Leonard Consultancy

SBNI Safeguarding Board for Northern Ireland

An Evaluation of how Safeguarding Board for Northern Ireland member agencies are effectively responding to and managing Child Sexual Exploitation within Northern Ireland

28th February 2020

Acknowledgements

Leonard Consultancy and Associates want to acknowledge and thank the Safeguarding Board for Northern Ireland, its member agencies and their staff for their co-operation, assistance and engagement throughout this review.

In particular we would like to acknowledge the Trust CSE Leads, PSNI CSE Teams who facilitated the case file reviews, the focus groups and provided the access to the information we required.

We would also express our gratitude to those young people who also took part in the review.

Unconnected to this review, the Criminal Justice Inspection Northern Ireland (CJINI) had undertaken an inspection of the Criminal Justice agencies response to and management of CSE. In light of this and particularly because of the multi-agency nature of tackling child sexual exploitation SBNI Independent Review Team liaised with the CJINI Inspectors to share methodology and learning where appropriate and beneficial. The 15 case files examined for the SBNI Review were also assessed by the CJNI review team. The approach helped inform respective findings, although the evidence and recommendations remained separate to each.

Reviewers

This review was undertaken by Leonard Consultancy and Associates, led by Marcella Leonard, Sam Hughes and Duncan Sheppard. Curriculum Vitae of all reviewers can be accessed at www.leonardconsultacy.co.uk .

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List of abbreviations

ABE	Achieving Best Evidence in Criminal Proceedings (NI)
AHP	Allied Health Professions
CAMHS	Child and Adolescent Mental Health Service
CPCC	Child Protection Case Conference
CPSS	Child Protection Support Services (EA)
CPR	Child Protection Register
CSE	Child Sexual Exploitation
CRU	Central Referral Unit (Police Service of Northern Ireland)
DoH	Department of Health
DoJ	Department of Justice
EA	Education Authority
EOTAS	Education Other Than at School
GP	General Practitioner
HSCT	Health and Social Care Trust
Joint Protocol	Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2018)
LAC	Looked After Child who is in the care of a HSC Trust or is being provided with accommodation by a HSC Trust
LAC Review	Looked After Child Review of Arrangements
NICHE	Computerised system for managing information relating to criminal activity, criminal records, persons and incidents (Police Service of Northern Ireland)
NIHE	Northern Ireland Housing Executive

NIPS	Northern Ireland Prison Service
NSPCC	National Society for the Prevention of Cruelty to Children
PIA	Pre-Interview Assessment
PBNI	Probation Board for Northern Ireland
PPANI	Public Protection Arrangements for Northern Ireland
PSNI	Police Service of Northern Ireland
SBNI	Safeguarding Board for Northern Ireland
YJA	Youth Justice Agency

Terminology

The terminology in this report is taken from Department of Health: Co-operating to Safeguard Children and Young People in Northern Ireland (August 2017)

Sexual Abuse occurs when others use and exploit children sexually for their own gratification or gain or the gratification of others. Sexual abuse may involve physical contact, including assault by penetration (for example, rape, or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside clothing. It may include non-contact activities, such as involving children in the production of sexual images, forcing children to look at sexual images or watch sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via e-technology). Sexual abuse is not solely perpetrated by adult males. Women can commit acts of sexual abuse, as can other children.

Exploitation is the intentional ill-treatment, manipulation or abuse of power and control over a child or young person; to take selfish or unfair advantage of a child or young person or situation, for personal gain. It may manifest itself in many forms such as child labour, slavery, servitude, and engagement in criminal activity, begging, benefit or other financial fraud or child trafficking. It extends to the recruitment, transportation, transfer, harbouring or receipt of children for the purpose of exploitation. Exploitation can be sexual in nature.

Child Sexual Exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce,

manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/ or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. Sexual exploitation can also involve children or young people being trafficked, within and across domestic and international borders, to engage in sexual activity with multiple perpetrators. Sexual exploitation may also involve more than one abuser and a number of victims. Sexual exploitation can take many forms and victims and perpetrators can be from any social or ethnic background

Online sexual exploitation of children and young people involves a range of offending which includes, but is not limited to, online grooming and can occur without a child or young person knows they are being targeted.

Commercial sexual exploitation of children involves the use of a child or young person in sexual activities for gain usually by adults. It is irrelevant whether or not it is perceived that the child or young person has willingly entered a commercial 'arrangement' with the perpetrator; it is still sexual exploitation and abuse. Commercial sexual exploitation may involve some level of organised abuse, where an adult uses a position of power to coerce the child or young person into commercial sexual exploitation. This may involve the misrepresentation of an enticement or 'reward' or benefit for the child or young person, but this is not always the case. Offences associated with commercial sexual exploitation of children are contained within the Sexual Offences (Northern Ireland) Order

Executive Summary

The Marshall Inquiry 2014 followed by the Pinkerton Review 2015 highlighted the need for the Safeguarding Board for Northern Ireland member agencies to respond in a greater depth to the form of sexual abuse which is Child Sexual Exploitation. Significant resources in terms of appointments of CSE Leads within the 5 HSC Trusts, CSE police officers, extensive CSE training programme to raise awareness and transfer knowledge to practice has taken place. A CSE Subgroup within SBNI was established to co-ordinate the response to Marshall and Pinkerton reviews and to embed the strategic approach to CSE in Northern Ireland.

This review found these focused efforts have been effective in embedding the awareness and knowledge of CSE as a form of sexual abuse across the SBNI member agencies. There was a confidence and competence from practitioners across the member agencies in their recognition and understanding of CSE as a form of sexual abuse with specific characteristics. The appointments of the CSE Leads in both HSC Trusts and Police has overwhelmingly had a positive impact in enhancing the information sharing and joint working between police and social workers. This has led to a shared understanding between both agencies and as such improved joint working.

The establishment of a CSE Master List was originally to focus on those young people who were deemed most at risk, to share intelligence for detection and disruption. Although there has been a concerted effort to move the language from CSE Master List to young people 'at risk', the language of Lists was still prevalent throughout the Review. This List had a beneficial function in providing a focus to gain a more informed opinion on the nature and extent of CSE in Northern Ireland. However, this list has developed into what presents as a parallel process where young people are assessed as 'at risk' of CSE are placed on one of 5 Trust Lists depending on which area they live and if assessed to be at high enough risk then placed on a second list known as the Regional CSE List held by PSNI. Although, in recognising CSE is a form of sexual abuse, these young people are not always assessed for or placed on the Child Protection Register as Suspected or Confirmed Sexual Abuse.

It is acknowledged the initial development of having specific 'lists' to identify the young people at risk of exploitation had good intent and was beneficial in focusing agencies in their role, however, as this specific form of sexual abuse has become more understood, a review of existing processes is recommended.

Acknowledging existing processes in Trusts that young people who are deemed at risk of or have been subject of CSE are either on the Child Protection Register or Looked After Children or Family Intervention Support. This means there is no regional consistency that a child who has been deemed to be at risk of or has been victim of CSE is protected by the Child Protection Procedures yet acknowledging CSE is child sexual abuse. This review found the young people who are deemed at risk of sexual abuse through exploitation, or have been confirmed as having been sexually exploited, are presenting with such a range of different forms of child abuse and adversities they should be assessed, managed and interventions provided as complex child sexual abuse. As such their protection requires the rigour of governance of the Child Protection Process to ensure effective multiagency working, sharing of information to reduce risk and promote recovery. Complex child abuse requires a coordinated, multiagency response which is sequential and individualised for the young person's needs to be effectively met.

Recommendations

The assessment and management of CSE as a specific form of complex child sexual abuse should be managed within the existing Child Protection Processes; strategically it is recommended Departments consider this review's recommendations and restructure the current assessment and management process for CSE to fully reintegrate it within existing Child Protection work streams.

A separate CSE Regional Strategy is not recommended but CSE should be embedded within the established Child Protection processes which will address the specific nature of this type of complex child sexual abuse.

The recommendations are for SBNI Member agencies to consider and take forward are:

Recommendation 1:

I. Those young people who are deemed at risk of sexual abuse through exploitation present with significantly varied and multiple forms of abuse as well as having experienced and experiencing adversities which require assessment, management and interventions which are sequential, specific and should be governed within the child protection processes.

In acknowledging CSE is a form of sexual abuse, it must also be considered as Complex Child Abuse as evident from case files; these young people are displaying emotional and behavioural responses to complex trauma. To singularly label CSE and therefore focus on potential / suspected / confirmed sexual activity minimises the extent of the multiple abuses and traumas they have and are experiencing.

Complex Child Abuse is often displayed through young people's experiences such as:

- ✓ disrupted family life;
- ✓ history of adverse childhood experiences;
- ✓ sexual, emotional, neglect and physical abuse experiences;
- ✓ problematic / inconsistent parenting;
- ✓ disengagement from education;
- ✓ going missing;
- ✓ exploitative relationships including sexual, commercial, physical;
- ✓ drug and alcohol misuse;
- ✓ poor health and wellbeing.

It is recommended the current process of assessing a young person and placing them on a CSE list is ceased. It should be replaced by instigating the Child Protection pathway when a child or young person is deemed at risk of sexual abuse through exploitation. This will ensure all relevant professionals and agencies are statutory bound to share information and work together. It is recommended the holistic assessment of the young person is not limited to the naming of CSE, but recognition must be made of the complexity of the abuses and adversities experienced.

Assessing the young person within Child Protection processes will also ensure more consistent recording of the nature of the problem for audit purposes.

Agencies may continue to hold their own register of young people at risk to aid specific targeting of resources but not instead of the Child Protection Register.

Recommendation 2:

Sharing of Information

I. A joint Health and Criminal Justice Departmental letter should be issued to all SBNI member agencies to affirm their commitment to

effective safeguarding and child protection by assuring the sharing of information within and between agencies is paramount.

II. As per Recommendation 1 to assess and manage CSE within existing Child Protection Procedures, SBNI agencies are afforded the structure for the sharing of information which is already facilitated through these procedures and which all SBNI agencies own.

III. SBNI member agencies train all their staff in their organisational and professional responsibility in sharing of information with other member agencies for effective safeguarding and Child Protection which includes clarification of GDPR / Data Protection and its interface with protection of the child.

IV. District Councils increase their engagement with SBNI agencies strategically, but also through increased information sharing and engaging in regional consistency of the night-time economy CSE awareness training.

Recommendation 3:

Regional Adolescent Drug and Alcohol Service

I. The establishment of an adolescent regional drug and alcohol community-based service equipped with a residential component which has the expertise to provide trauma informed assessment and therapeutic interventions for both the young person and their family. This service should provide seamless therapeutic support for the young person and their family from the residential facility in their return to home through the community-based services in the young person's locality. This could be integrated into the Regional Care and Justice Campus Department of Health and Department of Justice work stream.

Recommendation 4:

Return to Home Interviews

I. PSNI and Trust Social Work undertake a review of the purpose, function and practice of the return to home interviews with the young person's needs at the core of this review. In the ethos of co-production, the involvement of the young person in the design and implementation should be central to this review.

Recommendation 5:

Building and Sustaining Relationships with Families / Carers of Young People deemed 'at risk' of CSE

I. Relevant SBNI Member Agencies should consider the development of a specialist therapeutic programme of work with parents / families / carers of young people at risk of CSE / complex child abuse to assist them in their relationship with their child, understanding of sexual abuse, sexual trauma including harmful sexual behaviours, in managing their emotional needs, relationship with each other, identifying and creating support networks to build their resilience. Building resilience within family systems is at the core in assisting the young person develop strategies within their families and networks to manage emotional needs and life experiences.

   This specialist therapeutic programme should be extended to the young person and their family when the young person is post 18 years of age and this is considered within the Young Adult strategy proposed in Recommendation 12.

Recommendation 6:

Training

I. Multiagency CSE training takes place which includes all relevant agencies including health, social and criminal justice agencies. This training should not only provide education in respect of what is CSE, identification, assessment, management of the victims but also in respect of perpetrators of CSE, sexual and violent offending. Training should also consider the legislation and understanding of sexual offences, capabilities and limitations of each agency's roles and responsibilities but also their powers to aid prevention, detection, disruption and management.

II. Training should also include Online Child Sexual Exploitation (OCSE) which involves crimes committed by offenders who use Information Communications Technology (ICT) and the internet to facilitate the sexual abuse and exploitation of children. This could be integrated into Safer [1]in a Digital World SBNI Priority.

[1] SBNI Annual Report 2018-2019

III. Collaborative training alongside PPANI would enhance the breadth and depth of this training from both victim and perpetrator perspectives.

IV. HSCT's named paediatrician and named nurse as per Co-operating to Safeguard Children and Young People in Northern Ireland 2017 should be included in training development and where possible delivery across their professional groupings.

V. Criminal justice agencies PSNI, YJA,PBNI and NIPS are included within multiagency CSE training to enhance knowledge among practitioners from all relevant member agencies in relation to the capabilities and limitations of their roles, responsibilities and powers

VI. PSNI officers handing intelligence receive training in safeguarding and Child Protection to enhance their assessment of the indicators of CSE to alert CSE/Child Abuse officers of relevant information

VII. Practitioners across a range of settings including field work, residential, Secure Accommodation and CAMHS are trained in specialist trauma recovery therapy including sexual trauma to enhance integration of therapy in daily activities with young people alongside more formalised therapeutic interventions.

VIII. It is recommended engaging young adults who have lived experience to assist in developing training programmes.

IX. Agencies have a programme of refresher training which is regularly updated with learning from practice, data collection and any case reviews.

X. All personnel working in PSNI CRU should ensure their decision making is informed by their knowledge of their training in the' Protocol for Joint investigation of alleged or suspected cases of child abuse'. It is acknowledged that PSNI have implemented a review process by CRU supervisors to quality assure decisions made by CRU staff regarding joint or single agency investigation decisions.

XI. CRU staff to give consideration to aggravating factors, adding to the complexity of a case, in their decision making and not just the facts of the current referral i.e.; any previous HSC involvement, history of Domestic Abuse / Violence, use of drugs or alcohol and so forth.

Recommendation 7:

Night-time Economy

I. In recognising there has been engagement with the hospitality sector and night time economy including through public awareness campaigns[2], it is recommended this continues to ensure awareness raising with the seven[3] categories of industries and workers: law enforcement, caring / supportive roles, provision of hospitality and leisure, provision of retail services, transportations services, regulation, licensing and inspection of industries operating in the night-time economy, as a by-product of their working role. It is important to ensure there is regional consistency in any training / awareness raising delivered but also engagement with relevant bodies such as Hospitality Ulster, Councils, and taxi companies to promote a regional dissemination of the learning to prevent local gaps in awareness. A variety of delivery methods is recommended such as online courses, face to face training sessions, open meetings, leaflets, videos to engage as many personnel and organisations as possible.

Recommendation 8:

Collaboration between victim and offender management within and between agencies

I. To further enhance the response to CSE it is recommended greater collaboration and sharing of information between those practitioners within and between agencies working with victims and those with offenders such as PPANI Principal Officers and CSE Leads, PBNI Designated Risk Managers, PSNI offender managers and child abuse investigators. This may require a review of PPANI Manual of Practice.

II. Consideration of replication of the model of good practice in NHSCT where CSE, MARAC, PPANI, HSB staff are all co-located to assist in sharing expertise, knowledge, intelligence which increases effectiveness and efficiency in working together. Where co-location is

[2] SBNI Annual report 2018-2019

[3] NatCen and CECSA: Responding to child sexual abuse and exploitation in the night-time economy. Kerr et al 2017

not feasible consideration to be given to increased opportunities for greater collaboration between the aforementioned agencies.

III. The inclusion of a sexual / specialist health nurse in this team would address the significant deficit of health engagement in the management of CSE.

IV. An increase in capacity for Intensive Support Services to address waiting lists and extend working hours beyond 9-5pm to be available in the evening when young people are more at risk and staff need more support.

Recommendation 9:

Co-located CRU Team

I. It is recommended a Social Worker is based within PSNI CRU to aid joint decision making in respect of children and young person's concerns to enhance information sharing and merging the shared risk.

Recommendation 10:

Data collection

I. It is recommended there is a collation of data in relation to CSE which provides greater understanding of the nature of the problem which includes developing a profile of the perpetrators of CSE, online and in person CSE and victim profiles to aid early intervention. This should also include specific data to differentiate between the number of known victims of CSE and those who are potential victims. The integration and centralisation of the data collected by all agencies should take place to gain a comprehensive, accurate prolife of the problem in Northern Ireland to aid policy and practice developments.

Recommendation 11:

Accommodation

I. Relevant member agencies should consider the development of a range of suitable accommodation for 16 plus young people to reduce their movement across different facilities which increase their vulnerability.

Recommendation 12:

Young Adults

I. A strategic approach is developed to manage those young people who were deemed 'at risk' of CSE prior to their 18th birthday. Improve coordination between SBNI and Northern Ireland Adult Safeguarding Partnership to establish a Young Adults Safeguarding Strategy to maintain support for these young adults and a coordinated transition of care from children's to the Adult at Risk of Harm services.

Recommendation 13:

Males

I. Continued development of information material specifically for young males to raise their awareness of risks of sexual abuse through exploitation, education regarding issues such as consent and the law.

Recommendation 14:

NICHE Alert

I. It is recognised that PSNI have commenced placing information on NICHE alerts regarding children whose names are currently on, or have been added to, the CPR. This is to be commended and it is recommended that this be expanded to include Looked After children where CSE is a concern.

   These alerts should have direction attached to them to assist police when contact is made with this young person. For those children on CPR /LAC detailed individualised profiles are added which provide key information to enhance engagement of the young person such as:

   - what works in engaging the young person;
   - any special considerations such as disabilities, language, autism, ADHD;
   - who to contact;
   - where to return the young person.

II. It is recommended PSNI advise PBNI via the Reportable Incident scheme if the name of a PBNI service user is linked to a child / young person whose name is on the current Trust or Regional CSE Lists, Child

Protection Register and / or LAC where sexual abuse through exploitation is a concern.

III. It is also recommended a NICHE alert is also placed against individuals of concern such as those recipients of Child Abduction Warning Notices

Review Report

Chapter 1: Introduction

Introduction

1.1 This review was commissioned by the Safeguarding Board in Northern Ireland (SBNI) to evaluate the developments made by its member agencies following the Marshall Inquiry [4] (2014) and SBNI Thematic Review led by Pinkerton[5] (2015) reports of how Child Sexual Exploitation (CSE) was being assessed and managed in Northern Ireland. These reports assisted the SBNI agencies in raising the profile of what is CSE, its presentation in Northern Ireland and how agencies were both collectively and individually responding. This review was therefore to consider the developments in respect of CSE within and between SBNI agencies with specific time focus since Pinkerton et al (2015) report.

1.2 The Terms of Reference (Appendix 1):

The evaluation is to examine both at a strategic and operational level how the member agencies of the SBNI are effectively addressing CSE from prevention to intervention within Northern Ireland.

1.3 Taking account of the Marshall Inquiry recommendations and the findings of the SBNI Thematic Review, the aims of the evaluation were to:

- review the effectiveness of the strategic response to CSE regionally and locally by SBNI member agencies individually and collectively;
- review the effectiveness of the operational response to CSE regionally and locally by SBNI member agencies individually and collectively;

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[4] Child Sexual Exploitation in Northern Ireland: Report of the Independent Inquiry- Marshall 2014

[5]Getting Focused and Staying Focused: 'Looked After Children', Going Missing and Child Sexual Exploitation. A Thematic Review. QUB

- identify gaps, or areas where improvements could be made to the strategic and operational responses to CSE regionally and locally by SBNI member agencies individually and collectively;
- identify a baseline against which future progress will be measured, expressed in terms of outcomes for children, young people and families; and
- Consider whether a regional inter-departmental, inter-agency strategic framework, supported by a regional action plan is required to address the gaps/areas for improvement identified.

Effectiveness was considered under the themes of:

1. Prevention;
2. Identification / assessment;
3. Early Intervention;
4. Protection;
5. Treatment / therapeutic intervention.

1.4 The evaluation also assessed how the strategic and operational responses to CSE by member agencies is being felt and experienced by those vulnerable to exploitation and those who are victims of CSE.

1.5 This report is completed in consideration of key legislative, policy and strategic developments since 2015. These are outlined in Table 1:

Table 1: Key Legislative, Policy and Strategic Developments 2015 – 2019 Underpinning the Practice Response to CSE in Northern Ireland	
August 2015	Pinkerton, J., Bunting, L., Hayes, D., & Lazenbatt, A. *Getting Focused and Staying Focused: 'Looked After Children', Going Missing and Child Sexual Exploitation. A Thematic Review.* Belfast: QUB
Sept 2015	SBNI Child Safeguarding Learning and Development Strategy and Framework 2015-2018
June 2015	Missing Children Protocol (Runaway and Missing from Home and Care) HSCB & PSNI
2016	The Public Protection Arrangements NI (PPANI) Manual of Practice (revised 2016)
Nov 2016	Notification of Children / Families assessed as being at potential risk and their whereabouts remain unknown. HSCB
2017.	Department of Health NI *Co-operating to Safeguard Children and Young People in Northern Ireland.* Belfast
Dec 2017	SBNI Regional Core Child Protection Policy and Procedures
2017.	SBNI CSE Guides for Young People, Parents and Carers and Those working with them CSE Awareness Week February 2017 – delivery of 3 educational plays to primary and post primary schools, highlighting both male and female, Barnardo's Nightwatch NI project Development of Shout Out Speak Out campaign and relevant Information materials. Delivery of 'Crashing' - Theatrical performance in respect of young males vulnerable to and experiencing CSE
June 2018	Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland. Belfast: HSCB, PSNI and NSPCC
June 2018.	DoH Signs of Safety Implementation in HSCT's
2018.	SBNI Evidence Review – Developing Trauma Informed Practice in Northern Ireland
2018-2022	SBNI EITP Trauma Informed Practice Project
Jan 2019	Chelsea's Story delivered to 12,000 post primary schools and professional audiences

Chapter 2: Methodology

2.0 The methodology used for the Review was structured in 3 parts

1. SBNI Member Agencies CSE Audit
2. Case File Reviews
3. Focus Groups

2.1 SBNI Member Agencies CSE Audit

A CSE Audit questionnaire (Appendix 2) was sent to all SBNI member agencies namely:

- NSPCC;
- Barnardo's;
- South Eastern Health & Social Care Trust;
- Southern Health & Social Care Trust;
- Western Health & Social Care Trust;
- Northern Health & Social Care Trust;
- Belfast Health & Social Care Trust;
- District Councils;
- Northern Ireland Guardian Ad Litem Agency;
- Police Service Northern Ireland (PSNI);
- Probation Board for Northern Ireland (PBNI);
- Nursing;
- Health & Social Care Board;
- Youth Justice Agency;
- Public Health Agency;
- Education Authority;
- CINI;
- SBNI Faith subgroup;
- Include Youth.

The Audit questionnaire asked each agency to consider CSE in their agency role and responsibility under 5 broad areas:

1. Strategic
2. Practice –
    - Identification of CSE by the agencies;
    - Assessment of CSE risk;
    - Engagement with young people;
    - Interventions which can be drawn upon;
    - Prevention tactics and options.
3. Training
4. Multi-agency working, and;
5. Communication.

2.2 Review of Case Files

In recognition of the parallel Criminal Justice Inspection NI into CSE management within criminal justice agencies and their identification of 15 cases, it was deemed prudent to review the same case files. This would enable a breadth of the analysis of the file from both review perspectives. There was one additional file reviewed as part of this review with agreement with the Reviewers and the Trust CSE Lead. All cases reviewed were female.

The time period for review in each file was agreed to cover the period from SBNI Thematic Review (Pinkerton et al 2015) August 2015 to April 2019.

The files were reviewed in the relevant HSC Trust and a CSE Lead from another HSC Trust joined the review team to assist in the review.

The breakdown of files reviewed in each Trust was:

- **South Eastern Health & Social Care Trust – 2;**
- **Southern Health & Social Care Trust – 4;**
- **Western Health & Social Care Trust – 3;**
- **Northern Health & Social Care Trust – 4;**
- **Belfast Health & Social Care Trust – 3.**

Of the files reviewed 3 were managed within a Family Support Pathway, 3 were managed within a Child Protection Pathway, 8 were managed within a LAC Pathway and 2 children were subject to 'Dual Process' (Child Protection and LAC Pathways combined).

2.3 Focus Groups

The review team conducted nine focus groups; the breakdown of the focus groups is as follows:

- Education Authority;
- PSNI and HSC Trust CSE Leads;
- Child Care Centre;
- Residential staff from units in the Western HSCT;
- Residential staff from units in the Belfast HSCT;
- Beechcroft Unit;
- Lakewood Secure Unit;
- Two case specific focus groups – one in Southern HSCT and in Western HSCT;
- Discussions were also held with Nexus, Include Youth, PPANI Co-ordinator, Barnardo's Safe Choices.

2.4 Interviews with young people.

Trust CSE Leads and VOYPIC were asked to seek the permission of young people who were currently on the CSE list if they would agree to take part in the review. 2 young people agreed, and both were interviewed.

Chapter 3: Evaluation of SBNI Member Agencies CSE Audit

3.1 The aim of the agency CSE audit was to enable agencies to self-assess where their agency is at in terms of their response to CSE under the broad headings of:

- Strategic;
- Practice –

  Identification of CSE by the agencies;

  Assessment of CSE risk;

  Engagement with young people;

  Interventions which can be drawn upon;

  Prevention tactics and options.

- Training;
- Multi-agency working, and
- Communication.

17 completed questionnaires were returned to the review team. All other member agency representatives contacted the Review team to state given their role it would not be relevant to complete the questionnaire as formatted but were able to reflect on their agency observations of how CSE as a theme had developed since the Pinkerton Review. Their observations are integrated throughout the findings under each heading.

3.2 Strategic

This section addressed whether agencies have in place a strategic plan, policies and procedures for CSE and the connecting issues such as missing persons.

Statistical analysis of responses

- 53% of the respondents stated they had a strategic CSE action plan;
- 65% of respondents stated they had a strategic action plan for missing Young Persons from home/school/care;

- 71% of respondents stated they had a CSE policy in relation to CSE and Missing Young Persons from home/school/ care;
- 82% of respondents stated their agency had a specific CSE procedure;
- 77% of respondents stated their agency had a procedure for missing young persons from home/school/care;
- 88% of respondents stated their agency used language derived from SBNI CSE documents to ensure there a consistency of terminology;
- 53% of respondents stated that CSE action plan was not a standing agenda item at strategic meetings;
- 41% of respondents stated they had a specific CSE escalation policy but a further 35% believed their staff knew how to escalate using other procedures;
- 75% of respondents stated they had appointed a CSE Champion.

Those agencies that have a bespoke CSE action plan, Policy and Procedure advised they review and update these documents through experience, evaluation and analysis of cases discussed at local and regional meetings. These meetings are stated as being multi-agency so there is a uniformity of process to update these documents.

Those agencies such as PSNI, District Councils, PBNI, and NIGALA, who do not have a bespoke CSE policy, have CSE incorporated within existing Safeguarding/Child Protection policies. Although PSNI are developing a bespoke CSE policy at the time of this Review, they have developed a Strategic Action Plan specifically in relation to CSE.

The use of a specific CSE 'Champion' is used by 75% of the agencies this includes people whose role is only CSE but additionally people who are more generalist safeguarding roles such as a designated safeguarding lead.

The response from PBNI advised that as their role was primarily with adult offenders there was perceived less relevancy assessment of CSE in their strategic approach in seeing this as victim focus.

Agencies report a variety of methods to internally report CSE matters this includes completion of UNOCINI referrals, speak via their CSE leads, liaise with specialised teams, discuss with their line managers, and make safeguarding referrals including the specialist CSE assessment

form. All of these methods are reported as the beginning of a referral process within their agency.

Agencies report they refer CSE cases externally mostly via Gateway often under advice from a safeguarding/CSE lead within their own organisation. The Trusts themselves report they escalate cases through their CSE leads.

All agencies report that new staff receives some form of CSE training which is either incorporated into existing safeguarding induction training or there are specialised courses.

Some of the improvements stated by agencies which require further completion are as follows:

- Engagement with community groups to enhance learning and support of the BME and migrant population;
- Greater emphasis on getting information concerning CSE to community and voluntary groups to promote and raise awareness;
- More proactive approach in relation to the Night-time economy; this would ensure hotels/pubs/taxi's etc. are alert to this and are aware of how to share concerns;
- Drug use is a significant feature for many young victims of CSE; resources for addressing this needs to be enhanced significantly. Consideration needs to be given to a specialist facility for drug use in Northern Ireland;
- More awareness training of how CSE fits in with some agencies work and what role staff plays in identifying and preventing.

Summary:

In general, the responses to the questionnaire in the strategic section reveal all SBNI member agencies have a strategic approach to CSE within their agency role however the breadth, depth and responsivity of this varies. Their overall strategic response is inconsistent both within and between the member agencies when considering the transferring of their policies to practice. Issues such as sharing of information between agencies remain a significant concern. It highlighted a need for some criminal justice agencies to place CSE at a more central focus in their work in assessing, managing and providing interventions with offenders of sexual and violent offences: as the evidence provided by for example, PBNI indicated they had no CSE strategic action plan, policy

or procedure. There is a need for enhanced collaboration between Trust and Offender Management agencies in relation to the intelligence provided by young people and the modus operandi of known sex and violent offenders. This needs to be embedded in agencies strategic policies and procedures. PBNI have indicated their intention to become a member of the SBNI CSE Sub Group and this is a positive development. PSNI has a strategic plan in relation to CSE.

3.3 Practice

This section of the questionnaire considered what practice developments in terms of identifying, assessing, intervening and managing young people at risk of CSE. It additionally requested information on prevention strategies and good practice which could be shared.

Statistical analysis

- It is noted not all member agencies are required to hold this information as it is dependent on their particular function.
- 47% of the respondents stated they had figures of the number of young people deemed to be at risk of sexual abuse through exploitation whom they were dealing with or enquiries about young people who were suspected to be subject of CSE;
- 77% of the respondents stated they do not record the ethnicity of the those deemed to be at risk of sexual abuse through exploitation and of those who do record there was inconsistency interagency as to what categories of ethnicities were used;
- 41% of the respondents stated they used the Appendix 1A contained within the Regional Guidance to assess potential victim of CSE;
- 59% of the respondents stated they had no assessment to identify a potential perpetrator of CSE. 29% stated they would use the AIM2 assessment framework.

✓ **Identification** of those who are deemed at risk of sexual abuse through exploitation: the respondents reported this has been enhanced through the 'Missing on 3 occasions or more' data collection by the PSNI. This involves identification of a young person who goes missing on 3 occasions; this is reviewed by the CSE Leads and assessed against the

Appendix 1A risk assessment framework. The information from the 'missing 3' list is shared monthly between PSNI and H&SCTs. Daily review of occurrences by Public Protection Branch Detectives and District Policing also trigger an assessment of a young person at risk of CSE following from any incident that causes concern. These are the two proactive methods of identifying young people at risk of CSE which are extremely positive. Respondents reported the remainder of cases are identified through safeguarding referrals from families, other agencies, and members of the public and internally from PSNI and H&SCT staff.

The challenges reported by respondents which remain for the identification of young people at risk of CSE are summarised as:

- The number of vacant social work posts in the HSCT's;
- The frequent turnover of staff and use of transient agency staff leads to a lack of consistency and knowledge base;
- CSE is more difficult to identify in boys;
- Young people often do not disclose the abuse they experience, or even identify that they have been abused;
- The peer networks young people have can lead to an acceptance of/ normalization of CSE and given their vulnerability this can be manipulated by perpetrators;
- District Councils and other agencies described their main challenge as staff resistance to recognise CSE as their core business;
- The Education Authority do not have an information sharing agreement similar to PSNI and HSCT Social Services which means that the EA and CPSS may not be part of the process or flow of information.

✓ **Assessment** of CSE: Respondents reported cases have been guided by the introduction of the 'Appendix 1A' risk assessment framework which supports the identification of potential victims of CSE. This assessment framework is not used by all the agencies; Barnardo's use their Sexual Exploitation Risk Assessment Framework (SERAF) which is currently subject to national Review. The SBNI CSE Sub Group are aware of this review and are awaiting the outcome of same to consider if or how this should be implemented in NI. Those agencies that do not use Appendix 1A refer their concerns using current safeguarding procedures to the HSCT Gateway service. Those agencies which assess perpetrators of harmful

sexual behaviour under 18 years use the specialised AIM2[6] risk assessment framework.

The challenges identified in the assessment are summarised as:

- Not all SBNI member agencies using the same assessment tool;
- There is a lack of consistency completing the Appendix 1A especially with newly qualified staff, Social Workers and agency staff;
- The Appendix 1A was difficult to complete as the young person often does not engage fully with the social workers in terms of sharing their experiences, names of persons of concern, thereby affecting the comprehensive in-depth completion of the assessments by the CSE Lead and field Social Worker. The Appendix 1A is however completed regardless of whether the young person engages with the assessment or not;
- Different professional opinions about risk particularly, between Police and Social Workers;
- Assessment of convicted sex and violent offenders undertaken using the relevant risk assessment models for young people (AIM2[7]) and adults (Stable and Acute 2007, ACE, RA1 and RM2K).

'In the NHSCT, any identified adult is visited jointly by PSNI/Social Services and they are advised their name has come to attention of both agencies and why. Appropriate advice and information is provided to identified individuals and their responses recorded. This information is logged onto SOSCARE and PSNI systems for future reference. NHSCT complete Specialist Risk Assessment for adults, Adjudicated Threshold Panel highlights individual who may pose a risk to children; subsequent home visits undertaken, and their views obtained. For peer on peer abuse; consideration will be given to AIM Assessments' (NHSCT).

'There is an investigative strategy created when an offender is identified. This assessment is usually completed through discussion between CSAE team members and supervisors rather than a formalised assessment tool. This is forming part of PSNI ongoing review'. (PSNI)

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[7] AIM2 is now updated to AIM3

- ✓ **Management:** Using the Appendix 1A risk assessment and the CSE List a review process occurs every 8 weeks; CSE Leads monitor the CSE 'At Risk' cases using joint agency forums with PSNI and each H&SCT; however other agencies such as District Councils, Probation, Health, Barnardo's may not be invited to attend these meetings. Probation attends these meetings if invited where the individual is known to Probation. There are other meetings which involve the assessment, monitoring and supervision of CSE cases such as Looked After Children (LAC) Reviews, Child Protection Case Conferences (CPCC), HSCT strategic meetings, local neighbourhood police meetings plus regular professional supervision within each agency. These meetings provide a forum for primarily information sharing. HSCTs record and monitor CSE cases using 'SharePoint' / 'Soscare' and 'PARIS' with monitoring of cases being conducted by the CSE Leads. There was no evidence of a systematic review of individual cases by agency senior management.

  The dynamic nature of cases and how organisations managed the ever-changing category of risk. This is summarised as:

  - The CSE Assessments are updated by the Social Worker for the bi-monthly CSE Review Meetings to reflect the change in the young person's circumstances. The action plan is amended accordingly;
  - Reviews are often convened more frequently than bi-monthly if the young person's circumstances change/ deteriorate;
  - There is ongoing liaison between Police and Trust staff to update information and take action as necessary;
  - Meetings such as Risk Strategy Meetings are convened at short notice if required to consider new and escalating risks;
  - HSCT staff continuously assess the ongoing needs of the young people and this dynamic assessment dictates what action needs to be taken or what supports need to be given to the young person;
  - Where necessary alerts are provided to Regional Emergency Social Work Service to ensure appropriate response out of hours;
  - Review of Young Person's Individual Crisis Management Plan and safety plan;
  - There is analysis regarding patterns of incidents in conjunction with the Police.

- ✓ **Engagement** of young people deemed at risk of sexual abuse through exploitation: Respondents reported this was highlighted as challenging as many of the young people do not recognise the risks they are exposed to and engaging in and therefore do not engage with professionals. 'Return to home interviews' have been highlighted as an important part of understanding the behaviours of young people. These interviews are conducted by PSNI and HSCT staff and are conducted under the Missing Children Protocol (2015); however, it was acknowledged by PSNI that there is room for improvement in the quality of these interviews.

  The challenges reported by the respondents in engaging young people at risk are summarised as:
  - The recognition of the role of the 'Return to Home interviews' but the challenge of the timing, appropriate personnel, purpose and perception of the young people to this process;
  - Having enough time to engage and gain the trust of the young people;
  - Disruption mechanisms available when a young person turns 16, and where they are not subject of a Care Order;
  - Waiting lists for appropriate intervention services;
  - Young people not wanting to or unable to, for a wide variety of reasons, engage with the Police to progress an investigation;
  - Resistance from young people themselves engaging with supports due to their substance abuse, and due to the effects of grooming;
  - Young people going missing and not being available to engage with supports to address their therapeutic needs.

- ✓ **Interventions** which were recorded as being currently provided included;
  - NSPCC, NEXUS, Safe Choices, Include Youth, HYPE, VOYPIC, TSLAC, Women's Aid providing direct therapeutic work for victims;
  - CAMHS, CAIT, Young People's Partnership, DAMHS, DAISY / Start 360, TSS, Scaffold Service, LAC Nurse, LAC Family Placement Support Worker, Fostering Intensive Support Team, Fostering Frontline services, providing educative, specific therapeutic interventions;

- NHSCT Links Team, SHSCT based NSPCC, SEHSCT / Belfast HSCT Aim to Change, WHSCT Moving on Therapeutic Service providing interventions for adolescents who have sexually harmed;
- Residential staff providing educative and therapeutic work, diversionary activities, advocacy, building and sustaining relationships, liaison with police, CSE Leads;
- Community resources provided by Action for Children, Rainbow, Church groups, YMCA, LGBT Support services;
- Rowan SARC, PSNI and CSE Leads undertaking ABE interviews;
- PBNI / NIPS providing intervention for adult sexual and violent offenders;
- Range of statutory and legal powers.

The respondents commented that the challenges which remain for interventions are:

- Child Abduction Warning Notices cannot be used for young people aged 16 and 17 years unless subject to a Care Order,
- Emergency Protection Order or Police Protection Orders for children over 16 years of age without parental engagement;
- Agencies recognise the need for more trauma informed intervention programmes to enhance the current programmes;
- Having to have a mental health diagnosis to access CAMHS;
- Lengthy waiting lists to access Trauma Informed Interventions / services;
- One Respondent suggested that CSE should be brought under the category of Child Sexual Abuse (CSA) in the Child Protection Process

✓ **Prevention** of CSE is recognised as difficult by all agencies due to the nature and 'grooming' by the perpetrators of the young people at risk. However, there were 5 points which emerged within the questionnaire.

1. Education of the young people and their knowledge of what healthy relationships should consist of; the risks of consuming excess amounts of alcohol and taking drugs. This education should address the health and risk impact for young people both in the short term but also raising their awareness of the longer term effects of alcohol and drug misuse. Additionally, it was highlighted by respondents that the wider public awareness of the nature of CSE must be improved which, is important for the early identification of

vulnerable young people through information to parents/carers and the night-time economy.

2. Resources and the lack of availability of secure accommodation for medium and long-term interventions to be successful. It is acknowledged by respondents that short-term crisis units are available, but there is a perception that these are not successful in the long-term. The respondents stated there needs to be more resources to provide long-term interventions which deal with complex trauma young people have suffered.

3. District Councils have a role in the prevention of CSE and they should be more actively involved in the management of cases at a local level but additionally at a strategic level to assist formulating local prevention strategies with PSNI.

4. PSNI take a more proactive investigation strategy into the identification of perpetrators of CSE. It was highlighted by the respondents their perception was that PSNI will not investigate a perpetrator until they are positively identified by a young person. However, due to the nature of the grooming between the young person and the perpetrator, the identification of the perpetrator is often too difficult for the victim. The lack of informed understanding by partner agencies of the PSNI role and responsibility to investigate as well as their powers in general was very significant and requires to be addressed within training as soon as possible.

5. The Education Authority (EA) has developed with partner agencies- PSNI, Health Visiting and the NHSCT CSE Lead, a CSE [8]preventative programme for 13-14 year olds. At present this has been used in schools in the NHSCT area. This multiagency awareness programme could be delivered across all schools. An evaluation of this pilot has been positive and has been tabled with SBNI for consideration of implementing the programme regionally. This has been accepted and work is underway to deliver this across the region.

[8] Evaluation of Year 10 Pilot CSE Programmes in Schools Sept 17-June 19: Education Authority

Practice improvements highlighted in the questionnaire:

1. Introduction of Appendix 1A assessment framework across agencies. The new risk assessment tool is more comprehensive and provides an evidential base to measure escalation or reduction in risk.
2. The development and dissemination of the CSE Regional Guidance.
3. The appointment of CSE Leads within the Trusts and PSNI which has provided support for other staff providing a level of oversight/governance of CSE cases and a single point of expertise.
4. Improved collaborative and joint agency working through co-location, understanding of PSNI and Social Work roles, risk strategy discussions, regular meetings (Joint Ops Liaison Group).
5. Each young person has an appointed Police Officer.
6. Improved structure in place for the CSE assessment process.
7. Professionals are better informed through CSE training and CSE leads.
8. The roll out of Barnardo's 'Safe Choices' as a one to one service.

Summary

Practice within the area of CSE has greatly enhanced in the last 4 years. The knowledge of CSE, signs, presentation, unique characteristics is evident within the agency's questionnaires. The respondents reported a number of significant improvements they believed had enhanced their own practice, especially the exchange of information and collaborative working. There is recognition by the reviewers that a significant amount of work goes into preventing young people becoming subject to CSE and this is reflected in the number and diversity of interventions which member agencies conduct with young people. However, this needs continued focus and in particular ensuring the increasing risk of exploitation through technology is included in prevention approaches.

There is also a clear need for training agencies, specifically Trust social workers, in the understanding of the role of the PSNI in investigation, their powers and responsibilities. The level of misunderstanding of the PSNI role was significant in all cases reviewed which had a direct impact on decision making.

3.4 Training

This section of the questionnaire was aimed at understanding of the type, depth, frequency of training provided to professionals and others who work in the extensively wide field.

Statistical analysis

- 53% of the respondents stated their agency provided specific CSE role training;
- 47% of the respondents stated their agency had mandatory CSE training;
- 44% of the respondents stated their agency had not provided any CSE training in the last year;
- 59% of the respondents stated their agency do not provide any refresher CSE training.

The majority of specific CSE targeted training is provided by an independent supplier, Nexus to the HSCTs. The specialist CSE training provided by Nexus is split into two levels and is provided to front line HSCT staff who work with young people. CSE Leads from PSNI and HSCT support this training by providing additional inputs for staff.

All other member agencies have incorporated CSE into their safeguarding/child protection training with no specialist CSE training provided.

Respondents reported that the challenges in training can be summarised as:

- Training needs to continue to include the night-time economy including taxi drivers, hotels and bars;
- 'Chelsea's Story' has had a positive impact in the training;
- The use of technology to expand the training options to assist reaching other groups such as night-time economy;
- Online Child Sexual Exploitation identified as an increasing problem presenting challenges for practitioners' knowledge in understanding this specific mode of abuse and the specific impact it has on victims;
- The need for ongoing refresher CSE training to maintain a currency of knowledge;
- Increase the quantity of CSE awareness raising with parents and carers;
- Respondent raised the possibility of engaging those with lived experience of CSE in developing and delivering CSE training.

Summary

The knowledge gained from the CSE training has significantly improved the understanding of this type of sexual abuse. There is clear evidence of the embedded knowledge and awareness of CSE within the agencies, their policies and communication with other agencies. However, at this stage there is a need for a regional CSE training strategy to refresh current training programmes, deliver NI informed CSE Refresher training to all member agencies as well as continuing to develop training for relevant organisations such as those working within the night-time economy.

3.5 Multi-agency working

The questionnaires revealed a plethora of multi-agency working including meetings and processes;

- CSE joint operational liaison group meetings and strategic partnership meetings;
- PSNI representatives chair SBNI CSE Subgroup and e-Safety Forum;
- Risk strategy discussions /meetings which involve professionals from other agencies and organisations;
- Co-location of Senior Social Worker Practitioner (SSWP) for CSE in police station;
- Working arrangements between Juvenile Justice Centres (JJC) and CSE Leads. JJC staff forward completed CSE assessments to CSE Lead for young people known to their Trust;
- CSE Lead gatekeeper to referrals to Barnardo's Safe Choices. Referral meetings take place between CSE Lead and Safe Choices worker to prioritise, allocate and review cases;
- CSE Senior practitioner is a member of the Domestic Violence and Sexual Violence Partnership;
- CSE senior practitioner member of SBNI e Safety forum;
- CSE regional lead member of SBNI CSE Sub-group;
- CSE regional lead line manager of Principal Officer for Public Protection Arrangements Northern Ireland (PPANI);
- CSE senior practitioner regularly meets with youth drug & alcohol workers;
- CSE regional lead alongside CSE senior practitioners are members of the bronze stakeholders group to respond to the PSNI strategic action plan to tackle CSAE;
- CSE Leads attend Family Support meetings, CPCC and LAC reviews;
- CSE Leads have regular liaison with VOYPIC, Barnardo's Safe Choices manager, youth justice and supported accommodation providers;

- VOYPIC staff attend residential meetings of young people who are on the CSE list.

The primary purpose of these processes and meetings is highlighted as information sharing but additionally highlights trends, people and places of concern. Additionally, although the CSE Subgroup is attended by various agencies such as Education Authority, NSPCC, Barnardo's, PSNI and Trust Social Services, the majority of these meetings are attended jointly by PSNI and HSCT staff with no other agency present.

The appointment of the PSNI and HSCTs CSE Leads is unanimously welcomed and valued. The close working relationship between the two roles supports information sharing, understanding of different roles, responses are believed to be more co-ordinated, and generally a better understanding of the nature of CSE in that area.

There were a number of concerns raised about staff turnover within PSNI and delay to replace these staff that have left or are on long term sickness. This is reportedly having an impact on the effectiveness of co working posts. The turn-over and lack of social work posts being filled was also highlighted as a concern.

Western HSCT has a Multi-Agency Concern Hub whose staff report their colocation has greatly enhanced information sharing and collaborative working.

The Belfast HSCT joint PSNI pilot scheme for missing person team was reported as an example of good practice.

Summary

There are good examples of joint working between the CSE Leads in Trust and PSNI. However, there is a need to build on the existing positive changes which have been made between PSNI and HSCTs so it can include other relevant member agencies and other community and voluntary organisations to effectively deliver multiagency working.

3.6 Communication

Agencies were asked about the effectiveness of communication within their own organisations and externally.

The vast majority of agencies stated they communicate both internally and externally through the variety of different processes which are indicated in the previous section. The communication between the PSNI and HSCT are reported to have improved through these.

However, other agencies reported limited or no communication about CSE including best practice, lessons learnt and specific young people at risk. The exception to this is with nursing who commented that there was good communication with HSCT when the young person was in the Child Protection processes.

The PSNI stated they believed their internal communication can be enhanced through a bi-monthly meeting with area Inspectors and the CSE Lead for updates on young people who are at risk and the perpetrators.

The District Councils reported they have limited communication externally and this is an area they wish to improve through attendance at more operational and strategic meetings.

The Education Authority stated their Child Protection Support Services (CPSS) does not have any formal information sharing arrangement with other agencies. The EA acknowledged schools were often involved and communicated about young people's concerns, but this does not extend to CPSS. They felt this was a significant gap as it did not allow any central overview of CSE within education.

Agencies were asked about communication with young people at risk of CSE and if this can be improved or provide examples of good practice. Responses indicated the importance of creating sustained and consistent professional relationships with young people and that there was no simple solution or quick fix with communications. Good relationships and thus communications took time, patience and investment at both strategic and operation level to achieve any meaningful result.

Summary

The communication between PSNI and HSCTs have improved but there appears to be a 'disconnect' with other agencies unless the young people are managed within formal Child Protection Processes. There was a strong message from other member agencies of the need for improved communication and sharing of information beyond PSNI and Trust CSE Leads to enhance multiagency working.

3.7 Additional comments.

Organisations were asked if there were any further comments they wanted to make. There was a recognition that early identification was the key and a need to bring in the third sector and other agencies such as NSPCC, District Councils, and school nurses to meetings earlier to support PSNI and HSCT both operationally and strategically.

Chapter 4: Case File Reviews

Case files examples of the complexity in the young people's lives:

History of child (pre 10 years) and adolescent sexual abuse, neglect, familial suicides, exposure to and victims of domestic abuse and violence, drug and alcohol misuse and dependency, removal from parental care, admission to residential care, exposure to behaviours such as running away, at risk of or confirmed CSE, aggression and violence, self-harm, school suspension / exclusion.

4.1 16 cases were reviewed with a focus of time period from August 2015 to April 2019. All but one of these cases were identified by the HMIC Inspectors who were reviewing as part of the CJINI inspection of criminal justice agencies management of CSE. All of the cases reviewed were female. Of the files reviewed 3 were managed within a Family Support Pathway, 3 were managed within a Child Protection Pathway, 8 were managed within a LAC Pathway and 2 children were subject to 'Dual Process' (Child Protection and LAC Pathways combined).

4.2 The case files were reviewed in the relevant HSC Trust with a CSE Lead from another HSC Trust present.

4.3 The case files confirmed the depth of complexity of the young people, their life experiences to date, extensive adversities, drug and alcohol addiction, serious self-harm and suicide attempts, chaotic family patterns, multiple house moves, placement moves, suspended or out of mainstream schooling, pregnancies, miscarriages, sexual traumas, sexual and physical assaults. The sustained professional relationship building was evident in all cases and a clear sense of purpose to protect and assist the young person to stay safe by all professionals.

Overwhelmingly, the core role of the CSE Lead within the HSC Trust and where possible PSNI was the oversight of the CSE aspect of a young person's case. Throughout all case files the CSE Lead was evident in providing consultation, advice, guidance, coordinating CSE assessment, liaising with PSNI CSE Lead, linking with other HSC Trust CSE

Leads, providing overview opinion on the case and strategic oversight. It was evident the CSE Lead was well known and their role integrated within the HSC Trust as the lead point of contact regarding CSE. Of importance was the consistency of the CSE Lead in the young person's life when often numerous changes of Social Worker. CSE Lead and the Police CSE Lead attended a young person's Child Protection Case Conference and Core Group meetings.

4.4 Overall, there was strong evidence of positive proactive practice with the young people, the emphasis was on building the relationship, clear evidence of positive engagement with the young person, there was an absence of victim blaming language which is indicative of a greater understanding of CSE as a form of sexual abuse as opposed to lifestyle choice. Recording in files evidenced insight into childhood adversities, impact of chaotic family experiences, childhood abuses, alcohol and drug misuse as methods of coping as well as mental health fragility. There was clear evidence of the development and application of trauma informed practice and decision making. Evidence of the Signs of Safety approach to working with families and the young people was present.

4.5 There was strong evidence of good joint working between the young person's Social Worker, the CSE Lead Social Worker and the Police. Where relevant there was active involvement with other services such as CAMHS personnel and also agencies such as Youth Justice Agency (YJA). CSE Leads and Police meeting with residential units on a monthly basis enhanced the relationship between the staff but also enabled the young people become familiar with the CSE Leads as well.

4.6 There was strong evidence in residential files of continued building and maintaining relationships with the young person even during sustained, and relentless episodes of leaving the units and after assaults on staff.

4.7 Although there was Trust variation in the practice of the CSE Leads despite regional job descriptions, the role of the CSE Lead in undertaking all young persons who are 'at risk' of CSE, Joint Protocol interviews was very positive. This enables the CSE Lead to build the relationship with the young person, to be a familiar face at a time of stress and distress but also to build intelligence for possible future disruption.

4.8 There was evidence of good co-working with CSE Lead and PSNI in visiting adults who have been identified by the young people to aid disruption and these have resulted in those adults no longer having contact with the young people.

4.9 There is a natural investigative, inquisitive approach adopted by CSE Leads and Police CSE officers which is assisting in the gathering of intelligence to enhance disruption and detection. Examples of CSE Trust and Police Leads using the information gained to identify both Human Trafficking and adult male offenders.

4.10 There was also evidence of preventive action of referring other children to social services when they are located with young people already known to the Trust / Police. Also, of other health professionals being alert to concerning signs, an example there was evidence of ambulance staff reporting seeing a young person getting out of a car pulling up their trousers and an older male getting out and reporting this.

4.11 Good evidence of reduction in incidents of young people reported missing three or more times to PSNI for example in South Eastern Trust statistical overview March 19 – August 19 39.79% lower than same period last year.

4.12 Child Abduction Warning Notice's (CAWN) are seen as useful as well as Article 68 Children's Order letters from the Trust but there are limitations of the Article 68 only relating to children subject to Emergency Protection Order/ Care Order /Police protection. There is evidence of practitioners using Article 68 letter as a first warning and then, where relevant, serving a CAWN on the same person as a second warning. There is a perception that the CAWN carries more authority than Article 68 letter whereas both give the same warning to the person. There was evidence of consultation between PSNI and Trust CSE Lead as to which is the most appropriate warning notice should be undertaken and this is usually a CAWN as it is seen as a more robust response.

Issues arising from the review of case files included:

- Although there was strong evidence of the enhanced working relationship and sharing of information between CSE Leads and PSNI

CSE Leads exists, there was a significant gap in sharing information regarding the CSE List with relevant other professionals such as young person's GP, School Nurse and agencies such as Education Authority, Include Youth who have direct contact with the young person. Assessing and managing CSE within existing the Child Protection Procedures and its facilitation for information sharing within and between agencies will address this gap. It is also acknowledged multi-disciplinary colleagues are invited to review meetings and sent minutes, but this does not always equate to their attendance at same.

- There is strong joint professional working with CSE Leads and PSNI CSE Leads but the depth of the information, insight, knowledge they hold regarding the young person is not always made available to other relevant professionals within their own or external organisations. For example, detailed individualised profile of the young person is completed by allocated social worker with a regional safety plan which is sent to the relevant CSE Lead and Police Lead. Yet this information which would greatly enhance PSNI Response engagement with that young person, is not evident or easily accessed in the NICHE system. Within Trusts this could be improved by the communication between CSE Lead and PPANI Principal Officer.

- There was evidence that before action was taken by Trust social work staff, there was a perception by the social workers that the young person had to confirm sexual abuse had occurred and obvious signs were ignored such as requesting the morning after pill, stating they are 'in a relationship' with an older person, reporting of pregnancy scares as well as pregnancies and miscarriages whilst under 16 years of age. This lack of understanding of what are criminal offences, when to report, the role of police in investigation and their powers were evident in all cases reviewed. The fact a young person may not engage in a referral to PSNI does not prevent PSNI from undertaking an investigation so clarity on the role of PSNI and knowledge of criminal offences is essential.

- After a young person returned from a period of missing from a residential unit or home there was not always evidence or disclosure of sexual exploitation but there was in all of the cases reviewed evidence of sustained alcohol and drug misuse. Case files were recording daily drug use, including one young person having to be placed in an

induced coma due to polysubstance misuse. The level of drug and alcohol misuse was further reinforced by the young people interviewed and including their account of their peers.

- Residential staff and parents having to manage seriously drug induced young people without knowledge of the quantity and type of drugs taken. There is limited specialist training for residential staff never mind parents in managing drug and alcohol misuse to the level evidenced within the case files.

- The case file reviews evidenced the complexities the young people who are at risk of CSE present with. There is a need to ensure the appropriate level of training, supervision and professional standards of those working with them to maintain boundaries. As well as appropriate investigative processes and if necessary disciplinary action instigated on any staff named by a young person engaging in inappropriate or criminal behaviour.

- There was a pattern of PSNI CRU agreeing a single agency investigation, but a potential criminal offence was being evidenced within the referral. Yet when a single agency investigation was decided there were no governance structures in place to revisit this decision e.g. single agency decision for Social Services to investigate but no procedure in place to follow up this decision such as the Social Worker must report back to PSNI within 24 hours. Therefore, there were delays in the alleged offence being investigated or at worst not investigated at all.

Every case file reviewed evidenced disclosures or behaviours which were not automatically referred to police when criminal offences had potentially taken place which included underage pregnancies, miscarriages, online / technology based activities. While acknowledging the dilemma of potentially criminalising young people for behaviours they engage in which may have a direct causal link to their CSE abuse, it is important any possible criminal behaviour is discussed with police for considered management and decision making. The possible intelligence and disruption which could also be gained from young people when investigating criminal behaviour must

be considered within the complexities of reporting young people's disclosures or behaviours.

- Cases were deemed not 'at risk' yet the concerns could have met the 'suspected sexual abuse' criteria of the Child Protection Register but were not automatically referred for consideration. There was a delay in placing a young person on the CSE list, yet significant risks were evident.

- Evidence in some cases of sustained, volatile, aggressive behaviours from young people towards staff, of staff trying to maintain the young person as well as alert to the needs of the other resident young people.

- Scarcity of Secure Accommodation places and the level of behaviours having to be managed by residential staff whilst waiting on an available bed. On release from Secure Accommodation many young people are immediately returning to similar aggressive behaviours and / or exposing themselves to the same physical risks, environment, and re-joining other young people who are running from the unit as well as being sexually exploited.

- Routine checks with PPANI Principal Officers within Trusts were inconsistent thereby missing essential information regarding individuals of concern.

- CSE assessment follows the young person to Lakewood but was not evidence of this standard practice occurring when the young person is admitted to Beechcroft.

- On occasions there was a lack of evidence of a sustained co-ordinated specific CSE programme of intervention work with parents and carers of young people who are deemed at risk of sexual abuse through exploitation. Christie 2016[9], Parkinson and Wadia 2015[10] highlight parents wanting respectful, honest relationships with

[9] Christie, C. (2016) PACE *Services Evaluation Report*. Chanon Consulting (unpublished).

[10] Parkinson D. and Wadia A. (2015) *Working in Partnership with Parents to End Child Sexual Exploitation: an evaluation of PACE's services*. London: Charities Evaluation Services (National Council for Voluntary Organisations).

supportive professionals. Provision of education to increase the parents' understanding of the dynamics of exploitation and providing them with support to protect their child.

- There was a lack of category on LAC forms to indicate the young person is being or at risk of sexual abuse, or on the CSE List. In one case reviewed for the young person's LAC Review the CSE Lead nor CSE Police lead were invited, PSNI are not automatically invited to the LAC Review unless there is an ongoing investigation or concerns regarding the young person being a victim of a crime or engaging in criminalised behaviour but are automatically to CPCC.

- Evident in several cases was a delay in placing the young person on the CSE list as professionals were wishing to gain more evidence but not considering referral to Child Protection under suspected Sexual Abuse.

- PSNI CRU inconsistent approach to the decision making in the referrals. Evidence of CRU treating referrals as individual incidents and not collating the previous known history thereby often recommending single agency rather than joint investigation.

- There was some reluctance in passing on possible criminal offences to the police for fear of criminalising a young person, yet it was evident in some cases, passing on the details could have assisted in disruption and detection of offenders. There is a need for greater collaboration in respect of the knowledge, attitude and decision making regarding criminal offences in how these are managed jointly by social services and PSNI. A young person disclosing to her Social Worker that she believed that she had sexual intercourse with an older male and although she may have believed she had consented to this, if she was unable to recall the events due to drugs and alcohol consumption. It was not recognised that this may have constituted the offence of rape and was not reported to PSNI at the time.

- Although there was clear evidence of good communication, with individualised information on a young person being exchanged between the CSE Lead / SW and Police CSE Lead, this individualised

profile was not as evident in NICHE or in other agency files. Having an individualised young person profile easily accessible on NICHE for Response Officers with key 'what works well' information would be useful to assist in engaging the young person specifically by knowing:

- ✓ How to best approach the young person;
- ✓ What are negative triggers;
- ✓ How to engage the young person, what works;
- ✓ What and who's number to ring;
- ✓ Safe words;
- ✓ Any special considerations e.g. autism, language, culture.

- Increase of online / technology assisted sexual exploitation but incidents of online sexual offences not being reported to PSNI.

- Concern that when a young person has been deemed at risk of CSE but not proceeded to Child Protection there is a delay in allocation to family support social worker.

- When young people are found with adult females there was a perception that the woman poses less harm or a risk of exploitation than with a male.

- Information on NICHE not always updated.

- There needs to be an increase in the analysis of what are the factors which increase vulnerability and address these as proactively as possible such as neglect, previous sexual abuse, chaotic family life, drug and alcohol abuse, network with other young people who are 'running' from residential units.

Specific Case Learning

One case file review required escalation by the review team due to significant concerns regarding the sharing of relevant information. This case is currently subject to an Independent Review Process and therefore it is not appropriate to reference the specifics of the perceived areas of concern. However, the case highlighted some concerns which were also evident in other cases reviewed in relation to:

- Sharing of communication within and between agencies;
- Poor interface between criminal justice agencies and Trust social work;

- Lack of sharing of intelligence with Trust PPANI Principal Officers to aid categorisation of PPANI risk management and PBNI / PSNI Designated Risk Manager (DRM);
- Looked After Children in contact with known violent and sexual offenders;
- Lack of information sharing from custody agencies to Trust social work to protect victims from their alleged offenders on release from custody;
- Lack of collaborative working between criminal justice agencies and Trust to connect the modus operandi of known sex offenders and the young people at risk of CSE in that Trust area;
- Lack of formal standards in the communication of child protection relevant information between criminal justice agencies and Trust social work.

In summary, the practice issues which were identified within the case files were not specific to the young person being at risk of CSE such as:

- Information sharing – a lack of clarity as to what could be shared with whom;
- Multiagency working – strong joint working with police and Trust CSE Lead but not as integrated with other professionals / agencies;
- Collaboration within agency departments / services and between agencies;
- Collaboration between criminal justice and health / social care;
- A need for greater inquisitiveness and working with the young person with a wider lens to other professional / agency roles which could assist in protection / detection/ conviction;
- Improved understanding other agency roles, responsibilities, powers, capabilities and limitations of these;
- Recognition of criminal offences – poor recognition of the range of criminal offences by Trust Social Workers which could assist in detection and conviction.

Chapter 5: Focus Groups

"(There is) increased confidence among residential staff in managing the risk of a young person running from the unit. Developing the relationship is the priority, there are more strategies to try to solve the problem of a young person missing. The safety plan is more inclusive with the young person and the diversionary work is identified as well as the risks they are taking and being exposed to. We have more confidence to have different and bespoke strategies for each child to manage the risk".

Professional from one of the focus groups

5.1 The focus groups were convened to provide a forum for professionals in practice to have an opportunity to share their perspectives on developments since Pinkerton Review (2015) and their vision for future practice. All focus groups engaged well and their commitment to working with young people who are at risk of CSE and continuing to improve practice must be acknowledged.

5.2 There was a strong message from all the focus groups that CSE is very much embedded in their practice, there was a greater understanding and insight into the complexity which is CSE. The development of trauma informed practice throughout the SBNI member agencies was evident within the focus groups and how this has aided the identification, assessment and management of those young people who are deemed at risk of sexual abuse through exploitation.

5.3 The appointment of the Trust CSE Leads and a PSNI CSE Lead has been a significant positive development; their role has improved sharing of information between the two agencies. Although there is a CSE Lead Job Description, how each CSE Lead applies this role in practice differs across the 5 Trusts. Some CSE Leads have direct involvement with the young people undertaking PIA / ABE interviews and one to one work. For example, one CSE Lead attempts to visit the young people on their list on a weekly basis especially at times of crisis however this is also dependent upon the engagement and willingness of the young people.

5.4 Police check their systems every morning and forward relevant information to CSE Lead who then disseminates to relevant social worker. However there needs to be improved communication from

these checks to other agencies such as PBNI if these checks relate to an individual known to them. It is therefore essential all offenders subject to PBNI supervision are noted on NICHE.

5.5 CSE Leads put information such as 'See CSE Rep' on the SOSCARE / PARIS information system relating to the young person which enables other colleagues to be advised of concerns relating to CSE and to contact the CSE Lead for more information but this requires the Social Workers to maintain regular checks on SOSCARE / PARIS.

5.6 At the time of this review, PSNI CSE Officers did not have a job description therefore inconsistency in their practice throughout the 5 Trust areas.

5.7 There was a sense of greater communication between two agencies, sharing of expertise and knowledge, weekly messages from all Trusts regarding those deemed at High Risk.

5.8 Much improved relationships between residential homes and neighbourhood policing and where there are consistent police personnel this was reported as being especially beneficial.

5.9 Greater sense of police being more trauma informed and therefore an improved relationship with the young people and the role of the residential staff. Co-location of Police and Social Workers in Belfast Trust has been beneficial.

5.10 Greater sense of competence and confidence reported by residential staff in managing their young people who are at risk of CSE. Although acknowledging the reality of continued and at times sustained periods of young people leaving the home, the staff reported a more positive sense in their management of this. Identifying training in CSE as being core to this improved professional capability but this being supported by the roll out of ACEs, Trauma- informed practice, Signs of Safety as well as the residential homes having a common approach such as the 'pedagogy model' to assist in understanding the young people and their behaviour.

5.11 Residential staff making themselves aware of the young person's individual triggers, signs, words, clothes, behaviours so they can introduce diversionary tactics sooner. Staff reported there was a sharing

of concerns with the young person, naming the risk, having open conversations and having police attend care plan meetings.

5.12 When staff recognise the signs that a young person is going to leave, and after everything tried to prevent this, they then resort to risk reduction / risk management approaches which include:

- Making sure young person has phone charged;
- Agreeing safe words;
- Agreeing to keep in contact;
- Using the relationship to improve communication.

5.13 'Return to home interviews' remain inconsistent and of poor quality; there is inconsistency in who completes these and their purpose. Consideration of when and who is best placed to undertake these interviews was suggested by both CSE Leads / Police and Residential Focus Group staff. Evidence of police call handler ringing to try to undertake a return to home interview.

5.14 The impact is huge on both a young person and staff when other young people in a residential home who are leaving, misusing alcohol and drugs as well as those being sexually exploited. Residential staff are having to assess and manage significant risk in respect of drugs and alcohol, in terms of a young person's safety, other residents' safety and staff safety. In acknowledging the commitment of staff to managing this risk, it is an unacceptable risk due to its frequency and unpredictability. A regional drug and alcohol adolescent service is required to address the complexity which this addiction presents to provide respite for staff and residents but importantly specialist intervention for the young person.

5.15 Significant deficit in the provision of a range of suitable accommodation options as well as the limited secure accommodation places, including a 'step down' from secure as often the young person has used secure as a respite from behaviours but returns to these when returned to community.

5.16 All new social work field and residential staff receive CSE training, but this is not afforded to the Allied Health Professionals. AHPs have received safeguarding training and CSE is included but this misses the

learning from a wider practice base of safeguarding of not being trained alongside social workers.

5.17 The added benefit of having multiagency CSE training was highlighted in all focus groups, the insight gained regarding different roles, responsibilities, capabilities and limitations cannot be underestimated. There has been joint training with PSNI and Trust Social Workers, but this was reported not to have taken place in the last 2 years.

5.18 Training is provided by Nexus since 2016 with a target annual minimum of 400 people but this has been substantially exceeded. The training was targeted for Social Workers in Safeguarding, LAC, Residential services, CAMHS but has been extended to other organisations such as taxi drivers, EOTAS, NIHE, Sexual Health Clinic, addiction services staff and Youth and Community staff. This service has been extended to March 2021.

5.19 Include Youth provides group and one to one intervention with young people referred by their Social Worker because they have been deemed at risk or have been sexually exploited. However, Include Youth staff are not informed if any of the young people are on the CSE List but are informed if they are subject to the Child Protection Register. CSE Leads may not be aware the young person who is on the CSE List is attending Include Youth. There is a need in recognising the role of all agencies in addressing CSE and therefore in sharing information.

5.20 Staff in specialist services such as Beechcroft and Lakewood were positive regarding the awareness of information coming into the units with the young person, although Beechcroft raised the inconsistency of the CSE assessment not always being available. Beechcroft highlighted the continued risk the young people can be experiencing and have found PSNI response helpful when cars have been seen outside the unit. There was recognition of the 'respite' nature of the young person's time in the specialist units as often returning to same environments, risk and adversities when discharged. Both units acknowledged the greater awareness, knowledge and understanding of CSE among practitioners including PSNI Response Officers thereby increasing joint working effectiveness.

> Being more informed means there has been a change from accepting the young person is going to run to asking if they have their phone charged, asking the young person to stay in touch if they can. The issue of consequences is at the end of the conversation and not at the beginning. It is about their safety and well-being and understanding they are running due to the trauma they have suffered.
>
> **Focus Group**

5.21 The 'CSE List'

- The origin of a CSE list was to assist the PSNI in having an insight into the number of young people missing, gathering intelligence and placing a focus on this type of sexual abuse. It is accepted PSNI continues to see benefit from having young people deemed at risk of sexual abuse through exploitation flagged as it provides focus for investigation of offences, disruption tactics and engagement with partner agencies and the young person. The CSE List has developed into a process which meets some of the needs of the PSNI and Trust CSE Leads/ Social Workers but has minimal added benefit to other professionals such as education and health. Management of cases within Child Protection processes would address this issue.

- It was also asked in every focus group what was the added benefit to the young person being placed on the CSE List which the CPR would not provide. There was an acceptance within the focus groups the significant added benefit of the CSE List has been to harness the working together of Police and CSE Leads in detection, sharing intelligence and disruption tactics thereby indirectly assisting the young person. However, there is a need to improve the involvement of other agencies such as Probation in these tactics if the offender is under the supervision of Probation. The need to utilise all SBNI agencies resources / communication and sharing of information in respect of known offenders / individuals of concern can only but enhance any intelligence and disruption tactics.

- There are two types of CSE lists and 6 different CSE Lists. The first type of List is held by the Trust and is known as the 'at risk' CSE List. There are 5

Trust CSE Lists each owned by an individual Trust and are created in conjunction with the Police and contains young people who are suspected of being sexual exploited or associated with young people who are suspected of being sexually exploited. This means that these Trust CSE lists will contain young people who have not been sexually exploited, have not disclosed sexual abuse but have been deemed at risk of CSE by either their behaviour or association with other at-risk young people. This Trust List is recorded on Trust IT systems such as SharePoint by the CSE Lead to track the case and identify patterns and all social work managers have access to the SharePoint database. It results in text going onto SharePoint asking for any information regarding this young person to be passed to the relevant CSE lead. The second is known as the Regional 'CSE List' and is sometimes referred to as the 'High Risk' CSE List which means the young person is confirmed of being exploited and a flag goes onto NICHE. This latter CSE list covers the whole of Northern Ireland and is owned by the Police.

- The nature of the CSE List process means there is difficulty in clarifying data as to how many young people are being sexually exploited, direct at risk of being exploited and those by association with other young people. The dynamic nature of the list means a young person can be removed, placed back on the list, removed again which is important in terms of maintaining dynamic assessment but difficult to ascertain the nature and extent of the problem.

- Referrals emanate from a variety of sources but raised to PSNI from the 'missing 3 plus times' statistics as well as through Public Protection Units and District Policing.

- In accepting CSE is a form of sexual abuse, there is no automatic Child Protection referral for a young person who is deemed 'at risk' or confirmed of CSE. The CSE List has become a process under which the young person is reviewed, which is every 8 weeks. Although some young people may also be subject to the CPR and / or LAC processes as well as CSE List review. All young people known to Children's Services are subject to assessment under one of 3 pathways:

  (1) Family Support;

  (2)Child Protection;

  (3)Looked After Child.

With a number of young people subject to dual processes i.e. Child Protection and LAC. Being on the CSE regional list does not exclude a young person being subject to CP or LAC processes. All pathway assessments require multi-disciplinary input. It is accepted that all young people on the CSE List should be referred to Child Protection but this is not always the case for LAC due to the 'Dual Process' policy. There was evidence those young people deemed at risk of CSE living at home whose parents were struggling to manage the risk behaviours were not always managed within the Child Protection process due to a perception of being seen to 'punish' the parents. The overwhelming recognition of the paramountcy of the child, the child is deemed at risk and parents are unable to protect would warrant consideration of the protection afforded by the Child Protection Register.

- The perception of what being on the list means for the young person should also be considered, for some young people they are ashamed at being on the List, for others it is a 'badge of honour' and described it as such in how peers on the List see it but there was evidence they do not always know they are on one of the Lists.

A brief description of the CSE List process involves the following:

- When a young person is considered 'at risk' of CSE, discussion takes place with the CSE Leads (both Trust and Police) and the Social Worker; the Social worker completes Appendix 1A, consults with CSE Lead, CSE Lead and Social Worker meet with CSE police colleagues.
- There are three options:
  1. The young person is added to the 'at risk' CSE List which is held by the Trust CSE Lead and more information to be gathered by the social worker for the Appendix 1A;
  2. Refer to a local Detective Inspector to make the final decision if the young person is to be placed on the Regional CSE List. This means they are confirmed at risk of being exploited;
  3. No further action is required / revert back to social worker to monitor and advise if further concerns become known.

- Police go with field Social Worker to meet the young person and their parents and explain the young person is now on the regional CSE list.
- Young person is reviewed every 8 weeks.
- Young person can be removed from the regional CSE List.

- The Trust CSE List young people have a Care Planning meeting every month, although perceived multiagency, other professionals such as GP, school nurse, LAC nurse are not informed the meeting is in respect of CSE hence may not be aware of the need to attend.
- There is a perceived no escalation process if the Trust CSE Lead disagrees with the Police Detective Inspector decision on whether the young person name goes on the regional CSE List. Although PSNI states there is an escalation process through the CSE quarterly meeting and to the Child Abuse Detective Chief Inspector. This escalation process should be made more widely known to CSE Leads and referring social workers.
- If the young person is not placed on the Regional CSE List, the field Social Worker will continue to monitor the young person in respect of CSE concerns and will bring any new concerns / information to the CSE Lead's attention.
- There is no formal process for a young person to apply to not be flagged on police systems.
- The assessment process of determining if a young person's name goes on the Trust 'at risk of CSE' is prone to subjectivity and there is no formal appeal for the young person to be removed from the List.
- All CSE Assessments (Appendix 1a) are retained by the CSE Lead regardless of the outcome for statistical analysis by the CSE Lead. This information is collated and sent to the HSCB on a monthly basis. This is replicated by all the HSCTs.
- The CSE risk assessment is reviewed by the allocated SW, Trust CSE Lead and CSE Lead Practitioner for PSNI bi-monthly which informs the UNOCINI pathway assessment and plan – the outcome will be shared and reviewed at CPCC, FS Review or LAC Review.
- The CSE Lead collects local data and analysis regarding the 3 + missing reports for onward referral to HSCB.
- All the CSE Lead's within the HSCTs convene a monthly regional meeting chaired by the Regional CSE Lead (SEHSCT). This forum allows for standardisation of practice across the region, ensuring all Trusts are dealing with the assessment information in a similar fashion. However, all CSE Leads operate slightly differently in terms of their direct role with the young people.
- The monthly Operational Liaison Group Meetings monitor the information shared and produce mapping and themes of information.
- There is a Bi-Monthly Review of each young person whose name is on the regional CSE List. Information is updated and reviewed and shared

appropriately in these meetings between HSCT and PSNI. However, there is a need to ensure information is also shared with relevant other agencies such as Probation DRM if the offender is under Probation supervision.

> There is greater awareness, a different attitude to how the young people are being treated by staff including police, there is a greater awareness of risk. Staff are actively trying to find them, more emphasis on diversionary activities and on building the relationship. There is an immediate identification of things which can help such as car number plates, listening for names, sharing information within and between residential homes. Having constant contact with the CSE Lead is really useful to coordinate and link the information.
>
> **Focus Group**

The added benefits of the CSE list as perceived by professionals included:

- ✓ CSE Lead oversight for intelligence, disruption, helps keep them safer, coordination of the case;
- ✓ Every child on the regional CSE list has identified police officer and field Social Worker;
- ✓ CSE Leads attends meetings, builds relationship with the child, enhances communication between police and social services, Police review relevant information at their morning meetings and refer on where relevant to the CSE Lead who update the risk assessments, make and identify links between children, identify patterns, CSE Lead takes the lead in CSE matters , manages the 'missing 3 times list', young person gets to know the CSE Lead and Police who will visit them and endeavour to build a relationship;
- ✓ Field Social Workers do 'Independent return interviews' within 72 hours – unless missing 7 days then another Trust CSE lead does that interview;
- ✓ CSE Lead 'gate keeps' referrals to Safe Choices – they meet monthly with Safe Choices;

- ✓ CSE Lead overview of your case, who we are concerned about and what action is happening, who I am at risk from, National Referral Mechanism – access to the independent guardian service;
- ✓ CSE List Action Plan is developed and reviewed.
- ✓ There was an incorrect perception the police had increased powers if the young person was on the CSE List;
- ✓ The young person is flagged on the Police NICHE if on the CSE Lists and on Trust SOSCARE / PARIS systems.

Overwhelmingly when all focus groups were asked as to what the benefits to the young person were being on the CSE List, it was accepted the significant benefit of the List is the sharing of information and joint working between the CSE Lead and Police. However, this sharing of information must ensure other agencies who are involved with the young person such as Education, Probation, Include Youth, VOYPIC and Prison are included where relevant. Management of children and young people via the Child Protection procedures would address this issue.

Young people's view

The young people who agreed to take part in the review were interviewed and both discussed their own experiences as well as providing commentary on their peers. Of significance they reported:

- Taking of alcohol and drugs as being a main focus on each occasion they left their accommodation;
- Not experiencing sexual abuse on all occasions;
- '*Having made the list'* and this being seen as a 'badge';
- Not knowing whether they remained on the 'List 'or how to come off the list;
- Not being aware of who knew they were on the 'List';
- They reported they had limited insight to the risks they were exposed to hence concern of repeated incidents in the future.

Overall in considering the current process of the assessment and management of young people who are deemed at risk of or confirmed sexual abuse through exploitation, it is considered this process has had a positive role in placing a focus on this type of sexual abuse since the Marshall and Pinkerton reports. It has enabled a focused approach to training, knowledge transfer to practice to the practitioners of the member agencies.

Of significance has been the enhanced joint working between the PSNI and Trust CSE Leads, the sharing of information and intelligence which has enhanced detection, disruption and conviction.

However, the sharing of information and improved multiagency working has not, on all cases, transferred to all other agencies and professionals. There has been a process which has aided enhanced joint working but must be increased to multiagency working. The presentation of those young people deemed at risk of or confirmed sexual abuse through exploitation would be best considered complex child abuse and as such assessed and managed as a complex case with integrated multiagency working governed by the child protection process.

Of concern, was the fact that out of 16 cases, 3 known convicted sex and violent offenders were in contact with young people who were all Looked After Children and subject to the Child Protection Register. One case required escalation as part of this review this resulted in the increasing of their PPANI risk management to Category 3. All 3 offenders were under current supervision of criminal justice agencies thereby raising concerns of the lack of sharing information and collaboration within and between agencies. The risk posed by known convicted sex and violent offenders whose modus operandi includes adolescent female should be shared and known by CSE Leads so as to limit risk of further sex and violent offending. All registered sex offenders are flagged in police systems as are young people at risk of CSE, but the review identified some gaps in the sharing of this known information within and between agencies. The challenge of identifying and managing risk of those individuals not convicted and not known to agencies is acknowledged but all efforts from all agencies must be made to reduce likelihood of any young person known to Trust Social Services and in particular those subject to the Child Protection Register and / or Looked After Child status having any contact with convicted sex / violent offenders who are managed under the PPANI. A review of PPANI Manual of Practice is recommended to enhance current practice.

Greater collaboration between Criminal Justice Agencies and Social Care is necessary to reduce likelihood of convicted sex and violent offenders posing a risk to LAC and young people on the Child Protection Register. Managing the young people as part of Child Protection Processes is required to ensure quality collaboration, multiagency working, sharing of information and sequential targeting of individualised interventions for such complex child abuse. A review of existing processes and procedures within the PPANI

Manual of Practice, the annual training of designated risk managers (DRMs) in respect of identification of CSE, potential offender modus operandi linking with at risk CSE young people and the sharing of communication / intelligence between criminal justice and Trust is considered to strengthen existing practice.

The review of the working of the CSE List has clearly highlighted its benefit in placing a focus on this specific type of sexual abuse as well as enhancing the joint working of PSNI and CSE Leads. There is an extensive array of meetings, sharing of statistics, sharing of intelligence which has developed alongside the CSE List which on the whole has an important function.

However, at this stage when CSE has been embedded in knowledge and awareness of the practitioners in the member agencies it is time to review the existing CSE assessment and List process. Practice based issues identified in this review were often linked to uncertainty regarding sharing of information, lack of understanding and awareness of the powers of other agencies with offenders and criminal activity. There was a lack of multiagency working on occasions but strong joint working between PSNI and CSE Leads but within different departments / services / roles within both PSNI and Trusts there were gaps in sharing information. Of significance was, at times, the singular focus involvement with the young person rather than considering wider multiagency approach to child protection

- what other agency / professional would need this piece of information?
- what powers has another agency / professional which could assist in protecting this young person?
- what other searches in IT system would provide more information?
- what other agency / professional could have a role with this young person?
- what other criminal offences are being potentially disclosed which could assist in disruption / detection?

In considering the complex nature of these young people, governing this work through Child Protection processes should limit the singular approach to these complex cases.

Overwhelmingly was the fact a young person not being on the Child Protection Register created a different response from other agencies than if they were. For those criminal justice, health, education and voluntary sector agencies a child on the CPR will trigger clear responses yet when a young

person is on a List deemed at risk of sexual abuse, it does not trigger the same response. The recognition of CSE as Sexual Abuse requires the governance rigour of the Child Protection Process in particular for the member agencies and voluntary organisations to trigger information sharing and child protection responsibilities.

Chapter 6: Summary of Findings

6.1 Since the Marshall Report and Pinkerton et al review it is evident that agencies have taken seriously the problem of CSE and sought to improve practice to tackle it. This is evidenced by the appointment of CSE Leads, both by HSC Trusts and PSNI. The past four years has seen the introduction of a CSE risk assessment structure involving consultation between social work and police CSE leads.

6.2 It was noted, both through the file review and focus group meetings, that there was an absence of victim blaming language and negative, 'lifestyle choice' attitudes expressed. This indicated an increased awareness of CSE as a form of child sexual abuse and a willingness to deal with it as such.

6.3 A view was expressed by both HSC Trust staff and Police Officers that joint agency training regarding CSE was beneficial. They commented that joint training increased understanding of each other's roles, responsibilities, powers and limitations whilst also building relationships. It is noted that this type of joint training has not occurred in recent years and concerns were expressed that through staff 'turn over', in all agencies there is a danger that stereotypical attitudes and misunderstandings of the young people at risk of CSE present may potentially develop.

6.4 Good relationships with partner agencies were highlighted as a key factor when attempting to deal with CSE. Social Workers and Police Officers agreed that the development and appointment of CSE Leads had improved relationships between the two agencies and had increased opportunities to communicate and share information. It was also viewed as a very positive development where CSE leads took an active role in engaging with the young person, being involved with any case investigation rather than having a management or overview role. It was also a positive development that in some areas PSNI neighbourhood officers visited HSC Trust residential units regularly and sought to build positive relationship with young people.

6.5 Throughout this review reference has been made to the 'CSE List', a list of young people who are deemed to be at risk of sexual exploitation or who are suspected to have been sexually exploited. It is apparent that, although a risk assessment will have taken place regarding each individual young person deemed to be at risk of sexual abuse through exploitation, there is no standardised objective criteria for adding an

individual to the regional CSE list and the assessment is based on an analysis of the existing factors and professional judgement. It is understood that a list of young people may have initially been developed to identify and direct resources towards young people believed to be at the highest risk of exploitation. However, some years on, this list has become a process creating undefined 'levels' of risk. Young people considered at highest risk are added to the regional high-risk list whilst others, where risk may still be identified, are not, but may be on a HSC Trust list. For young people whose name has been included on the list, this prompts the PSNI to create an alert on that person's profile on NICHE and their case is reviewed regularly. However, there is no automatic process in place to inform PBNI if a Probation service user is linked to a child on the CSE List.

6.6 The perception of some professionals that a young person's name been added to the CSE list brings with it, greater police powers, increased support services and an increased ability to share information is a misunderstanding. It is unclear what added value inclusion on the CSE list brings for the young person, apart from what would be identified as good police/social work practice for any young person where CSE is a concern.

6.7 There is little doubt that the development of the CSE list has brought some benefits. The relationship between Trust Social Workers and Public Protection Police Officers has improved as opportunities to meet face to face, share information and discuss and agree investigation strategies have increased. However, although the benefits are evident for Trust Social Workers and Police Officers there is little identified benefit to other agencies. There is limited evidence that information and decision making between police and Social Workers is shared with other agencies. The management of CSE appears to have become a joint agency process rather than a truly multi-agency process. Multi-agency professionals do not necessarily attend review/strategy meetings they are invited too, but also the lack of information shared between professionals and relevant agencies. This also affects the true meaning of multiagency / multi-professional. With this there has arisen the focus of dealing with the 'sexual exploitation' rather than the complex underlying vulnerabilities of the young person.

6.8 The development and maintenance of a CSE list appears to have become a parallel process to existing statutory Child Protection Procedures. Whereby a child suspected to have been sexually abused

may have their case discussed, by multi-agency professionals, at a Child Protection Case Conference and a decision made regarding the addition of their name to the Child Protection Register. A young person who is suspected to have been/being sexually exploited is discussed by Social Worker and Police Officer and a decision made regarding adding their name to the CSE list.

6.9 The CSE list also raises the question of what actions are taken regarding those young people who are discussed and assessed at being at risk of sexual exploitation, but a decision has been made not to add their name to the list. It is acknowledged that PSNI has taken the positive step of directing officers, via NICHE, to inform the CSE leads of any interaction/concerns they may have with these young people.

6.10 Work has commenced by PSNI to update NICHE to include children and young people whose names have been added to the Child Protection Register

6.11 Information Sharing: It is the view of the agencies involved in this review that the sharing of information has improved over the past number of years. However, some gaps still exist, both within and between agencies. Information and intelligence submitted within the PSNI is subject to an intelligence handling process. It is often the case that this process can take days or even weeks, resulting in the information not been made available to Police Officers for some considerable time. This may be a resource issue for PSNI.

6.12 The processing of police information is conducted by specific intelligence officers. Unless these officers are alert to the indicators and complexities of CSE there is a danger that important information may be added to the police NICHE system without actually being brought to a particular officer's/unit's attention e.g.; CSE lead/Public Protection. In turn, this may result in important information not being shared with partner agencies.

6.13 Similarly, Social Workers and staff from other agencies must also be aware of information they should share with PSNI. The file review revealed a number of occasions whereby young people, under the age to consent to sexual activity, had disclosed engaging in sexual activity or pregnancy was suspected and police were not informed. In these instances, the male person involved remained unidentified and it was not established that no inequality, force, fear, coercion or exploitation

existed. There is a need for better understanding across all professional groups regarding responding to and undertaking assessment of underage sexual activity as well as what constitutes a criminal offence.

6.14 The referral mechanism between PSNI and Social Services for cases of alleged or suspected child abuse, including CSE, is outlined in the 'Joint Protocol' guidance. The PSNI's Central referral Unit is the single point of contact for referral and information exchange in this process. It is at this early, referral stage that some issues have been noted. Following referral each agency conducts 'background checks' and exchanges information to assist in an agreement of how best to proceed with the investigation. On occasions background information has been précised, with important information omitted, resulting in an inappropriate agreement of how to proceed being reached. For example, a young person being missing from home for hours in the company of a number of older males being shared simply as a 'missing report – returned home.'

6.15 There also appeared, on occasions, to be a lack of analysis of the information shared. Often the decision agreed upon was based solely on the case being immediately referred in isolation of background information. It was seen that a number of cases were agreed as 'Single Agency PSNI Investigations' even though the young person had extensive previous or current social services involvement relevant to the current concerns. Where investigations are agreed as 'police only' some are allocated to uniform officers for investigation. This may be appropriate, but the risk exists that information obtained during the investigation is then not reported back to CSE/Public Protection officers and shared with partner agencies, as appropriate.

6.16 Referrals to/from PSNI CRU are agreed as 'Joint Investigation', 'Police Only Investigation' or 'Social Services Only Investigation'. It was evident that where many cases were agreed as 'Social Services Only Investigations', this decision was not congruent with Joint Protocol guidance. Agreeing at this stage that Social Workers alone investigate a case to establish the presence of consent, inequality, coercion or exploitation and indeed to recognise and identify criminal offences raises the risk of 'missing' the presence of criminal offences. It is viewed as a positive step that PSNI CRU have developed a quality assurance mechanism whereby CRU supervisors and managers 'dip sample' and review decisions agreed by CRU staff and Social Workers.

6.17 In summary, the overall findings of this review were positive, with the gaps identified and areas for consideration more related to general practice rather than CSE specifically. The CSE management process used at present, and use of a CSE list, grew out of a need to identify and manage the problem some years ago.

6.18 The current approach of not placing the victims of sexual abuse by exploitation on the Child Protection Register is based on the 'risk indicators' and educating these young people not to place themselves 'at risk'. When a young person is placed on the Child Protection Register as at risk of sexual abuse the focus is on protecting them and the risk issue is placed on the perpetrator. The 'at risk' indicators which are extensive means the focus is on the behaviours of the young person as opposed to the risk posed by the perpetrator. Also, some young people are placed on 'at risk' by being in the company of another young person who may be on the CSE list but no evidence that they are or will be sexually abused through exploitation.

6.19 The language applied to the young person as of being 'at risk' or assessed as low, medium or high risk by a subjective process with CSE Risk assessment items which Brown et al (2016, 2017) found had never been validated or evaluated empirically means not naming the young person as a victim of sexual abuse. Some young people are deemed at risk of CSE only by the nature of being in the company of another young person who is already 'at risk'. Therefore, there is a need to critically consider the criteria for 'at risk'. The language needs to recognise the young person as a victim rather than the categorisation of low, medium or high' Agencies responses are therefore victim led and driven with child protection the core role of the agencies. The current language being used in reference to the young people range from no concern at risk, suspected at risk, confirmed at risk but not confirmed sexually exploited / sexually abused to indicate how many young people have been sexually exploited indicating all deemed 'at risk'. These categories or language referred to in the case files would / should parallel the suspected sexual abuse and confirmed sexual abuse of the Child Protection Register but not all young people suspected at risk or confirmed at risk are subject to Child Protection Registration. Although agencies are stating there is no longer a Master List, or the use of high, medium or low, the threshold for the regional CSE List is perceived to be if the young person is deemed at high risk of CSE. So, a commonality of language used regionally should be considered.

6.20 The definition of CSE continues to focus on the behaviours and therefore the fact it is a form of sexual abuse this should be reflected in the process of how victims of sexual abuse through sexual exploitation are managed. This has a direct impact on how the young person is perceived and feels they are perceived by professional.

6.21 There requires further targeting of the appropriate response to the perpetrators of sexual abuse by exploitation and re focusing the fact the young person is a victim of sexual abuse within the Child Protection system will aid this refocus. Therefore, criminal justice agencies tasked with managing offenders must have a stronger collaboration role with Trust HSCT CSE Leads in sharing information, identifying the modus operandi of the offender, potential victim targeting and use of powers to aid disruption of CSE activity. This may require a review of the PPANI Manual of Practice.

6.22 The developments to date of increasing knowledge, awareness and practice in managing CSE as a form of sexual abuse has been effective in the member agencies. However, this review would recommend those processes which have been developed to date to manage CSE are reviewed and the integration of CSE within the Child Protection processes will provide governance to ensure and promote effective multiagency working to address this complex form of child abuse.

6.23 There is evidence of preventive work through education and awareness raising with organisations but also with young people through SBNI targeted events but also member agencies such as Education Authority, Include Youth, CiNi as well as other voluntary organisations. This work is commended and encouraged to be increased especially with males, ethnic minority groups and increasing awareness of exploitation through technology.

6.24 The case files reviewed did not lend to identification of early intervention given these young people were already deemed at risk or had been sexually exploited and their case histories evidenced significant forms of abuse and multiple adversities. It is in the recognition of the increasing vulnerability to CSE when having been a victim of other forms of abuse and adversities which lends to the need to consider Child Protection processes sooner rather than delay to intervene as soon as possible to reduce vulnerabilities.

6.25 As highlighted the core issue within this review is the need to place the young people within the Child Protection process to have governance over multiagency working, sharing of information and holistic assessment and interventions. The cases are evidence of complex abuse and as such require child protection rigour for all agencies to collaborate effectively.

6.26 There was evidence of interventions in the form of education, one to one support, CAMHS, Safe Choices, Beechcroft however limited evidence in terms of addressing a core vulnerability of drug and alcohol misuse due to lack of residential facility leaving the risk to be managed in open residential units. There was a lack of evidence of planned educational work with families and carers and of sexual trauma specific work.

Chapter 7: Recommendations

7.1 Recommendation 1:

Recommendation 1:

I. Those young people who are deemed at risk of sexual abuse through exploitation presented significantly varied and multiple forms of abuse as well as having experienced and experiencing adversities which require assessment, management and interventions which are sequential, specific and governed within the child protection processes.

In acknowledging CSE is a form Sexual Abuse, it must also be considered as Complex Child Abuse as evident from case files, as these young people are displaying emotional and behavioural responses to complex trauma. To singularly label CSE and therefore focus on potential /suspected / confirmed sexual activity minimises the extent of the multiple abuses and traumas they have and are experiencing.

Complex Child Abuse is often displayed through young people's experiences such as:

- ✓ disrupted family life;
- ✓ history of adverse childhood experiences;
- ✓ sexual, emotional, neglect and physical abuse experiences;
- ✓ problematic / inconsistent parenting;
- ✓ disengagement from education;
- ✓ going missing;
- ✓ exploitative relationships including sexual, commercial, physical;
- ✓ drug and alcohol misuse;
- ✓ poor health and wellbeing.

It is recommended the current process of assessing a young person and placing them on a CSE list is ceased. It should be replaced by instigating the Child Protection pathway when a child or young person is deemed 'at risk' of CSE. This will ensure all relevant professionals and agencies are statutory bound to share information and work together. It is recommended the holistic assessment of the young person is not limited to the

naming of CSE, but recognition must be made of the complexity of the abuses and adversities experienced.

Assessing the young person within Child Protection processes will also ensure more consistent recording of the nature of the problem for audit purposes.

Agencies may continue to hold their own register of young people at risk to aid specific targeting of resources but not instead of the Child Protection Register.

7.2 Recommendation 2:

Sharing of Information

I. A joint Health and Criminal Justice Departmental letter should be issued to all SBNI member agencies to affirm their commitment to effective safeguarding and child protection by assuring the sharing information within and between agencies is paramount.

II. As per Recommendation 1 to assess and manage CSE within existing Child Protection Procedures, SBNI agencies are afforded the structure for the sharing of information which is already facilitated through these procedures and which all SBNI agencies own.

III. SBNI member agencies train all their staff in their organisational and professional responsibility in sharing of information with other member agencies for effective safeguarding and child protection which includes clarification of GDPR / Data Protection and its interface with protection of the child.

IV. District Councils increase their engagement with SBNI agencies strategically, but also through increased information sharing and engaging in regional consistency of the night-time economy CSE awareness training.

7.3 Recommendation 3:

Regional Adolescent Drug and Alcohol Service

I. The establishment of an adolescent regional drug and alcohol community-based service equipped with a residential component which has the expertise to provide trauma informed assessment and therapeutic interventions for both the young person and their family. This service should provide seamless therapeutic support for the young person and their family from the residential facility in their return to home through the community-based services in the young person's locality. This could be integrated into the Regional Care and Justice Campus Department of Health and Department of Justice work stream.

7.4 Recommendation 4:

Return to Home Interviews

I. PSNI and Trust Social Work undertake a review of the purpose, function and practice of the return to home interviews with the young person's needs at the core of this review. In the ethos of co-production, the involvement of the young person in the design and implementation should be central to this review.

7.5 Recommendation 5:

Building and Sustaining Relationships with Families / Carers of Young People deemed 'at risk' of CSE

I. Relevant SBNI member agencies should consider the development of a specialist therapeutic programme of work with parents / families / carers of young people at risk of CSE / complex child abuse to assist them in their relationship with their child, understanding of sexual abuse, sexual trauma including harmful sexual behaviours in managing their emotional needs, relationship with each other, identifying and creating support networks to build their resilience. Building resilience within family systems is at the core in assisting the young person develop strategies within their families and networks to manage emotional needs and life experiences.

This specialist therapeutic programme should be extended to the young person and their family when the young person is post 18 years of age and this is considered within the Young Adult strategy proposed in Recommendation 12.

7.6 Recommendation 6:

Training

I. Multiagency CSE training takes place which includes all relevant agencies including health, social and criminal justice agencies. This training should not only provide education in respect of what is CSE, identification, assessment, management of the victims but also in respect of perpetrators of CSE, sexual and violent offending. Training should also consider the legislation and understanding of sexual offences, capabilities and limitations of each agency's roles and responsibilities but also their powers to aid prevention, detection, disruption and management.

II. Training should also include Online Child Sexual Exploitation (OCSE) which involves crimes committed by offenders who use Information Communications Technology (ICT) and the internet to facilitate the sexual abuse and exploitation of children. This could be integrated into Safer [11]in a Digital World SBNI Priority.

III. Collaborative training alongside PPANI would enhance the breadth and depth of this training from both victim and perpetrator perspectives.

IV. HSCT's named paediatrician and named nurse as per Co-operating to Safeguard Children and Young People in Northern Ireland 2017 should be included in training development and where possible delivery across their professional groupings.

V. Criminal justice agencies PSNI, YJA, PBNI and NIPS are included within multiagency CSE training to enhance knowledge among practitioners from all relevant member agencies in relation to the capabilities and limitations of their roles, responsibilities and powers.

[11] SBNI Annual Report 2018-2019

VI. PSNI officers handing intelligence receive training in safeguarding and child protection to enhance their assessment of the indicators of CSE to alert CSE/Child Abuse officers of relevant information

VII. Practitioners across a range of settings including field work, residential, secure accommodation and CAMHS are trained in specialist trauma recovery therapy including sexual trauma to enhance integration of therapy in daily activities with young people alongside more formalised therapeutic interventions.

VIII. It is recommended engaging young adults who have lived experience to assist in developing training programmes.

IX. Agencies have a programme of refresher training which is regularly updated with learning from practice, data collection and any case reviews.

X. All personnel working in PSNI CRU should ensure their decision making is informed by their knowledge of their training in the' Protocol for Joint Investigation of Alleged or Suspected Cases of Child Abuse'. It is acknowledged that PSNI have implemented a review process by CRU supervisors to quality assure decisions made by CRU staff regarding joint or single agency investigation decisions.

XI. CRU staff to give consideration to aggravating factors, adding to the complexity of a case, in their decision making and not just the facts of the current referral i.e.; any previous HSC involvement, history of Domestic Abuse / Violence, use of drugs or alcohol and so forth.

7.7 Recommendation 7:

Night-time Economy

I. In recognising there has been engagement with the hospitality sector and night time economy including through public awareness campaigns[12], it is recommended this continues to

[12] SBNI Annual report 2018-2019

ensure awareness raising with the seven[13] categories of industries and workers: law enforcement, caring / supportive roles, provision of hospitality and leisure, provision of retail services, transportations services, regulation, licensing and inspection of industries operating in the night-time economy, as a by-product of their working role. It is important to ensure there is regional consistency in any training / awareness raising delivered but also engagement with relevant bodies such as Hospitality Ulster, Councils, and taxi companies to promote a regional dissemination of the learning to prevent local gaps in awareness. A variety of delivery methods is recommended such as online courses, face to face training sessions, open meetings, leaflets, videos to engage as many personnel and organisations as possible.

7.8 **Recommendation 8:**

Collaboration between victim and offender management within and between agencies

I. To further enhance the response to CSE it is recommended greater collaboration and sharing of information between those practitioners within and between agencies working with victims and those with offenders such as PPANI Principal Officers and CSE Leads, PBNI Designated Risk Managers, PSNI offender managers and child abuse investigators. This may require a review of PPANI Manual of Practice.

II. Consideration of replication of the model of good practice in NHSCT where CSE, MARAC, PPANI, HSB staff are all co-located to assist in sharing expertise, knowledge, intelligence which increases effectiveness and efficiency in working together. Where co-location is not feasible consideration to be given to increased opportunities for greater collaboration between the aforementioned agencies.

[13] NatCen and CECSA: Responding to child sexual abuse and exploitation in the night-time economy. Kerr et al 2017

III. The inclusion of a sexual / specialist health nurse in this team would address the significant deficit of health engagement in the management of CSE.

IV. An increase in capacity for Intensive Support Services to address waiting lists and extend working hours beyond 9-5pm to be available in the evening when young people are more at risk and staff need more support.

7.9 Recommendation 9:

Co-located CRU Team

I. It is recommended a Social Worker is based within PSNI CRU to aid joint decision making in respect of children and young person's concerns to enhance information sharing and merging the shared risk.

7.10 Recommendation 10:

Data collection

I. It is recommended there is a collation of data in relation to CSE which provides greater understanding of the nature of the problem which includes developing a profile of the perpetrators of CSE, online and in person CSE and victim profiles to aid early intervention. This should also include specific data to differentiate between the number of known victims of CSE and those who are potential victims. The integration and centralisation of the data collected by all agencies should take place to gain a comprehensive, accurate prolife of the problem in Northern Ireland to aid policy and practice developments.

7.11 Recommendation 11:

Accommodation

I. Relevant Member agencies should consider the development of a range of suitable accommodation for 16 plus young people to reduce their movement across different facilities which increase their vulnerability.

7.12 Recommendation 12:

Young Adults

I. A strategic approach is developed to manage those young people who were deemed 'at risk' of CSE prior to their 18th birthday. Improve coordination between SBNI and Northern Ireland Adult Safeguarding Partnership to establish a Young Adults Safeguarding strategy to maintain support for these young adults and a coordinated transition of care from children's to the Adult at Risk of Harm services.

7.13 Recommendation 13:

Males

I. Continued development of information material specifically for young males to raise their awareness of risk of sexual abuse through exploitation, education regarding issues such as consent and the law.

7.14 Recommendation 14:

NICHE Alert

I. It is recognised that PSNI have commenced placing information on NICHE alerts regarding children whose names are currently on, or have been added to, the CPR. This is to be commended and it is recommended that this be expanded to include Looked After children where CSE is a concern.

These alerts should have direction attached to them to assist police when contact is made with this young person. For those children on CPR /LAC detailed individualised profiles are added which provide key information to enhance engagement of the young person such as:

- what works in engaging the young person;
- any special considerations such as disabilities, language, autism, ADHD;
- who to contact;
- where to return the young person.

II. It is recommended PSNI advise PBNI via the Reportable Incident scheme if the name of a PBNI service user is linked to a child / young person whose name is on the existing Trust or Regional CSE Lists, Child Protection Register and / or LAC where Sexual Abuse through exploitation is a concern.

III. It is also recommended a NICHE alert is also placed against individuals of concern such as those recipients of Child Abduction Warning Notices

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Department of Health NI (2017). *Co-operating to Safeguard Children and Young People in Northern Ireland*. Belfast

Kerr et al. (2017) *Responding to child sexual abuse and exploitation in the night-time economy*. NatCen and Centre of Expertise on Child Sexual Abuse

Marshall, K. (2014). *Child Sexual Exploitation in Northern Ireland: Report of the Independent Inquiry*. Belfast: RQIA, ETI and CJINI.

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Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland. (2016) Belfast: HSCB, PSNI and NSPCC

Appendix 1:

Terms of Reference

Leonard Consultancy

An evaluation of how Safeguarding Board of Northern Ireland member agencies are effectively responding to and managing Child Sexual Exploitation within Northern Ireland

Terms of Reference

1. Aims of the Evaluation

1.1 The evaluation is to examine both at a strategic and operational level how the member agencies of the SBNI are effectively addressing CSE from prevention to intervention within Northern Ireland.

1.2 Taking account of the Marshall Inquiry recommendations and the findings of the SBNI Thematic Review, the aims of the evaluation are to:

- review the effectiveness of the strategic response to CSE regionally and locally by SBNI member agencies individually and collectively;
- review the effectiveness of the operational response to CSE regionally and locally by SBNI member agencies individually and collectively;
- identify gaps, or areas where improvements could be made to the strategic and operational responses to CSE regionally and locally by SBNI member agencies individually and collectively;
- identify a baseline against which future progress will be measured, expressed in terms of outcomes for children, young people and families; and
- consider whether a regional inter-departmental, inter-agency strategic framework, supported by a regional action plan is required to address the gaps/areas for improvement identified.

Effectiveness will be considered under the themes of:

1. Prevention
2. Identification / assessment
3. Early Intervention
4. Protection
5. Treatment / therapeutic intervention

1.3 The evaluation will also assess how the strategic and operational responses to CSE by member agencies is being felt and experienced by those vulnerable to exploitation and those who are victims of CSE.

1.4 The evaluation will also take cognisance of relevant other inspections / reviews currently or in process of being initiated by reviewing organisations during the evaluation time period. Specifically, the evaluation will work in parallel with the current Criminal Justice Inspectorate NI Inspection[14] '*An Inspection of how the criminal justice system deals with Child Sexual Exploitation in Northern Ireland'.*

2. Methodology

Task	Detail
Design, distribute and evaluate CSE self-assessment questionnaire to SBNI member agencies	• Design a strategic and operational response self-assessment questionnaire structured along the 5 themes outlined above for completion by SBNI member agencies. • Distribute the questionnaire to SBNI member agencies. • Collate and evaluate responses.
Critically evaluate the strategic and operational response to CSE	• Review the strategic and operational responses to CSE by SBNI member agencies individually and collectively through a critical examination of policy, procedure and practice. • Observational evaluation of the relevant strategic and operational SBNI member meetings relevant to CSE and specifically evaluate: ✓ the nature of the relationship between PSNI and HSC Trusts, with a specific emphasis on the

[14] Criminal Justice Inspectorate NI Inspection[14] '*An Inspection of how the criminal justice system deals with Child Sexual Exploitation in Northern Ireland'* ongoing

	extent to which co-location facilitates effective co-working and communication. ✓ the exercise by PSNI of its duty to prevent/ detect/ disrupt crime associated with CSE; ✓ The exercise by HSC Trusts of their duties to protect and safeguard children and young people at risk of/ who are victims of CSE; ✓ the effectiveness of the communication between PSNI and HSC Trusts social services and mode of working including co-located CSE and joint working. To also consider communication between and with other key agencies such as Education Authority / GPs and other health professionals • This part of the evaluation will be undertaken through observational analysis of following meetings • Monthly Regional HSCB and PSNI meeting • SBNI CSE Subgroup • Quarterly CSE meeting • 5 Trust Strategic Liaison meetings • Bi monthly CSE Police and Social work leads meeting • Operational Liaison Groups
Gain operational overview of the strategic and operational response to CSE through engagement	Undertake focus groups with 1. Trusts / PSNI CSE Leads 2. Community and Residential staff 3. Other Member Agencies, NICTS's, GPs, YJA, GUM clinics, A&E Dept., CiNi, Education Authority, VOYPIC to (aligned to the 5 themes above) specifically consider: • Proactive measures undertaken for <u>prevention</u> within and across agencies • The application of <u>identification</u> and assessment processes for those vulnerable to and at risk of CSE • Comprehensive overview of <u>early intervention</u> processes and practice within in and across agencies • Practice measures utilised for <u>protection</u> within and across agencies • Availability and access to <u>intervention and treatment</u> regionally and locally • Their insight into the effectiveness of the strategic and operational processes and practice in enhancing the engagement of young people vulnerable to and those at risk of CSE
Review the file/s which will be	Undertake a multi- agency social care perspective 'deep dive' of the same CSE file/s identified by CJNI in their CSE inspection of criminal justice agencies

subject to the CJINI Deep Dive inspection from a Social Care Perspective	Estimated 30 cases 10 cases per Consultant 1 day per case
Assess the experience of young people vulnerable to and at risk of CSE	Undertake a focus group with young person advocacy body such as VOYPIC to gain insight into the young people's experience under the 5 themes outlined above
Evaluation Report	Completion of evaluation report for SBNI within a 6-month time frame

Appendix 2:

SBNI MEMBER AGENCIES CSE AUDIT

SBNI Member Agencies CSE Evaluation

The purpose of this questionnaire is to assist your agency in reviewing your CSE strategic, management and practice developments and response since the Marshall and Pinkerton Reviews. The questions, albeit are generic, we would ask that you complete it in as much detail as possible and please add any additional relevant information at the end of the questionnaire.

Please complete the questionnaire in considering where you have developed your CSE workstream as an agency but also to assist in identifying both as individual agencies and as a Safeguarding Board collective, what may need to be further developed and next steps.

SECTION A: AGENCY

Agency: Please select one of the following:

Social Services ☐
PSNI ☐
Youth Justice Agency ☐
Probation ☐
GP ☐
Voluntary organisation (which?)_____ ☐
PHA ☐
Education Authority ☐
Nursing ☐
Health & Social Care Board ☐
District Council (which?)_____ ☐
Church (which) ☐

SECTION B: STRATEGIC

In this section please state what CSE strategic policy and procedures you have in place within your agency.

Policy and Procedures

1a: What strategic action plan, policies and procedures does your agency have in place in relation to CSE and Missing Young Persons from home/school/ care?

- **Does your agency have a CSE strategic action plan in relation to CSE Yes / No**
- **Does your agency have a CSE strategic action plan in relation to Missing Young Persons from home/school/ care: Yes/No?**

- **Does your agency have a CSE policy in relation to CSE and Missing Young Persons from home/school/ care: Yes/No?**

- **Does your agency have a procedure in relation to CSE**

Yes / no

- **Does your agency have a procedure in relation to Missing Young Persons from home/school/ care: Yes/No?**
- **Does your agency use language derived from SBNI CSE documents to ensure there a consistency of terminology used in your agency's action plan, policies and procedures as well as between agencies? Yes / No?**

Any further comments?

1b: How is your agency's CSE action plan, policy and procedures reviewed?

Action Plan:

Policy:

Procedures:

1c: Is CSE / Safeguarding Action Plan an agenda item on your management Board?

Yes / No?

Please give details:

1d: Does your agency have a specific CSE escalation policy in relation to the young person's perceived risk?

(Please tick)

Yes ----- **No -----**

Comments (give brief details of the escalation process):

1e: Does your agency have a 'CSE Champion' or single point of contact (SPOC) for CSE? (Please tick)

Yes ----- **No -----**

If yes above how do your staff become aware of the CSE SPOC / Champion?

1f: How do you raise a CSE referral internally within your agency?

1g: How does your agency raise a CSE referral externally to PSNI / Trust CSE Leads?

1h: How are your new and existing staff informed of your agency CSE policies and procedures?

1i: In reviewing your strategic response through policies and procedures in respect of CSE, which areas does your agency need to enhance and / or develop?

SECTION C: PRACTICE

Assessing need and identifying risk of CSE.

2a: How many potential / confirmed CSE referrals has your agency dealt with in the last 12 months? Please confirm numbers of both potential and confirmed.

Males_____ **Females**_____

Do you record the ethnicity of the young people: **Yes / No?**

If so, please give the range of ethnicity groupings

Ethnicity:

2b: Please provide, where appropriate, details of what is the assessment framework / tool / model / specific criteria your agency applies to identify potential / confirmed CSE both from:

- **Victim perspective?**

- **Perpetrator perspective?**

2c: How is your assessment information shared internally with other professionals?

2d: How is your assessment information shared externally with other agencies?

2e: What is your process for monitoring assessment information shared internally within your agency?

What is your process for monitoring assessment information shared externally with other agencies?

2f: Please outline the monitoring processes your agency has in place to record and manage ongoing young person specific progress or further risk? Please include your monitoring processes when information is passed externally from your organization and how you monitor the action taken

2h: Does your agency ensure return interviews are conducted in accordance with good practice? If so outline the governance arrangements in respect of this.

2i: Please describe what formal and informal interventions / support your agency provides to CSE victims (potential or confirmed)?

2j: How has your practice of assessment and engagement / relationship building with young people at risk of CSE been enhanced since the Marshall and Pinkerton Reviews and the work of SBNI CSE workstream

2k: How does your agency address the emotional, behavioural and mental health presentation of young people who are at risk of CSE?

2l: How do you ensure your agency dynamically adapts your assessment, intervention and / or engagement with the young person once you are informed of a new specific incident / change of category of risk?

2m: What training / support / guidance do you deliver to your staff to assist them in re- engaging with a young person following a new incident / change of category of risk becoming known?

In other words, how and how timely does your staff get to know 'what specifically works' with the young person after each new incident from other agencies / meetings?

2n: In reviewing your agency practice with CSE – What challenges do you meet in respect of these core areas:

Identification

Assessment

Engagement

Intervention

Prevention

SECTION D: TRAINING

3: Continuous learning and development

3a: What training does your agency deliver in respect of CSE?

3b: Has agency and role specific CSE training been devised for your staff?

Yes/No. If yes, please provide a broad outline.

3c: Is CSE training mandatory for your staff? Yes/No

3d: How many (and what level of staff) have accessed it over the last year?

3e: Who delivers the training and what is their role within your agency?

3f: Is the training informed by SBNI / CSE Research? **Yes/No**

3g: Is there refresher training? **Yes/No**

3h: Is the training delivered on a multi-agency/multi-disciplinary basis? If yes, give details of the other agencies involved.

---

3 i: How do you measure the effectiveness of the CSE training and its application to practice within your agency?

3j: In reviewing your CSE training, are there any areas which you feel require to be improved / addressed through SBNI to ensure consistency and responsivity to the engagement of young people by your agency?

SECTION E: MULTIAGENCY WORKING

4: Multi-agency working

4a: What multi-agency CSE processes and practices are you aware of?

4b: What are the processes for sharing of information and who decides 'who needs to know'?

4c: What is your positive and constructive feedback experience of the co-located posts (PSNI and Trust CSE leads) Marcella – can we clarify what we are looking for from this question – is it from agencies 'other' than PSNI / HSCT's

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4d: What CSE specific meetings is your agency involved in and are there other meetings which you feel your agency should be in attendance at?

- **What is the purpose of these meetings?**

4e: How is information disseminated from CSE related meetings to your agency?

4f: From these meetings, how timely do you find out about specific incidents /change in category of risk of a young person?

4g: How is information from CSE meetings disseminated through your agency to relevant staff to assist them in their next engagement with the young person? Do we need to insert lines here to facilitate the response to this question?

How responsive can your staff be to a young person following an incident – is it impacted by timeliness of information sharing between or within the agency / training of staff?

4f: In reviewing your multiagency working, what areas may require enhancement to ensure effective, timely, bespoke responses of engagement with young people in respect of CSE?

SECTION F: COMMUNICATION

5: Communication

5a: Please describe how you see effective communication demonstrated within your agency and between agencies in relation to CSE?

5b: In reviewing your internal agency communication are there areas which require further enhancement or assistance?

5c: In reviewing your agency communication between other agencies, are there areas which require further enhancement or assistance?

5d: With the centralized 'list' of young people who are assessed to be at significant risk of CSE, has the information about specifically 'what works' in engaging a young person been passed to your agency in a timely manner

and then cascaded to all relevant professionals in your agency to ensure young person tailored responses?

_____

_____

6: Any other comments?

Please use this space to say anything else in relation to the prevention, identification, assessment, and intervention of CSE?

Thank you for taking the time to complete this questionnaire – please return all completed questionnaires to marcella@leonardconsultancy.co.uk by 31st May 2019

Any queries regarding the questionnaire, please contact Marcella