuse within the family noted.
April 2012	<b>Child G</b> moved into YPDA (Young Persons Direct Access housing)
May 2012	<b>Child J</b> identified by statutory agencies as visiting a house where she was at risk of CSE.
May 2012	<b>Child I</b> moved into YPDA.
June 2012	Neighbourhood police officers identified concerns about anti-social behaviour, including drug misuse and inappropriate sexual activity at a house close to the YMCA (House A).
10 <sup>th</sup> June 2012	YMCA staff noted concerns about some of the residents, including three of the five subject to this review visiting a house , where there was believed to be drug use and sexual abuse of them by the men who were described as ' <i>preying on the girls in the project.</i> ' On police advice YMCA staff began to log any incidents connected to the address and inform the police. YMCA gave letters to the residents to pass on to the 'lads' at House A telling them they were banned from the premises.
12 <sup>th</sup> June 2012	Information from one of the children concerned stating that another of the children was staying at House A
23 <sup>rd</sup> June 2012	<b>Child G:</b> CAMHS made referral to CSC regarding history of sexual vulnerability and possible exploitation. Around this time CSC were making links between the girls and the men at House A and a Strategy Meeting was planned.
26 <sup>th</sup> June 2012	Social worker identified that 3 of the children concerned were friends.
28 <sup>th</sup> June	LAC nurse concerned about the presence of men outside the YMCA

2012	and the intimidating effect. She and Streetwise then ran a group health session attended by some of the children. There was discussion in the group that further increased their concern.
5 <sup>th</sup> July 2012	<b>Child I:</b> referred to Streetwise by social worker as at risk of CSE. A Strategy Meeting took place with regard to three of the children concerned and one other young person.
10 <sup>th</sup> July 2012	<b>Child G:</b> CAMHS made a further referral to CSC.
16 <sup>th</sup> July 2012	Strategy Meeting regarding another young person at YMCA.
19 <sup>th</sup> July 2012	Information from the police to YMCA that men at House A appeared to have moved to a different address.
8 <sup>th</sup> August 2012	Sexting workshop at YMCA run by Streetwise worker. One of the children concerned attended
16 <sup>th</sup> August 2012	Prostitution workshop at YMCA run by Streetwise & Kairos with a YMCA worker present. One of the children concerned attended.
22 <sup>nd</sup> August 2012	<b>Child G:</b> CAMHS escalate concerns to CSC team manager, who took the view that Child G was not at risk. Police called by YMCA due to an incident when two men were being aggressive to staff and residents. Police also dealt with a large group of men outside the building.
23 <sup>rd</sup> August 2012	<b>Child H</b> made allegations to Police re sexual abuse, interviewed, but not willing to make a statement due to fear of repercussions.  One of the children concerned barred from YMCA as considered a risk to the other girls. Incident when five men break into her B&B to find her, police called and CSC informed.
24 <sup>th</sup> August 2012	<b>Child I:</b> Safeguarding meeting – Child I allocated a Streetwise worker.
3 <sup>rd</sup> September 2012	<b>Child G</b> referred to Streetwise by Social Worker identifying that she was believed to be at risk of CSE.
7 <sup>th</sup> September 2012	Streetwise and Kairos ran a group at the YMCA. One of children made a disclosure of CSE and police informed. Kairos worker accompanied the child to an ABE interview. She attended a second ABE interview later in the month.
11 <sup>th</sup> Sept 2012	<b>Child K:</b> Social Worker made a referral to Streetwise.
18 <sup>th</sup> September 2012	Three men arrested by the police in connection with CSE following allegations by one of the children concerned and another young person. The men subsequently bailed. The police investigation was recognised as likely to be complex. Strategy Meeting regarding a number of young people, including three of the children concerned. Police believed the arrests of the men could put them at risk. Two of the children concerned agreed to talk to the police.

## 4. APPRAISAL OF PRACTICE

### 4.1 Introduction and context

4.1.1 This section will analyse the quality of the most significant features of the services provided to the children during the time period under consideration. Where practice appears to have fallen short of what either at the time, or now, we consider to be good practice, it will seek to explain why this was the case. Section 5 will then consider if, and to what extent, current practice has improved and what this identifies about the need for future practice development and improvement.

4.1.2 Prior to September 2012, neither the multi-agency partnership nor the key statutory agencies in Coventry had experience of identifying or responding to complex episodes of Child Sexual Exploitation. Whilst awareness of CSE was being highlighted at a national level, at this point in Coventry the development of a multi-agency approach to CSE was at a comparatively early stage and this was reflected in frontline practice. The Local Safeguarding Children Board (LSCB) had established a CSE Focus Group in February 2012 in response to the publishing of the significant report by CEOP of 'Out of Mind, Out of Sight'. By September 2012 the CSE Focus Group had established a work plan including:

- Developing procedures and protocols
- Setting up an operational multi-agency group to manage children and young people at risk
- Awareness raising
- Training of workforce, parents and carers
- Taking part in West Midlands Area CSE Strategic group to develop best practice.

As such, the group's work reflected its purpose to '*scope out and gain an understanding of the scale of the problem in Coventry*'<sup>5</sup> rather than to work as an operational group.

4.1.3 Knowledge and information regarding Child Sexual Exploitation was considerably less well known during 2010-2011 than it is today and in Coventry, as was the case in many authorities, was not recognised as such a priority issue at that time. Nevertheless there was a growing national awareness of the phenomenon and agencies could reasonably be expected to have had some early awareness and begun to consider potential strategies and ways of working. There were some key documents that should have been made available to practitioners working with children and young people, particularly the 2009 Supplementary Guidance to Working Together regarding Child Sexual Exploitation and the Barnardo's report of 2011, Puppets on a String. Other information was also available regarding investigations into CSE, including the Derby Serious Case Review (2009)

---

<sup>5</sup> Coventry Safeguarding Children Board Annual Report 2011-12 and Business Plan 2012-2015

and the convictions of nine men in February 2012 following a major police investigation in Rochdale.

- 4.1.4 It should also be noted that during the time period under consideration within this Review, there is reason to believe that the quality of children's safeguarding in Coventry was not consistently reaching good enough practice standards. In January 2014 both Children's Services and the Safeguarding Children Board<sup>6</sup>, were judged by OFSTED to be inadequate. None of the contributors to this review have suggested that practice during the period under consideration here should be assumed to be fundamentally different. The OFSTED inspection referred to '*key weaknesses in children's social care*' and many of these are mirrored within the experience of the children subject to this report. As a result of the OFSTED inspection the Local Authority has been working to an Improvement Plan<sup>7</sup> overseen by the Department for Education.
- 4.1.5 Since 2012 major changes have been made in Coventry in the way that agencies respond to CSE and these will be referenced more fully in Section 5.

## **4.2 January 2010 - May 2012**

- 4.2.1. All five of the children subject to this Review were known to a range of services prior to June 2012, the time which effectively marked the starting point that culminated in the police investigation. All of the children had been in contact with Children's Services and three of them became Looked After Children as they had been accommodated by Children's Services after their parents were no longer either able or willing to look after them. Referrals had been made to Children's Services about each of them identifying a range of concerns including possible sexual abuse within the family, neglect, placement breakdowns, drug use, mental health problems and self-harm.

### **Safeguarding response to the children's identified risks and needs.**

- 4.2.2. Setting aside whether or not these concerns might have indicated there were vulnerabilities for Child Sexual Exploitation, what could reasonably have been expected was that they would result in wider concerns about the children's welfare including the need for a safeguarding response. Whilst different agencies did identify concerns it was often this holistic approach to assessing and managing the risks to the children both at home and in the outside world that was either delayed or absent.
- 4.2.3. The quality of the response by Children's Social Care to four of the children prior to CSE being identified gives cause for concern. There was very worrying information being forwarded to CSC about the circumstances of all

---

<sup>6</sup> The Local Safeguarding Children Board is the key statutory mechanism for agreeing how the multi-agency partnership works together to safeguard children. For further information see Working Together 2015, chapter 3.

<sup>7</sup> The Improvement Plan is a high level plan designed to address the areas for improvement identified by the statutory Improvement Notice from the Government.

four children. Both the written records and the contributions of staff to this Review suggest too often there was a lack of meaningful assessment and a failure to recognise the seriousness of some of the risks facing these children. For example, Child I was subject to two referrals to CSC in 2010, but there is no evidence that a good quality assessment took place, or whether either Child I herself or her school were spoken to, it is simply recorded that these allegations were unsubstantiated. When in May 2012 the Young Person's Direct Access housing provider made a referral to Children's Social Care (CSC), an Initial Assessment was completed. However, the actions that followed appear to have been almost entirely focussed on practical issues, that is, her financial situation and accommodation, rather than reflecting her complex emotional and psychological needs and the resulting vulnerabilities.

- 4.2.4. 14 year old Child G 's presentation to hospital on three occasions in as many months during 2011 demonstrates the problems in ensuring that safeguarding concerns are recognised in the A&E setting. It was not until the third occasion that a referral was made by a consultant to the police and CSC, despite the fact that this was the third injury, the previous two being of a similar nature. Without detailed information about the circumstances of these two injuries and the context in which she was treated, it is not possible to reach a conclusion about the quality of individual practice episodes. However it highlights once again the limitations of A&E as an opportunity for identifying abuse or neglect in children. It is likely that the referral to CSC was made possible on this occasion because Child G was not just treated in A&E but admitted to a ward, which provided greater opportunity to respond to safeguarding concerns, not purely the presenting injury. On this third occasion there was good communication from the hospital to the police and social care and it also led to the involvement of CAMHS.
- 4.2.5. The response of CSC to the referral again raises questions about the way the needs and risks of older children were understood. The hospital were concerned that given the circumstances of the injury Child G might be '*in danger*' at home. She was also known to be self-harming, using drugs and to have witnessed domestic abuse, there was also a (disputed) history of sexual abuse within the family setting. What is therefore surprising is that this did not reach the threshold for any assessment by CSC whose involvement was brief. Similar to the response to Child I, Children's Social Care did become involved with Child G at the point when aged 16 she was required to leave home and moved into Direct Access accommodation and therefore needed to be assessed for financial support. There is no information to suggest that her wider needs other than the financial needs were assessed at this point.
- 4.2.6. The assessment and intervention in relation to Child J during this period was particularly worrying and will be considered in more detail. In March 2010 Child J's school attempted to initiate a CAF but only one meeting took place as it is understood that Child J's mother would not agree to take part and a CAF requires consent from the family. The school's concerns at that meeting led them to make a referral to CSC and there was also an anonymous referral specifically referencing CSE. It was good practice that

the school escalated their concerns, first to the CSC Referral and Assessment Team Manager, subsequently to the police. However, CSC's ultimate decision remained as no further action. Given the family history, the school's serious concerns about missing episodes and the direct reference to CSE, and in the absence of any explanation for the decision, this would not appear to be good practice.

- 4.2.7. The next referral to CSC just a few months later regarding specific and serious issues of neglect also did not appear to have resulted in a comprehensive assessment and was not considered to meet the threshold for intervention by CSC. Instead the case was referred to the Family Intervention Project (FIP). It is of note that FIP themselves referred Child J back to the Referral and Assessment team as they were concerned about the reasons behind Child J's behaviour, particularly the frequent running away from home and felt it needed a '*more comprehensive assessment and intervention*'. Whilst the actions of FIP were appropriate, the need for such an assessment should have been apparent to the Referral and Assessment team based on the information that was available at the time.
- 4.2.8. It is also revealing that the vulnerabilities and risks to Child J's younger sibling seem to have been acknowledged earlier than those to Child J. In 2011 there appears to have been a Core Group relating to Child J's younger sibling. But although there is no immediate evidence that the risks to Child J whether of neglect within the family, or vulnerability outside it, were any less, the response to her needs was noticeably slower.
- 4.2.9. Throughout her time at school, there is evidence of persistent attempts to support Child J by school professionals including the Education Welfare Officer, who visited frequently, arranged transport to collect Child J and take her to school, informed police of missing episodes and had contact with other agencies involved with the family. It has now been recognised that there also needed to be a more strategic approach to ensuring that Child J's persistent periods of being missing from home and school were always reported, rather than sometimes relying on the mother to do so. One explanation for the school not always contacting police or social care when Child J was missing, could be their experience that whenever they contacted CSC it was '*batted back*' to them.
- 4.2.10. Given the quality of information available to this Review and the fact that these events took place between 4-6 years ago, it has not been possible to achieve a detailed understanding of the decision making at the time. The conclusions of the OFSTED report in 2014 however are likely to be pertinent:
- "Social workers in the referral and assessment teams have very high caseloads and this means that they cannot do their job properly... (they) do not always receive the right level of supervision from their managers to enable them to discuss cases fully and make the right decisions for children and young people to improve their outcomes and ensure their safety and welfare"*
- 4.2.11. The pattern of response to these children, before CSE was explicitly identified, reflects what has now been recognised as a common feature in

safeguarding. That is that the safeguarding needs or neglect of adolescents is less likely to be recognised or meet the thresholds for intervention than that of young children. Members of the Review Team reflected that in common with the wider national picture safeguarding in Coventry was much more focussed on the neglect of young children than it was on the neglect of adolescents. Coventry's policy on neglect which has been in place since 2011 does draw attention to this common tendency, but there is no supporting information to evidence that this was prioritised in frontline practice at the time:

*“There is a tendency for professionals to underestimate the effect of neglect on older children and adolescents and to judge any concerns around neglect in relation to this group as less serious”.*

### **Significance of adoption breakdown**

- 4.2.12. Two of the 5 children had been adopted and had lived with their adoptive parents for a number of years. The children had left their adoptive homes prior to the timescale of this Review, but given the potential impact of their life experiences on their later vulnerability to CSE, the Review considered this merited consideration as part of the Review.
- 4.2.13. As the adoptions had been arranged outside of Coventry there was no requirement for the involvement of Coventry Children's Services in the early years. However, the response by CSC when the parents did request help with both children in 2005/2006 was appropriate. Both families were referred to the Adoption Support Team and there is clear evidence that significant attempts were made by that team to provide help and support to both the children and the parents.
- 4.2.14. During that period the Post Adoption Social Worker allocated to the families had both a good level of specialist knowledge about adoption breakdowns and the time and resources to work with the family. There was also an informal collaborative working arrangement with a Consultant Child Clinical Psychologist from CAMHS who had specialist knowledge in this area and worked with one of the children. As a result these professionals developed a proper understanding of the difficulties facing the families, the level of early life disruption that the children had experienced and the impact this now had on their relationships with their adoptive parents.
- 4.2.15. Despite their involvement, the Adoption Support Team was unable to prevent the breakdown of these two adoptions. Both professionals contributed to this Review and demonstrated a significant level of knowledge about the difficulties arising out of their early experience that face some children living in adoptive families, as well as considerable empathy towards the adoptive parents. Whilst CSE had not specifically been named as a risk by them, both these professionals identified that the children were highly vulnerable, with significant problems in making healthy attachments and in regard to their sense of identity. The Clinical Psychologist described one of the children as: *“vulnerable to abusive experiences, particularly because she already takes responsibility for the behaviour of people who have not treated her appropriately and fails to report abusive behaviour”*



- 4.2.16. It would be wrong to ascribe statistical significance to the fact that two of the five children had experienced adoption breakdown. Nevertheless the similarities between the two and the very particular emotional vulnerability that is linked to adoption breakdown is striking. As in the case of these two children, families who experience adoption breakdowns typically do not come to the attention of the safeguarding agencies at an early stage and this limits the opportunity for early intervention with these children and makes successful intervention considerably more difficult.
- 4.2.17. Figures regarding adoption breakdown are limited but the most recent research in the UK<sup>8</sup> concludes that approximately 2 to 9% of adoptions break down, with age at the time of adoption (i.e. over 4 years old) being the strongest indicator for breakdown<sup>9</sup>. The research also confirms the degree of vulnerability of young people moving after an adoption breakdown into supported housing which is so clearly reflected in stories of the children in this review:

*“Young people, who left their adoptive family aged 15 years or older found it very difficult to access Children’s Services and were signposted towards housing or benefit advice. They had no entitlement to leaving care services and were financially poor, lonely, and vulnerable to further abuse.”*

- 4.2.18. Given the significance of adoption breakdown that has been highlighted in this Review, a recommendation has been made to the Board as follows:

**Recommendation:** The Board to ensure that learning from this SCR regarding the vulnerabilities following adoption breakdown are shared with relevant professionals and the implications for pre and post adoption support in Coventry considered.

### **Looking beyond the behaviour: recognising CSE**

- 4.2.19. Child Sexual Exploitation was explicitly recognised by some of the professionals prior to the events of summer 2012. Although CSC intervention with Child J was slow to start, by summer 2011 she was specifically identified as being at risk and a Child in Need Plan put in place. The decision not to place her on a Child Protection plan, as was the case with her younger sibling, was at this point a conscious one in recognition of her age. The intention was nevertheless clear at the Initial Child Protection conference that the concerns for Child J were as great as they were for her sibling and their plans should be reviewed together. There was evidence of a strong chairing of this conference, one of a number of occasions when conference chairs and IROs have provided a good steer in decision making.
- 4.2.20. The professionals who appeared to identify CSE most quickly in relation to the other children were those staff working for Streetwise and Kairos, and the Looked After Children Nurse. Streetwise is a Children’s Society project initially funded by Comic Relief to conduct return home interviews with young

---

<sup>8</sup> Selwyn, J et al (2014 : 275)

<sup>9</sup> Selwyn J et al (2014:19)

people who had run away or gone missing and help reunite them with their families. Over time as they worked with the children Streetwise began to identify a repeating pattern which they recognised as Child Sexual Exploitation. In September 2011 the project, which consisted of a manager and two part time workers shifted its focus entirely to Child Sexual Exploitation, working to raise awareness amongst other professionals and to support children and young people at risk. However, despite attempts by the manager to formalise their role, Streetwise was not a member of the key multi-agency networks, including the LSCB and the Missing Children Panel, nor had it been commissioned by Health or Social Care and as such, despite several attempts, found it difficult to influence policy or the approach to CSE at the strategic or higher operational levels.

- 4.2.21. The School Nursing service was also involved with some of the children, all of whom were to some degree difficult to engage. In early 2012 the school nurse who had contact with Child J was very concerned about her. She clearly understood that Child J was being exploited, but although she tried to develop Child J's trust was unable to get her to speak to her about what was happening. The school nurse's description of her own frustrations at being unable to help Child J is something that was reflected by a number of the professionals: *"I could see it happening, but felt powerless to help"*.
- 4.2.22. Whilst some individuals clearly did recognise that the children were at risk of sexual abuse it was also the case that this was not always recognised as CSE. The indicators and warning signs of CSE, which with hindsight and greater familiarity we can now identify, were often not recognised as such. At times they were seen more as a feature of the children's behaviour or something they need to just take responsibility for. What is apparent is that too often agencies and professionals seemed unable to look beyond the behaviour of the girls and recognise the full reality of what they were experiencing.
- 4.2.23. A recurring feature with several of the children is that they were identified as being sexually active at an early age including having contact with men online. For several of the children there was information about previous sexual assault or allegations of sexual assault which were later withdrawn. It is evident for example that both social workers and foster carers were concerned about one child's safety following allegations in 2010 of *'sexual incidents'* with older teenagers and men as well as in relation to men she had contact with on social media. However it is not evident that this represented a conscious recognition that this child might be experiencing CSE or be at significant risk for the future. It was also the case that at times the language used about the children, for example, references to promiscuity, was highly judgemental and demonstrated a lack of understanding of the degree to which they were in control of what was really happening to them.
- 4.2.24. All of the children were known to be going missing from home or school, sometimes for quite significant periods of time, including overnight or for a few days. The police have now identified that there were at least 96 occasions in which these children were reported to them as missing and it is

likely that the actual figure was actually much higher. Information about the police response to the children in 2010 and 2011 is very limited as due to software problems with the recording system in early 2012, all the previous missing records were removed from the missing person system, with the result that the only information available to the Review from the police prior to 2012 relates to one of the young people, Child J. However, there is nothing to suggest from the records of other agencies that the Police had prior to 2012 identified any link between the children's missing episodes and the possibility of CSE.

- 4.2.25. Education staff were particularly concerned about Child J's frequent absences and worked hard to ensure she was in school in order to complete her education, with the outcome that despite her difficulties she was able to achieve a number of qualifications before leaving school. However, the absence of the children from school also limited their schools' opportunity to engage with them and to achieve a better understanding of what was happening in their lives.
- 4.2.26. There were a number of occasions prior to June 2012 when the children either made direct allegations that they had been sexually assaulted or spoke of historical sexual assaults that had taken place. Some of these were subject of Strategy Meetings between the Police and Children's Services and led to the Police beginning investigations, although it was not until the major police operation in 2012 that any of these investigations led to criminal charges. On more than one occasion allegations were made by the children and then withdrawn and there existed a level of scepticism about the allegations within the police. One of the children gave a description of sexual assault by a number of men after she had gone missing, which with hindsight, looks like a 'text book' description of CSE. However what is recorded is that she had been sexually active since she was 13 and that she *'admitted she had lied'*.
- 4.2.27. The withdrawal of, or unwillingness to, pursue allegations does create a genuine difficulty for a police investigation, particularly when the allegation relates to events that happened some time ago. Whether there was the basis for prosecutions on these occasions is not something that this Review is in a position to judge. However, the lack of any prosecutions prior to the events of summer 2012 at the very least raises questions about the level of understanding and persistence the police showed in investigating the allegations. The fact of a delay in reporting, or withdrawal of a report is not in itself indicative of a false allegation. There is now a much wider understanding of what can appear contradictory behaviour by children in relation to reporting sexual abuse or being willing to make statements.
- 4.2.28. Another common feature was the way in which the children presented for health, including sexual health treatments. Often presentations would be via acute services, such as A&E rather than through their GP which can have the effect of masking any pattern of attendance. The Hospital Trust has identified at least 15 attendances at A&E for these children during the time period. On a number of these occasions the child concerned had been drinking and the approach as described was to allow them to *'sober up and*

go', demonstrating a failure to recognise that these were children who needed a safeguarding response. On one occasion a Sister from A&E did inform CSC when one of the children said that she was drinking a bottle of vodka a day. However, there is no information that any action was taken as a result of this. One of the children attended A&E with bruises and 'love bites', and other presentations were with possible pregnancies or miscarriages, but the potential significance of these was not understood. At the time the screening processes at A&E did not include an alert to the possibility of CSE, although this has now changed.

- 4.2.29. Individual presentations at A&E should at least on some occasions have raised concerns about the children's welfare and this has been recognised by the Trust and action taken to raise awareness and improve systems. However, it would not be reasonable to judge that an average of three presentations per child over the 2 year period should or could have been seen as a pattern by A&E staff. The key relevant contact between GPs and these children was in relation to requests for contraception. Information within the children's medical records, as well as documented attendances at A&E, would have identified them as vulnerable with complex social histories. However, there is no evidence that the doctors questioned the children about the circumstances in which they were sexually active. Frequently there was no information recorded about who the child's sexual partner was and there appears to have been an inherent unquestioned presumption that they were consenting to sexual activity. The Named GP for the Clinical Commissioning Group, who provided a report for this Review, described this as being absolutely in line with current professional practice. This will be considered further in Section 5.
- 4.2.30. There were many other signs amongst the children indicating either vulnerability to CSE or that CSE was actually taking place. These included deteriorating physical appearance and self-care; self-harm; substance misuse; being given gifts including mobile phones; socialising with older peer groups; tiredness; being collected in cars by older men. These often gave cause for concern, but as has been described above, professionals did not always understand their potential significance.

### **Multi-agency working**

- 4.2.31. As is so frequently the case with Serious Case Reviews there were at times problems and weaknesses in working across agencies and sharing information effectively. Many of the practitioners involved with these children were unaware of other services or individual professionals who were also involved. The underlying problems are very familiar, ranging from: difficulties with databases; limited resources; individuals not recognising the significance of information they held; assumptions that other agencies would be dealing with the identified problems. One example of how this manifested itself was in the involvement of the school nurse in formal child protection procedures. The school nurse was not provided with information about Child Protection Conferences or other multi-agency meetings regarding one of the children she worked with. Neither did she get a response when she followed this up. Practice now is that the MASH

identifies the relevant practitioners to be invited to Conferences. However it was common practice at that time for school nurses or their service not to be invited to CP conferences. This both reduced access to information about an individual child, but also in the context of CSE meant that a potential source of information that might link individual children being abused within a network, was lost.

- 4.2.32. Other multi-agency meetings also effectively excluded some professionals and organisations who could have provided helpful information. This was particularly keenly felt by the voluntary sector organisations, such as Streetwise, who felt strongly that their role was not understood or taken seriously. The manager at the time spoke about her frustration that Streetwise was not represented on Coventry's Missing Children Panel, which reviewed those children who were going missing, despite the obvious role they played in working with this group of children. What this reflected was the absence of a clear strategic approach ensuring that information was shared with the right organisations, based on an understanding of CSE and the often complex links between the victims and perpetrators.
- 4.2.33. Those workers who did identify and raise concerns, felt frustrated at what they experienced as a lack of response from Children's Services, this can be seen in their actions and records. Whilst there is evidence of one occasion when a school professional attempted to escalate matters with little success, it would appear that services felt unable to influence CSC's decisions. Since this time regular meetings have been established between schools and other agencies such as the police and CSC which provide an opportunity for raising concerns at a senior level. What is more difficult to assess is the degree to which front line professionals, including managers, feel able to challenge colleagues from their own or other agencies.

### **4.3. June 2012: Identification of CSE and the multi-agency response**

#### **Identifying and investigating what was happening**

- 4.3.1. Although Child J had already been recognised as being 'at risk' of CSE and was by March 2012 on a Child Protection Plan for sexual abuse, this had not led to any of the perpetrators being identified, nor to a decision to investigate whether others were also at risk. 15 year old Child J was living in a Children's Home where she was being assessed, but she continued to cause concern to staff and social workers. When in May 2012 after her social worker called the police because Child J had been assaulted by her boyfriend, she was described in police records as '*prostituting herself*' and the alleged assault was not recorded. This, like other similar episodes demonstrated a failure to understand that Child J was a child who required protection, or that she might be being exploited.
- 4.3.2. The fundamental shift in the safeguarding response to these five young women came during the summer of 2012 when the activities at the house close to the YMCA where three of them were living were becoming increasingly visible to different agencies. It was also becoming apparent that

more than one of the children was involved. Although there was some very good individual work, the subsequent response by the agencies was not without its problems. The lack of any agreed multi-agency process for managing such a situation or a shared professional understanding of CSE and its impact on victims undoubtedly contributed at times to a disjointed approach, some delay in intervening to protect the children and a sense of intense frustration for some professionals. In the words of one of the professionals involved:

*“We followed established rules at the time, but the perpetrators didn’t follow our rules.”*

- 4.3.3. By May 2012 the LAC nurse had met with two of the children. The LAC nurse was experienced in working with children in care, she had undertaken training in gang based violence and had made a point of following developments nationally in order to develop her own knowledge about CSE. The LAC nurse became aware of the number of children that were going missing and began to be concerned that there was something worrying taking place in Coventry. She consciously made efforts to make lots of visits to the children she was responsible for in an attempt to build trust. What is evident here, and will be a repeated feature, is the degree to which the system was reliant on individual workers who had educated themselves about CSE, to identify what was happening.
- 4.3.4. The LAC nurse provided a powerful picture of her first visit to one of the children at the YMCA in June 2012. There were a number of Asian men ‘*hanging around*’ outside and although they were not directly abusive, she described it as an ‘*intimidating atmosphere*’. During her meeting she could hear the doorbell constantly ringing, but when she spoke to the staff about it, she felt they were not particularly aware that there was something wrong about this and that the behaviour felt like it had become normalised. As a result of her concerns she contacted Streetwise in the hope that they might work together with some of the children and young people in the YMCA. Staff at Streetwise had been concerned about CSE in the city for some time and had been involved in providing awareness raising and training both to young people and to other professionals. It was following one of these awareness meetings run by Streetwise and Kairos that one of the children told the Kairos worker that she was experiencing exploitation and agreed to give a police interview. Although she subsequently withdrew due to fear of repercussions, this direct statement from one of the children was a crucial step in the overall investigation. The support of the Kairos worker for the child during the process and as long as she wanted it subsequently was an example of the good practice that did exist.
- 4.3.5. At around the same time the Community Police Sergeant was also becoming aware of anti-social behaviour, various allegations of drug dealing, parties and sexual activity in the house close to the YMCA. He identified that this might be CSE and agreed with his inspector to make more inquiries, including visiting the YMCA and making checks on some of the men concerned. Within a week he had collated information which was forwarded to the Public Protection Unit of the police, ultimately leading to the major

investigation being established. Prior to this there had been no proactive attempt by police to seek intelligence about what was happening in the area and surprisingly little contact from local residents about the unusual activity. The officer concerned described his response to what he saw as being a result of instinct combined with specific intelligence.

- 4.3.6. The response of this individual officer, in contrast with some previous police officers, highlights both the strength and a weakness in policing and wider safeguarding. What was very positive was that the Community Sergeant, supported by his Inspector, drawing on personal skills and awareness was able to identify what was taking place and effectively set in motion the subsequent police operation. The weakness however is the reliance on some particularly able individuals, in picking up an issue of concern that is not a particular focus for the overall system. In this case it did result in a much quicker response than has been seen in some of the other high profile CSE cases. Nevertheless by not having an established proactive approach to the possibility of CSE the police within Coventry may have missed an opportunity to intervene at an earlier stage.
- 4.3.7. National guidance on investigating complex child abuse had been in place since 2002. The guidance is based on the expectation of an early multi-agency approach:

*“Complex abuse investigations should be undertaken as a joint operation involving the police and social services, with the Crown Prosecution Service being involved at an early stage as appropriate”<sup>10</sup>*

This however was not put into effect at as early a stage as possible in this point in Coventry and this created problems. The Police experienced difficulties for example in not initially having a single point of contact within Childrens Services, which itself is likely to have contributed to wider communication problems with other partner agencies. There was a three month delay before a Major Incident Room was set up, which is understood to be as a result of resourcing difficulties. The strengths and weaknesses of this investigation, which have been very apparent to this Review have been candidly analysed by the Senior Investigating Officer who provided a debrief to the Safeguarding Children Board and included:

- Early safeguarding Strategy Meetings not being focussed enough.
- An initially slow acceptance by senior management in CSC and the police that what was taking place was CSE
- Lack of good communication from the police and CSC to other organisations about the significance of the information they had provided.
- Initially a lack of knowledge around ‘Organised Abuse’ Strategy Meetings and the need for a tailor made approach

- 4.3.8. Whilst CSE was now being recognised, it took some time to establish a comprehensive process examining how the perpetrators and all the victims, not only these five children, might be linked together. Staff at Streetwise

---

<sup>10</sup> Home Office and Dept of Health (2002:5)

described their frustration at the lack of co-ordination across services in the early weeks and their concern that the complexity of the abuse was still not being recognised. A decision was made, led by the manager at Streetwise to put into place fortnightly meetings of the 4 key voluntary sector organisations working directly with the children. These were :

- Streetwise,
- Kairos, a small project in the same building as Streetwise, which worked with adult women involved in prostitution and shared an understanding of the significance of CSE.
- a project working on trafficking
- CRASAC, the Coventry Rape Advisory service.

Other agencies such as the police were invited but never attended.

4.3.9. This group arranged for each young person identified as a victim of CSE to be allocated a worker in one of the organisations, but also began a process of collating the information that they were beginning to see and building a coherent picture of what was happening. They started, what is now a familiar process within specialist CSE investigations, of identifying and mapping out as much information as possible that might be relevant: names, nicknames, venues, car registrations, links between individuals both perpetrators and victims. This information was eventually physically taken to the Police PPU as the group felt they were not being heard in any other way. That small, poorly resourced third sector agencies were taking on this task rather than the Police reflected the lack of senior leadership and resources during these early stages, not the commitment of the individual investigating Police Officers.

4.3.10. The Community Sergeant met with staff at the YMCA and asked them to record information about any activity or allegations regarding the house they were visiting. It is evident that staff at the YMCA were routinely recording information and allegations from other residents as requested. Whilst this was important in itself, there is less evidence that the YMCA staff viewed themselves directly as having a wider role in safeguarding. There is no doubt they were worried about the children and were trying to deal with a very difficult situation but the YMCA's activity seemed to be focussed primarily on identifying the criminal and anti-social behaviour on behalf of the police. YMCA staff did not routinely become involved in these particular group events organised by the LAC nurse and Streetwise. There are contradictory perspectives on why this was the case, but given that the events took place in YMCA premises it is surprising that they did not take a more active role.

### **Responding to the children's needs during the period of investigation**

4.3.11. By the end of June 2012, it seems to have been understood across the various agencies that there was a significant problem of abuse and exploitation. The Police investigation was transferred from the neighbourhood team to the Police Protection Unit and safeguarding plans began to be put in place for 4 of the children. At this point no connection had



been made between what was taking place at the house close to the YMCA and with Child J's experience. Staff at the children's home where Child J was living had however not long previously contacted the Police and reported that they suspected that Child J was being groomed as she was very frequently collected by an unknown 'asian man' driving a BMW, alongside other indicators.

4.3.12. What is evident over the next 3 months is that many of the services and the professionals continued to have limited understanding of the impact of CSE on the children, or how best to respond to what was happening. Examples of this included:

- CSC responding to a referral from CAMHS about Child G by referring her on to Compass for advice work rather than considering that this was evidence that she was at risk of significant harm and considering Child Protection processes.
- Professionals focussing on telling the children that they should keep away from the men, or instructing parents of their responsibility to keep their children safe.
- YMCA giving letters to the children to take to the perpetrators telling them they were banned from the premises, despite staff themselves being uneasy at having to ask the men to leave the site.

What this revealed was that many of the professionals did not understand the degree to which the girls were controlled by the men, emotionally, physically, through supplying them with drugs, through physical abuse and threats.

4.3.13. The social work response was very mixed. Some social work staff and managers appeared to have limited understanding of the level of risk the children faced. For example in August the social worker, with management support, concluded that Child G was no longer at risk because she was '*working with professionals*' and so closed the case. A recording at the time is revealing: "*Child G is 16 and therefore capable of making decisions about consensual relationships...social care can only advise and make recommendations.*" Irrespective of whether she might or might not still be subject to abuse, this was a 16 year old child who was understood to have been sexually exploited and had no meaningful family support. A supervision note relating to one of the other children around the same time stated that she was someone who:

*'lies convincingly...for some reason she seems to love the way of life she is carving out for herself, but she will disclose nothing'*

4.3.14. Other social workers, although they may have struggled to make progress, evidenced greater awareness of the risks and vulnerabilities of the children they worked with. An example was a social worker responsible for Child J towards the end of the period under consideration who evidenced a good understanding of Child J's history and vulnerability. Child J was to be moved

to a different residential home. The social worker recognising that Child J, whose safety remained fragile, was likely to be unsettled by the move, intervened to try to enable her to stay. She was frustrated that the system was not flexible enough to allow this to happen and clearly recognised the significance of stability of both placements and relationships for this child.

- 4.3.15. The lack of active senior management involvement for many of the agencies meant that front line practitioners who were facing a complex and at times highly distressing set of circumstances often lacked support or direction. As the seriousness of the situation became clear there was little evidence of this being recognised by agencies or the safeguarding partnership as a critical incident that needed an urgent joint response at senior levels. A social worker spoke of the impact of feeling that she had to 'fix' everything but feeling isolated and lacking effective support or structures in which to work. The same social worker felt that the managers who were trying to be supportive were really 'muddling through' themselves.
- 4.3.16. For a period of a few months some workers, particularly, but not uniquely, the voluntary sector workers appear to have held a disproportionate amount of responsibility for the children. The two workers from Streetwise and Kairos, provided a powerful description of the emotional and professional toll on them of working with these children in the absence of clear and robust support from the statutory partnership. Both professionals were very experienced in working with vulnerable young people and gained excellent support from the manager at Streetwise and the informal group which met fortnightly. Nevertheless continually hearing about highly disturbing abuse of these children and knowing that they were continuing to experience this abuse, was extraordinarily difficult for them and for others. One of the voluntary sector workers who was a trained social worker, reflected that her professional training made her painfully aware that she was carrying a level of risk which given her role at the time, she was not in a position to manage. One of the social workers who was given a particular role with a number of children experiencing CSE, despite having very limited experience, described this as a highly damaging experience. The description given reflects the lack of a structural understanding of the nature of what was taking place, and the potential impact this could have in the absence of a very robust structure for individual workers. For a while there was evidently a lack of recognition of the degree of organisational responsibility not only for the children, but for the wellbeing of practitioners working with this type of abuse.
- 4.3.17. The central role of the YMCA Coventry and Warwickshire requires some consideration, both in the service it provided at the time and because of the implications for commissioning of such services. Staff have been subject to criticism by a number of professionals who felt they should have been much quicker to recognise the problem and more proactive in working with the children and young people in the project. It should be noted that the YMCA does not entirely share this perception. It is the conclusion of this Review however that there is some reason to conclude there were weaknesses, although it is important to see these in the context of the organisation as a whole.

- 4.3.18. The YMCA found itself at the centre of what became a major CSE investigation, for which it is clear it was not prepared. Some staff told the review they had no training in CSE and limited safeguarding training, although it is the case that the YMCA did have in place training for staff as required by their commissioners. The building was made up of self-contained flats and the role of the Housing Co-ordinator, who was effectively the day to day manager, was dealing with all the practicalities from staff rotas to health and safety. The interim YMCA Housing Co-ordinator at the time said she was not having supervision and there was no safeguarding supervision. She was required to attend Strategy Meetings which she felt unprepared for and where she was not in a position to make key decisions.
- 4.3.19. The location of the building and range of residents meant that it could be a demanding and stressful place to work and it would appear that staff had to some extent become used to behaviour which was felt by other professionals visiting the building to be much more concerning. At the time the Housing Co-ordinator's line manager had responsibility both for operational issues and safeguarding. With hindsight this meant there was no-one in a position to take a step back and ensure there was a more questioning or strategic view of what was taking place or to provide more of a specialist safeguarding perspective. Since this time a new system has been put in place to ensure there is a manager who is able to fulfil this role.
- 4.3.20. The YMCA project in Coventry is part of the national YMCA Federation but is not directly managed by YMCA England. YMCA England itself runs a number of housing projects, but others, such as the project in Coventry are self-governing and managing. YMCA England has established advisory policies and procedures, including safeguarding policies, and these were in place at YMCA Coventry and Warwickshire. Although it was not a requirement, YMCA Coventry and Warwickshire could have approached YMCA England for advice or support, but did not do so at this time. What this has highlighted is the potential to find more effective ways of sharing support and information across the YMCA Federation, particularly when a member project is facing a complex safeguarding situation. As a result of this Review discussions have taken place between YMCA Coventry and Warwickshire and with YMCA England and it is a recommendation of the Review that the final report is shared with YMCA England and consideration given to any wider learning for the Federation as a whole.

**Recommendation:** This SCR to be shared with YMCA England in order for the lessons to be considered within the wider organisation, including access to safeguarding support for members of the Federation.

#### **4.4 The longer term approach to working with victims of CSE**

- 4.4.1. The time period set for this Review has meant that there was less evidence available about the nature of practice in working with the victims of CSE in the longer term. However it was apparent to the Review that this is one of the particularly complex challenges for agencies and required some

consideration. At the time of these events the focus was predominantly on identification, investigation and arrest, but there are clues even within this limited time to the difficulties that were being experienced and pointers and what this might mean for future involvement with young victims of CSE.

- 4.4.2. Only one of the children, Child J, was subject to a longer term plan of intervention after it had been identified that she was at risk of CSE. From August 2011 she was a Child in Need, although this changed in November 2011 to when she was placed in Foster Care under S20 of the Children Act, making her a Looked After Child. Also in March 2012 she became subject to a Child Protection Plan on the grounds of Sexual Abuse. What can be seen over this period is a predominantly reactive approach to crises rather than a clearly laid out plan of work.
- 4.4.3. It is widely recognised now that working with children and young people who are subject to CSE is extremely complex and success is rarely something that can be achieved, if at all, within short time frames or by single agencies. The vulnerabilities that often allowed children and young people to be groomed at the outset can be very complex, as can be seen from the limited picture drawn of these five children. Those vulnerabilities often continue to be used as a hook by the perpetrators even when children are subject to Child Protection Plans or Looked After by the Local Authority. Whilst there were undoubtedly some workers who were skilled and committed, it is difficult to judge whether they had adequate organisational support including access to managers with the skills or knowledge to properly support them and enable them. It is of interest that one of the IROs at the time commented that LAC Reviews should not be being used as analysis and decision making forums, suggesting that this was not taking place as part of normal management oversight and supervision.
- 4.4.4. Child J's experience also reflected the difficulty in establishing effective placements for children experiencing CSE. Child J spent a brief period in foster care, but this quickly broke down because she immediately and repeatedly went missing. Whether this was a suitable placement is not something that this Review can judge. However it does raise the question as to how effectively placements for a young person were assessed, whether a family based placement was most suitable and if so, what skills, training and support would the carers need to have had in place. What Child J's experience also demonstrates is the inability of the system to accommodate the individual needs of each child.
- 4.4.5. A foster placement for a child such as Child J would need to manage the behaviour that led her to be accommodated in the first place, as the behaviour, which was directly linked to her vulnerability and abuse, could not be expected to change in the short term and might not change during the period a child is in care. This may require a shift in thinking for both the those arranging the placement and the foster carers who will need to show persistence in the face of continuing risks; *'seeing past challenges to the need for compassion and unconditional acceptance'*<sup>11</sup>

---

<sup>11</sup> Shuker, L (2013:94)

- 4.4.6. For all of the children accessing appropriate, long term safe accommodation was a significant issue and it is not easy to detect a clear strategy for housing them. All five eventually found themselves in semi-independent accommodation, which they were poorly equipped to cope with. Supported accommodation such as the YPDA (Young People's Direct Access) accommodation or the YMCA in reality did not have the skills and capacity to meet these children's needs. Some of the children because of their circumstances were unable to maintain this type of accommodation and faced eviction because of their behaviour. The challenges that applied to Child J in foster care equally applied to the children in semi-independent accommodation and at times they struggled to meet the requirements placed on them. When Child J was found a placement in which she showed signs of settling, she was only able to stay there short term as its purpose was assessment. The system did not have the flexibility to allow her to stay.
- 4.4.7. Although none of the children had reached the age of 18 by the end of the period under review, this would have been a point for those not Looked After by the Local Authority when access to support would have come to an end. For those Looked After children the support from the Local Authority would have continued until 21. The absence of any meaningful transition into adult services for children who are likely still to have significant problems beyond the ages of either 18 or 21 is a cause for serious concern. We know from experience elsewhere, that some of these young people will still be involved with individuals who have been suspected of abusing them; they may be in long term relationships with them and possibly have children with them. We also know that CSE can impact on the victim's wellbeing into the future and can also affect children they may have. The impact of having been exploited can also re-emerge later in life<sup>12</sup> when those who are now adults may struggle to access appropriate services. This was a concern repeatedly identified by practitioners and senior managers in Coventry and results in a recommendation to this review:

**Recommendation:** The LSCB share this SCR with the Adult Safeguarding Board and review options for joint working or commissioning of services for the victims of CSE.

## **4.5 How the children's voices were heard and how they engaged with the professionals**

- 4.5.1. An important aspect of this Review was to gain understanding of the children's perspective on their experience. That we have not been able to achieve contributions directly from the young people concerned represents a significant gap in our understanding. The Review has, as far as possible, attempted to understand what the children might have been trying to say to professionals about their experience from what we know of their stories and

<sup>12</sup> Research in Practice (2015: 79)

the stories of others who have had similar experiences. The review has drawn on three other key sources of information to supplement what was available regarding these five children:

- Meeting with the Coventry Young People's CSE Reference Group
- National research
- Published Serious Case Reviews

4.5.2. Limited research has as yet been undertaken in relation to children and young people's perspectives on CSE<sup>13</sup>. The Cascade research which heard directly from a small number of young people who had experienced CSE identified a number of key issues including:

- Vulnerability to CSE arising as a result of other issues and feeling 'invisible' to practitioners and their families
- Instability in their care.
- Difficulties with family and relationships
- Risky activities (including alcohol and drug use) representing a way of asserting themselves and feeling in control
- Exchanging sex for some young people being the least worse option

4.5.3. Direct information about the children's views is hard to identify within the records that are available and where it is available it is of a mixed quality. Some positive information can be identified, for example, one of the children wrote a thank you letter to her school for their support after she left, and there is evidence within the children's records of some professionals working hard to gain their trust, seeking to hear their views and attempting to understand what was happening to them. The worker from Streetwise described being surprised at how much one of the children was willing to say about the abuse she was experiencing, evidencing that the children were at times willing to speak to trusted professionals given the opportunity and time to do so. Conversely there is evidence of poor practice regarding one of the children on two very significant occasions in that she was moved from her foster placement without consultation or discussion after disclosing sexualised incidents and secondly required to change school without any evidence of her wishes being taken into account.

4.5.4. What is very apparent from both the records and the information provided by the professionals was that the children's 'voice' could predominantly be detected through their behaviour, requiring a level of awareness and skill on behalf of individual professionals. Some professionals demonstrated a strong sense of what the children were telling them - '*reading between the lines*' where the child could not talk openly. One of the children was described as being '*desperate for help*' but at the same time refusing to talk to any of the agencies about what was happening to her. However, as has already been noted in this report, frequently the signs and symptoms of what was happening to the children went unrecognised, and even when disclosures were made this did not result in a positive outcome for them.

---

<sup>13</sup> Hallet, S (2015)

- 4.5.5. A thread that can be seen running through much of the response to the children is too great a reliance on direct disclosure from the children as to what was happening to them. In reality less than 1 in 10 disclosures are made to professionals<sup>14</sup>. This study by Cossar and others on behalf of the Children's Commissioner suggests that there is a '*spectrum of disclosure*' with four aspects: **hidden; signs and symptoms; prompted telling** and **purposeful telling**. The study identified that **prompted telling** could follow a sensitive response from a professional recognising a sign or symptom, or a gradual building up of trust with a professional over time. **Purposeful telling** required the young person to understand what was happening to them and deliberately approach someone, which was likely to be extremely difficult for most young people. It further identified that the personal qualities of the individual professional, rather than the agency, were crucial and included: "*reliability, privacy, continuity and power to act and change the situation.*"
- 4.5.6. The central role of the relationship that is developed between a professional and a young person receiving help or care is widely recognised and supported by a range of research. There is evidence that some individuals were working hard to achieve trusting relationships with the children and also evidence that some of the children were developing trust in those relationships. An example of this was one of the children specifically requesting to have contact with her previous adoption support worker. However, this is again focussed on individual workers, whereas from an agency perspective it appears only to have been the voluntary sector group led by Streetwise that took a strategic decision to prioritise relationship building and consistency during this period. Outside of the timeline for this Review it is the case that individual police officers working on the investigation regarding these children as well as on subsequent investigations, have often developed into being a very significant professional for some of the children. However this is recognised as being an unsustainable model given the police's role and their need to withdraw following completion of an investigation or trial.
- 4.5.7. Whatever the skills and qualities of individual workers, in the absence of a strategic approach from their agencies, these professionals could only make limited progress. Problems for professionals needing a more strategic solution included:
- Lack of confidence and skills in working with this age group and/or in relation to CSE.
  - Frequent changes of allocated worker
  - Agency roles and demands limiting opportunities to build relationships over time
  - Children with significant attachment problems being required to work with large numbers of professionals affecting the ability to build relationships "*it was doomed to fail*".
  - The children being unable or unwilling to speak to professionals because of the risks from the perpetrators of them making disclosures

---

<sup>14</sup> Cossar, J et al (2013:v)

4.5.8. Whilst the young people subject to this review were not able or did not wish to contribute, another recent SCR<sup>15</sup> which did benefit greatly from the young people's involvement provides some powerful messages, which clearly resonate with evidence from this Review including:

- *Recognise that it is very hard for us to see ourselves as victims and therefore to have any insight into what help we need. When we are displaying difficult and challenging behaviour, we want professionals from all agencies to have a greater awareness of this, especially schools.*
- *Know it is embarrassing to talk about sex – really important that you must not look embarrassed or go red, this just shuts us up.*
- *It is hard to say what is happening - we worry that it will get back to our families or to some of the people who did this, who might hurt us.*
- *If you want us to share, do stuff with us; find places that are comfortable out of your offices.*
- *Children need a safe place to go – this is very important.*
- *The public need to be aware of what can happen and report things*
- *There should be services on demand and at night when we really need you<sup>16</sup>*

Whilst it is crucial that each young person's needs are assessed and responded to individually the voices of these young people from Bristol offer an important addition our understanding of CSE.

4.5.9. A further important contribution to this review came from the Coventry Young People's CSE Participation Group. This is a group of young people who have agreed to work together with youth work staff from the Horizon team to contribute their views to the multi-agency approach to CSE in Coventry. These young people were generous in the way they gave their time and thoughtful in sharing their views with the Review. In particular they were able to give a perspective on how young people more generally might view CSE. There was a widely shared view that most young people still know very little about CSE and that education within schools was not really working. Whilst, for example, they could remember seeing a performance of Chelsea's Choice, a theatre production designed to raise awareness of CSE with young people, it seemed to have had little impact on them. Their analysis was that it took place in front of a large year group and no-one would want to be seen showing an interest in front of their peers.

4.5.10. This group of young people all felt that more could be done in schools to get young people thinking about '*healthy relationships*' so that they might recognise when they were not in a healthy relationship. All felt that there were not enough lessons about personal and social issues and that lessons on sexual and intimate relationships should begin in Year 7. In particular they felt quite strongly that Child Sexual Exploitation is not a useful term as far as young people are concerned. Their perspective was that the reference to '*Child*' meant that teenagers would not see it as something that

---

<sup>15</sup> **The Brooke Serious Case Review into Child Sexual Exploitation, Bristol LSCB, 2016**

<sup>16</sup> Messages from young people adapted from the Brooke SCR.



referred to them. Evidence has been provided to this Review that there is some very positive work taking place in some schools, however, the messages from these young people remains an important one.

- 4.5.11. When asked about who they would talk to if they had a concern about CSE, there was a strong collective view that they would find it difficult to talk to a parent and probably would not tell a teacher. They identified that the person they would speak to would be the youth worker working with them on the group, but also mentioned particular community police officers who they had got to know. This reflected many of the lessons from research which is that it is individuals that young people develop trusting relationships with that are key to any disclosure. Finally they spoke of the importance of peers who could offer support and suggested a confidential helpline might be useful – although there were different views about this.
- 4.5.12. To summarise, the strongest themes emerging from this analysis are in relation to the importance of relationships with key professionals and for all professionals to have a much better understanding of how and why young people may disclose their concerns. These issues are subject to a recommendation:

**Recommendation:** That the LSCB and partners consider how to promote and develop a relationship based model of working with older children who present as vulnerable and at risk.

## 4.6 Summary

- 4.6.1. In assessing the overall experience of the children in this case, it must be acknowledged that ultimately their needs were not adequately met and they remained at risk and vulnerable for too long. However, the picture of services is a mixed one, with evidence not only of poor or ineffective practice but of good, determined practice by some individuals and agencies. The police investigation when it was fully initiated was treated seriously and within three months it took the form of a full Major Incident Inquiry. For the children and those supporting them, this did represent a difficult period of delay, but it did not represent the entrenched failure to take these offences seriously that has been a pattern familiar from some other CSE investigations nationally.
- 4.6.2. It is evident now that all the children had experienced significant problems prior to the summer of 2012 when it was recognised that they were either experiencing CSE or were at high risk of CSE. The full extent of the children's problems and vulnerability would not have been apparent to all of the agencies or professionals at the time. Neither would it have been a simple matter of predicting that these children would be subject to CSE. Nevertheless there was enough information about each of the children which had it been collated and properly assessed could have led to a very different response.

4.6.3. Where there were weaknesses in the practice, these were often related to underlying issues now very familiar when we review historic CSE. These included:

- Lack of practitioner knowledge
- Lack of agency knowledge
- Critical or judgemental attitudes which reflected a lack of understanding of the impact of CSE.
- Skill and knowledge base in working with adolescents
- Resource pressures – for police investigation
- Resource pressures - social care
- Availability of suitable long term accommodation.
- Absence of a strategic multi-agency approach

4.6.4. In the absence of a strategic approach to CSE at Service or Board level at this time it is not entirely surprising that front line practitioners were often slow to identify that what was happening was CSE or struggled to respond despite recognising the signs. Practitioners informed this Review of the lack of information and training provided to them about CSE and some described themselves as '*gleaning*' what knowledge they could from the press. Several of the agencies have explicitly recognised that their knowledge base and experience of working with children who were at risk of CSE was quite limited and that this had an impact on the way they and their staff were able to work with them. For example, Compass, whose primary role was working with substance abuse have identified that this in effect meant they were working within quite a narrow focus and that their staff did not have the confidence or understanding to explore information given to them, which could have identified that CSE was an issue.

4.6.5. It has been a feature of this Review that the quality of the information available from some agencies, but particularly Children's Services has often been of a poor standard and therefore judgements about the actual quality of practice have at times been difficult. Nevertheless what is clear is that there was quite variable practice on an individual level and little evidence of clear management oversight or direction. To at least some degree the experience of this Review appears to reflect the conclusions of the OFSTED inspection in January 2014 about the quality of safeguarding practice more generally.

## **5. CURRENT PRACTICE AND THE IMPLICATIONS FOR FUTURE WORK**

### **5.1 Introduction**

5.1.1. Given the passage of time since the events analysed in relation to these five children, a key purpose of this Review was to consider:

- Could the same thing happen now?

- Has the approach of agencies evolved and what is there that still needs to be done?

5.1.2. No safeguarding partnership can be in a position to say that it is able to prevent all incidences of the abuse of children whichever form it takes. The nature of child sexual abuse and exploitation means that it is particularly difficult to eradicate and those who are determined to exploit and abuse children will find different means to do so, as the authorities become more successful in responding and detecting CSE. There is clear evidence however that the police, Children's Social Care and other key partners now have considerably more intelligence about the risks of CSE in Coventry and are proactively identifying and investigating cases. The Partnership has significantly more information about the numbers of children at risk, the potential perpetrators and how they link together. Evidence of intervention for example includes an increase in the number of harbouring notices over time and the undertaking of more forensic medicals for children who are believed to have been subject to abuse. A case audit undertaken in October 2015 concluded that:

*The professionals involved in working with children and young people at risk of CSE work well together and are engaged and dedicated to their work. Individually and as a group they held vast amounts of information on these children and were working often in very challenging circumstances to engage and protect those young people.*

5.1.3. Since 2012 there have been fundamental shifts in practice and approach to CSE both at a national and a local level. In Coventry this includes the development of a multi-agency CSE strategy and the setting up of a specialist multi agency team - the Horizon team - with dedicated workers who have established a good level of understanding of the complexities of working with CSE and an ever increasing knowledge base regarding the potential areas of risk for children and young people living in Coventry. It is also evident that there has been a significant reappraisal of the way in which complex CSE cases are now being investigated by the Police and Children's Social Care with a specific Complex Abuse Procedure for CSE now in established use in Coventry. The effectiveness of this approach is demonstrated by the fact that Coventry is currently running a number of serious and complex CSE operations across the city. There is also evidence from the increasing use of the required screening tool for CSE and subsequent referrals that there has been a cultural shift by front line practitioners in recognising the early signs.

5.1.4. The CSE Strategy is based on the three themes of Prevent, Pursue and Protect, it is regularly reviewed and gaps in the work plan identified. The CSE Strategy appears to be a dynamic strategy with strong leadership and good participation from agencies. A comprehensive toolkit has also been developed for professionals working with children and young people covering both procedures and practice. With regard to wider safeguarding practice Coventry Local Authority and LSCB has also been working to an Improvement Plan for the last 2 years following the OFSTED Inspection in

February 2014. Whilst this is not yet finalised, evidence of relevant improvements have been provided to this review.

- 5.1.5. The following section provides a number of examples of the developments in Coventry since September 2012. Whilst this cannot provide a comprehensive description of all the work that is taking place it does offer a picture of the range of changes that have taken place during the last 4 years. What becomes evident is that those significant weaknesses identified during the timeline of this review have all been considered by the relevant agencies and many changes resulted. This is not to suggest that practice is now perfect, that there may not be gaps in services or areas for improvement; however it does evidence that Coventry's response to CSE is crucially different to the response in 2010-2012.

## 5.2 Changes in practice

- 5.2.1. A crucial area is that of **early intervention services** provided to children, including older children and young people as these are a fundamental contributor to the future prevention of CSE. The approach to early intervention can be considered to have two different aspects. Firstly early intervention with children who are already known to be experiencing difficulties within their families. Secondly, preventative strategies for children and adults across the community.
- 5.2.2. The formal structure for Coventry's early intervention services is the Children and Families First Service within the Local Authority. This service works in partnership with schools, in particular providing the response to problems with attendance and provides a named worker to each school. The Service also co-ordinates CAF activity. All the staff in the service have now been trained in CSE and risk assessment and some workers have undertaken specialist training in Protective Behaviour Programmes. The senior manager is a member of the CSE Strategic Group. A detailed analysis of the role or effectiveness of the early help service provided within Coventry is beyond the scope of this Review. Its strategic role and approach is evidently actively reviewed and discussed at a senior level.
- 5.2.3. The quality of decision making within Children's Social Care regarding assessments and intervention with the children concerned has been a significant feature of this review. It has highlighted questions about the understanding of and focus on neglect in adolescents and whether good enough decisions were being made about thresholds for intervention, such as Child in Need or Child Protection procedures. Although there is evidence that children are now being referred to the Horizon team when CSE is identified, the Review is still left with questions about the consistency of practice regarding CSE across the neighbourhood teams and this remains a challenge to Children's Social Care. A multi-agency case audit was undertaken in October 2015 with future audits planned and these should provide an important contribution to measuring the quality and consistency of work over time.

- 5.2.4. Secondly is the issue of **preventative strategies** which are focussed on both children and adults within the wider community. Considerable work has been undertaken to raise awareness across Coventry and this represents one of the key facets of the CSE Strategy. Schools have a significant role to play in prevention with children. The research undertaken by Research in Practice in 2015 particularly identified the role of schools who they state *“represent an ideal forum for addressing attitudes and knowledge gaps”*<sup>17</sup>. Whilst there is evidence of considerable activity in some schools, the comments of the young people’s participation group raises some challenges about effectiveness. One area for potential development across the strategy is in relation to assessing impact of the activity. This is subject to a recommendation within this review.
- 5.2.5. Amongst the developments are
- Targeted work with proprietors of bed and breakfast accommodation, hotels, clubs and pubs, taxis, transport providers, shopping centres and food outlets, sports and recreational centres
  - Mandatory CSE training for taxi drivers
  - High profile CSE awareness week in 2016
  - Over 800 children taken part in awareness training sessions delivered by Streetwise
  - Use of social media to reach wider community and young people, including See Me, Hear Me website
  - Radio and TV advertising and other presence
  - Range of CSE training for practitioners by LSCB and across individual agencies
- 5.2.6. The improvement in the **investigation and identification of CSE** within Coventry is marked and is most apparent in the approach adopted by the Police alongside the specialist multi-agency Horizon team. West Midlands Police now has a dedicated Police CSE team in Coventry, although the resources available to the team are fully stretched. The Horizon team was established in May 2015 and consists of an experienced Social Work Team Manager, 2 Social Workers, a Police CSE co-ordinator, 2 Children and Family Workers, 2 detached Youth Workers and a Health Worker. The team has a high workload including mapping and investigation, providing awareness training, working directly with high risk children and young people, undertaking and supporting others doing risk assessments, working on safety plans. High priority is given to providing good quality supervision and also access to other support as necessary in recognition of the demands on team members and to avoid ‘burn out’ of staff. The balance of the team’s work is continually under review and there is a conscious awareness of the risks connected with providing a specialist service and the potential for this to deskill other workers.
- 5.2.7. The management of children missing from home or care had been an area of particular concern for the Board and partner agencies. The

---

<sup>17</sup> RIP (2015:67)

Board now receives regular updates on missing children as well as analysis of wider trends.

5.2.8. There is evidence of **improved information gathering and sharing**. This includes the use of a '5x5x5' intelligence form by which professionals can inform the police of any information of concern which then contributes to the overall police intelligence regarding CSE. The Horizon team also collects soft intelligence and are regularly refreshing their own knowledge regarding areas where children and young people gather and may be at risk. Two standing groups, the Missing Operational Group (MOG) and the CSE Operational Group (COG) ensure a multi-agency response to individual children and young people who go missing or are at risk of CSE. Other developments include:

- Training of a wide range of professionals in the CSE screening tool
- Developmental work underway on working with boys and young men
- A Multi-Agency forum in place for the management of perpetrators.
- Commissioning of supported accommodation for children and young people now includes requirements relating to CSE
- Range of disruption activities
- Clear pathway for referring children where an agency has a concern about CSE through the MASH team and from there to the Horizon team.
- Active focus on work with residential homes.
- Specific targeting of work with Looked After children.

At an anecdotal level practitioners who contributed to this Review also described a number of important improvements, including a shift in culture and a wide 'buy in' at senior levels of the priority given to CSE. They described better inter-agency communication and spoke of how valuable the Horizon team was as a resource to staff.

5.2.9. One other area where there has been a significant development with the potential for future impact not only locally but at a national level is in regard to the approach taken by **GPs when in consultations with sexually active children**. What was identified by the Named GP for Coventry was that the advice established for GPs when providing contraception to children (known as the Fraser Guidance) had for many years led to the common unintended consequence of directing GPs to focus exclusively on the protection of unwanted pregnancies in children, but without any corresponding focus on the safeguarding risks which a child may be facing.

5.2.10. As a result a new Guidance Document has been issued by the Local Medical Committees in Rugby and Coventry advising GPs not only to consider the appropriateness of prescribing contraception, but also asking a number of questions which might identify if the child is being exploited and with a clear statement that if this is the case there is a professional obligation to report this to the police. As well as launching the guidance and including it within IT systems, it has also been forwarded to NHS England for further

consideration. CCG Commissioners have also ensured that the contract bids for termination of pregnancy services include a specific requirement to engage with the CSE agenda.

- 5.2.11. Whilst this Review has not been in a position to comment in detail on the approach to **long term post abuse work**, this has nevertheless been raised on numerous occasions by practitioners and managers during the course of the Review. Provision of services in the medium to long term, for young people who have been exploited, represents one of the hardest challenges for partnerships. Significant changes have already been made to the commissioning of Supported Housing for children and young people, which now incorporates a specific focus on CSE. Similarly there is a recognition of the need for specialist fostering placements for older children. What is less apparent is whether there is a planned strategy for meeting children and young people's wider therapeutic needs. It is therefore the recommendation of this Review that work is undertaken to identify best practice in relation to longer term work and consider the implications for providing appropriate services to young people who have experienced exploitation in Coventry.

**Recommendation:** The Board to co-ordinate a task and finish group to consider the longer term needs of those children and young people who have experienced abuse and how these can be met within Coventry.

## 6. CONCLUDING COMMENT

- 6.1. The purpose of a Serious Case Review is to learn from the case in order that improvements to practice can be put in place and more effective help offered to families in the future. It is apparent that the services provided to these five children and their families fell short of what is understood to be good practice both now and also at the time. The children's vulnerability was not recognised and adequately acted on at an early enough stage making effective intervention increasingly difficult to achieve as they became more vulnerable to exploitation. Working with CSE is extremely complex and requires a high skill and knowledge base, which evidently was not consistently in place prior to 2012. Nevertheless there was also evidence of committed and positive practice which should not go unrecognised.
- 6.2. Significant changes to practice have however been made in the intervening 4 years. The conclusion of this Review is that these changes can reasonably be expected to have had a genuine impact on prevention and reduction of CSE in the city, although inevitably there will continue to be challenges for services in maintaining and improving the services to children and young people and identifying new risks.
- 6.3. Any number of detailed recommendations could be made for consideration as part of the current CSE strategy, from the nature of the training programme to enhancing the role of the third sector within the strategy. However a conscious decision was made at the outset of this Review to take a

proportionate approach, which reflected the level of work already being undertaken. This proportionate approach therefore includes the making of recommendations, the focus of which will be a small number of key areas arising out of the learning.

## 7. RECOMMENDATIONS FOR THE BOARD

- 7.1. **Recommendation:** The LSCB to ensure that assessing the impact of Coventry's CSE strategy on outcomes for children is identified as a priority including giving consideration to the option of commissioning a research led project to identify the outcomes.
- 7.2. **Recommendation:** That the LSCB and partners consider how to promote and develop a relationship based model of working with children who present as vulnerable and at risk.
- 7.3. **Recommendation:** The Board to co-ordinate a task and finish group to consider the longer term needs of those children and young people who have experienced abuse and how these can be met within Coventry.
- 7.4. **Recommendation:** The LSCB share this SCR with the Adult Safeguarding Board and review options for joint working or commissioning of services for the victims of CSE.
- 7.5. **Recommendation:** The Board to ensure that learning from this SCR regarding the vulnerabilities following adoption breakdown are shared with relevant professionals in order for the implications for post adoption support in Coventry to be considered.
- 7.6. **Recommendation:** This SCR to be shared with YMCA England in order for the lessons to be considered within the wider organisation, including access to safeguarding support for members of the Federation.



## REFERENCES

**Cossar, J et al (2013).** It takes a lot to trust (Office of the Children's Commissioner)

**HM Govt (2015) :** Working Together to Safeguard Children

**Hallet, S (2015):** Child Sexual Exploitation: Problems and Solutions from the perspectives of young people and professionals

**Munro, E (2011)** The Munro Review of Child Protection: Final Report a child-centred system

**OFSTED: (2011)** Ages of Concern: Learning Lessons from Serious Case Reviews

**Research in Practice (RIP): (2015)** Working Effectively to address Child Sexual Exploitation

**Selwyn, J et al (April 2014)** Beyond the Adoption Order: challenges, interventions and adoption disruption

**Shuker, L (2013):** Evaluation of Barnardo's Safe Accommodation Project for Sexually Exploited and Trafficked young people.