

Child Sexual Exploitation in Northern Ireland

Report of the Independent Inquiry

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November 2014



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FOREWORD AND ACKNOWLEDGEMENTS

Foreword

The United Nations Convention on the Rights of the Child (UNCRC) reminds us that every child should be able to grow up in a family environment, in an atmosphere of happiness, love and understanding.

Sadly, this simple aspiration is often not fulfilled. This report looks at how child sexual exploitation (CSE) takes place in Northern Ireland. It explores how children and young people, parents, communities and professionals can work together to understand what is happening and take steps to ensure that we support children and young people to enter healthy relationships and avoid abuse. It is also important to send out a strong message to those who abuse children that the community in Northern Ireland is determined to ensure that they fail in their attempts, and that they are caught and convicted if they offend.

The threats to children and young people's happiness, safety and wellbeing change shape over time, and it can be hard for caring adults to keep up. Systems and targets devised to counter one threat may not be sensitive enough to pick up and address new and emerging dangers. The fast changing world of technology and social media presents a particular challenge. The positive benefits they bring are accompanied by new threats. It is widely acknowledged that children and young people are much more skilled in using new technologies than their parents, carers or other professionals. Those seeking to abuse children recognise this and quickly skill themselves up to exploit the opportunity this knowledge gap presents.

A constant theme in our discussions across Northern Ireland has been that most of the activities that we now call child sexual exploitation are not new, however advances in technology have exposed more children and young people to them. Child protection systems need to be geared to identifying and responding to new and emerging threats. Adults need to become as skilled in social media as children, young people and abusers. Both young people and parents have emphasised to us the need for adult awareness and skills to be enhanced.

In recent years, there has been an increase in awareness of child sexual exploitation across the UK and its relationship with trafficking. Law and policy around trafficking emphasise the need to avoid blaming the victim. Increasing sensitivity to the plight of child victims has resulted in a recommendation from the Office of the Children's Commissioner for England (OCC) that any references to the prostitution of children should be replaced with child sexual exploitation. We endorse that recommendation and any references to prostitution in this report should be read in that light.

This report is informed by the insights and experiences of young people and parents, some gained through meetings with members of the Inquiry Board and some through consultations commissioned by the Inquiry. Whilst the conclusions of the Inquiry reflect what they have told us, it is informative and respectful to record in full the recommendations from these consultations, which are set out in Appendix 1.

In producing this report, we were mindful, not only of the formal terms of reference given to us, but of the task assigned to us by the groups of young people consulted on our behalf by Children in Northern Ireland, who said the Inquiry Board should:

- tell ministers what young people think
- make sure CSE is taught in schools, and
- get everyone to work together (education sector, police, youth service, social workers)

We submit this report with a commitment to satisfying these expectations.

Acknowledgements

We have received so much cooperation and goodwill from individuals, agencies both voluntary and statutory, and schools that it would not be possible to list them all individually. They have met with us to help shape our methodology, submitted responses to the call for evidence, met us again to tease out particular issues and responded to a substantial number of requests for information and clarification as the story of CSE in Northern Ireland unfolded. They were reflective and self-critical at times, acknowledging gaps in process or service provision, but also pointing us in the direction of areas of good practice.

The agencies who undertook our consultations with young people and parents approached the task with enthusiasm, and we hope that we have justified their faith in this undertaking. The young people themselves have engaged enthusiastically, always bringing fresh insights and wise advice.

We are particularly indebted to those individuals who came to speak to us – parents, young people, young adults and members of the public – who shared their experiences and insights with us, often at some personal cost.

The Inquiry Board approached its task with dedication and was exceptionally well supported by staff from RQIA who went the extra mile to ensure the Inquiry was on track and progressed efficiently.

EXECUTIVE SUMMARY

Background

In September 2013, a Ministerial Summit was held on the theme of child sexual exploitation (CSE) in Northern Ireland. The Police Service of Northern Ireland (PSNI) referred to Operation Owl, an investigation of allegations of CSE in Northern Ireland, which had resulted in a number of adults being interviewed and some being arrested.

Two weeks later, the then Minister for Health, Social Services and Public Safety, Edwin Poots, announced three actions to address this issue: an ongoing PSNI investigation focusing on 22 children and young people; a thematic review of these cases by the Safeguarding Board for Northern Ireland (SBNI); and an independent, expert-led inquiry into CSE in Northern Ireland, to be commissioned by the Minister for Health, Social Services and Public Safety and the Minister of Justice. The Minister for Education agreed that the Education and Training Inspectorate (ETI) would enjoin the Inquiry in relation to schools and the effectiveness of the statutory curriculum with respect to CSE.

The Inquiry was to focus on both children and young people living at home in the community and those living in care. This is an executive summary of the report of this Inquiry.

On 5 November 2013, Kathleen Marshall, former Commissioner for Children and Young People in Scotland, was appointed to lead the Inquiry and chair an Inquiry Board to which five other members were appointed: Sheila Taylor, Chief Executive of the National Working Group (NWG) for Child Sexual Exploitation in the United Kingdom; Fiona Smith, Children and Young People's Adviser from the Royal College of Nursing; Glenn Houston, Chief Executive, The Regulation and Quality Improvement Authority (RQIA); Noelle Buick, Chief Inspector, Education and Training Inspectorate (ETI); and Derek Williamson, Inspector, Criminal Justice Inspection (CJI).

The Inquiry was managed and supported by the Senior Project Manager and Administrative Team Supervisor from the Reviews Directorate in RQIA.

Terms of Reference

The Terms of Reference of the Inquiry were to:

- Seek to establish the nature of child sexual exploitation (CSE) in Northern Ireland and a measure of the extent to which it occurs.
- Examine the effectiveness of current cross sectoral child safeguarding and protection arrangements and measures to prevent and tackle CSE.
- Make recommendations on the future actions required to prevent and tackle CSE and who should be responsible for these actions.

- Report the findings of the Inquiry within one year of its commencement.

In addition, the Inquiry should:

- Consider specific safeguarding and protection issues for looked after children, taking into account the ongoing thematic review by the Safeguarding Board for Northern Ireland (SBNI).
- Seek the views of children and young people in Northern Ireland and other key stakeholders.
- Engage with parents to identify the issues they are facing and seek their views on what needs to be done to help them keep their children safe from the risk of CSE.

Exclusions:

The Inquiry was not to focus on the circumstances and/or responses to the 22 children who were part of the ongoing police investigation known as Operation Owl. This would be the focus of a separate Thematic Review being undertaken by the SBNI. However, available learning generated from this Thematic Review would be taken into account.

Methodology

In November 2013, initial meetings were held with relevant agencies to discuss the proposed methodology and identify key issues. A Call for Evidence was issued on 11 December 2013, with a closing date of 18 March 2014. A total of 50 submissions were received from organisations and individuals. Oral evidence was heard from some individuals and follow-up meetings were held with a number of agencies. The Youth Panel of the Commissioner for Children and Young People in Northern Ireland (NICCY) met Kathleen Marshall to discuss how best to communicate with young people.

The Inquiry commissioned consultations with young people and parents:

- Children in Northern Ireland (CiNI) - to consult groups of young people through its Participation Network
- Voice of Young People in Care (VOYPIC) - to consult looked after children/young people
- Parenting NI - to consult parents

Include Youth was later commissioned to form a group of young people to reflect on issues that had arisen as the Inquiry moved towards formulating recommendations. Many of the young people had been involved in earlier groups.

RQIA, CJI and ETI undertook three workstreams:

1. RQIA issued self-assessment questionnaires to five health and social care (HSC) trusts, which was followed by meetings within each trust area: senior management, managers and frontline workers from gateway, family support, looked after children (LAC) and 16 plus teams were represented.

Further meetings and focus groups were held with health professionals and professionals working across health and social care.

2. ETI undertook a thematic survey of 20 post primary schools and four special schools. Children from years 10 and 11, and their parents or carers were involved. Cluster group meetings were held with professionals working across the education and training sector.
3. CJI conducted semi-structured interviews and focus groups with frontline and management staff from organisations such as PSNI, Northern Ireland Prison Service, Northern Ireland Probation Service, Northern Ireland Courts Service, Youth Justice Agency and the Department of Justice (DOJ).

Taking into account the commissioned consultations and the ETI survey, the Inquiry consulted 580 young people and 795 parents. The Inquiry paid ongoing attention to the equality categories set out in Section 75 of the Northern Ireland Act 1998. The Inquiry report includes an analysis of human rights issues relating to children and young people.

The Nature of CSE in Northern Ireland

CSE can range from the planned or systematic exploitation of young people, to worrying relationships between young people under 16 and adults who are a few years older. It includes party houses where drugs and/or alcohol may be provided free in the first instance, but the young people enticed to the venue are later expected to pay for it with sex. It can be a relationship that starts off looking like a consensual one, but develops into an expectation that the young person has sexual activity with the partner's friends and associates. It may involve the young person being transported from place to place. Money may also change hands.

Increasingly today, children and young people can be exploited through the internet and social media; through grooming that may or may not lead to face-to-face contact; or through the generation and sharing of indecent images of the young person (sexting), which can become the focus of bullying and/or blackmail. CSE can affect males and females, but males are less likely to disclose or be identified as victims.

Many of those consulted by the Inquiry expressed the opinion that Northern Ireland was not experiencing the type of organised exploitation seen in Rochdale or Rotherham.

Nevertheless, the Inquiry received accounts of organised gangs linked with trafficking and drug dealing. Trafficking into, out of, or within Northern Ireland, can be a form of CSE, and drug dealing is often associated with CSE. Northern Ireland does not have the type of street gang culture identified in reports by the Office of the Children's Commissioner for England, as being associated with some forms of CSE.

The particular Northern Ireland dimension reported to the Inquiry was the involvement of powerful individuals with purported links to paramilitary organisations. Reports about this came from individuals, organisations and professionals. No-one suggested that CSE was a targeted activity of paramilitary groups.

It was a case of individuals using the authority of their paramilitary links and the fear it engendered, to exploit children and young people. The Inquiry was told that there were bars dominated by members of paramilitary groups, where there were lock-ins after hours and sexual exploitation took place. It is important to state that no-one identified names or locations in relation to these events. Some told us that they feared for their lives if they were suspected of having done so.

The party house scenario featured highly in discussions with agencies and young people. It is difficult to estimate the extent to which these are occasions for CSE because young people do not consider themselves as victims, even when they can acknowledge the vulnerabilities of friends and peers.

Parties are sometimes attended by, or organised by, adults. These were described as being mostly individuals or groups, rather than organised gangs, who coalesce around vulnerable children.

Alcohol and drugs render the young people vulnerable. Many adults reported their concerns about the extent of underage drinking and their experience that licensing laws were not routinely enforced. There was repeated reference to the increasing problem of legal highs. These are substances that produce effects similar to other drugs, but they are not subject to the same regulation. Their composition changes frequently to avoid them falling into restricted categories.

Developments in communication technology, while bringing many benefits, have increased the vulnerability of children. Even very young children have accessed pornography and tried to act it out. Young people's views about what is normal are affected by this and by other messages from the media. This has helped shape what some refer to as a new normality amongst young people, involving an expectation of multiple sexual partners, and sexual activity in circumstances where the existence of consent is often questionable.

Social media allows young people to extend their networks very easily and communicate with a wide range of people unknown to their parents. This vulnerability can be exploited by adults with malicious intent. Sexting is reported to be widespread in schools. Often these images will remain private to the sender and recipient, but they can be easily shared, with serious consequences for the young victim. Children with disabilities can be particularly affected by exploitation involving social media as many rely on this as a central and valuable tool for social engagement. Lesbian, gay, bisexual and transgender (LGBT) young people report deficiencies in relevant sex education. This, together with the limited opportunities for associating with other LGBT young people, due to cultural attitudes, renders them vulnerable to exploitation both online and in city venues.

The population profile of Northern Ireland is becoming more diverse. The Inquiry recognises it is difficult to engage with black and minority ethnic communities on this sensitive subject. Some of the new, immigrant communities bring cultural acceptance of relationships between young girls and older men.

Vulnerability to CSE

In 2011, Barnardo's NI published a report, *Not a World Away: The Sexual Exploitation of Children and Young People in Northern Ireland*. The research on which it was based included application of a risk assessment tool for CSE. This was later adapted for use by HSC trusts in Northern Ireland. The tool identified a number of underlying vulnerabilities that can facilitate CSE, as well as risk indicators identified as moderate or significant.

Underlying vulnerabilities include: abuse or neglect within the family; breakdown of family relationships and the lack of any substitute positive relationship; family history of domestic abuse, substance misuse or mental health difficulties; low self-esteem; and isolation from peers or social networks. The issue of bereavement is also recognised as a potential vulnerability.

Moderate risk indicators include: staying out late; multiple, unknown callers; use of the internet or a mobile phone that causes concern; sexual health issues; having peers or siblings who have been sexually exploited; misuse of alcohol or drugs.

Young people might also exhibit expressions of despair and be disengaged from school. They may be living independently and failing to keep in touch.

Significant risk indicators include: relationships with controlling adults that may involve physical or emotional abuse; unexplained amounts of money or expensive items; frequenting party houses or areas known for sex work; or entering or leaving vehicles driven by unknown adults. Periods of going missing overnight or longer heads up the list of significant risk indicators.

The significance of going missing from care had been identified in a 2006 report by the Social Services Inspectorate in Northern Ireland. Incidents have been recorded since 2005, but the information was not collated or analysed. In 2008, Michelle McIlveen, MLA, asked a series of questions of ministers, seeking to identify the numbers going missing from each trust area. The inability of the authorities to give this information led ultimately to an agreement to monitor the figures and to put in place an associated action plan. The Inquiry has ascertained that some of the actions in the plan have been completed, but others remain outstanding. In particular, there is a lack of analysis and oversight to form a strategic overview. The Inquiry received figures from a number of sources relating to children missing from family homes and from care, but the figures have different criteria and it is difficult to reconcile them to obtain a clear picture.

The Inquiry concluded that the vulnerability factors for CSE are well known. There is a particularly significant link with episodes of going missing. There is already work being undertaken to address some of the matters identified as underlying vulnerabilities for CSE. It is important that whatever is done in response to CSE should build upon this, rather than be seen to be in competition for time and resources. The identification of CSE as an emerging, developing and growing threat to children should give extra impetus to these existing commitments.

The Extent of CSE in Northern Ireland

It is widely acknowledged that, because CSE is not yet a recognised category for most official purposes in Northern Ireland, there are few definite figures that can be relied on to give a measure of its extent. The Inquiry drew largely upon the risk assessments; CSE notifications made to RQIA by HSC trusts; figures held by Operation Owl; and the caseload of the Barnardo's Safe Choices Service, which specialises in CSE issues. These showed that between 100 and 145 children are currently identified as at significant risk of CSE. However, the number actually experiencing CSE is likely to be significantly higher. In discussions about the extent of CSE in Northern Ireland with various stakeholders, including the education sector, the most common response was that what is known is likely to be the tip of the iceberg.

It was confirmed by respondents that, despite the fact that the Operation Owl cases involved children known to social services, CSE was a part of life for other children, and any child could be vulnerable to it. Agencies referred to increasing numbers of CSE cases relating to children from family environments, with no identified vulnerabilities.

The Inquiry concluded that, as awareness increases, it is likely that more cases of CSE will be identified. CSE must be regarded as a significant and growing threat to the welfare of children and young people. However, it is important to avoid a panic that leads to an unhealthy repression of and limitations on young people's lives and expectations of human relationships. The Inquiry received several comments from parents and young people about the need to avoid scaring children about the possibilities of exploitation. Young people were adamant that the response should be largely about empowering young people, rather than giving adults more power to control them. The response to the growing threat of CSE must be targeted and proportionate.

Safeguarding Looked After Children

Looked After Children were not the primary focus of the Inquiry, but are recognised as a particularly vulnerable group. Experiences prior to entering care often make them vulnerable, but the experience of care, particularly residential care, can increase this vulnerability. They may meet other young people with a history of exploitation who introduce them to exploitative networks. Concern has been expressed about the ability of staff in residential care to control behaviour and protect young people. Police officers expressed frustration about the time spent returning young people who have left a care home without permission. Staff recounted the measures they adopted to dissuade young people from leaving and to follow them when they did. Management were adamant that their staff were well trained and supported, while acknowledging the difficulty of the task.

Young people discussed the dynamics in residential care and compared it with foster care and family life. There was consensus, amongst them and adults, that the most important protective factor was the existence of a trusting relationship with a caring adult. HSC trusts said they were committed to facilitating that. Some emphasised that good relationships can withstand an element of challenge.

A professional working in a residential setting said, “We care enough to say no”. Mindful of the difficulties staff face in balancing the rights of young people regarding care and control, the Inquiry’s report includes an analysis of these issues in terms of children’s rights. It notes that a child’s right to be protected will be most effectively secured if their views are taken into account about how matters of care and control should be addressed.

Some believe there should be greater resort to physical restraint and secure accommodation in order to keep children safe. The Inquiry is firmly of the view that these must not be regarded as everyday responses to situations in children’s homes. There will be some situations in which these are justified. Some young people appreciate the feeling of safety within secure facilities. This sends an important message about what we need to provide to keep young people safe during vulnerable periods. Young people with experience of CSE should be involved in discussions about what a safe space would be like, drawing on models of good practice.

Preventing and Tackling CSE

There is a need for a comprehensive and well-resourced approach to awareness raising about CSE. It cannot be tackled by statutory agencies alone. Young people, parents, members of the public, those working in the community, such as taxi drivers, hoteliers and the entertainment and leisure industry, all need to be involved. SBNI has commenced an awareness raising campaign in line with their business plan in which CSE is identified as a priority. This is welcome, but many told the Inquiry that something more comprehensive, such as a public health campaign, was required. The language and approach need to be responsive to what young people and parents have said about how that message is communicated.

Northern Ireland’s existing commitment to early intervention and prevention should be reaffirmed and its implementation strengthened. Young people should be involved in a review of youth services, to promote provision of services that provide attractive and exciting alternatives to situations that could render them vulnerable to CSE.

Schools have been identified as having a key role in raising awareness, preventing, identifying and reporting CSE. Staff from the education and health sectors, and in particular the Northern Ireland Ambulance Service, say they need more training, and a simple tool to help them identify and report CSE. They need clear pathways for reporting 24 hours a day, seven days a week. Having feedback to let them know that their report was valued and acted upon will give them the confidence to make further reports.

In some communities, and amongst many of the young people, there remains distrust of the statutory authorities, particularly the police. Whilst the police and the criminal justice system have made improvements in recent years, victims are often reluctant to engage for fear that the system will not treat them fairly. There are few prosecutions and convictions for sexual offences against children and this exacerbates the reluctance to report and to engage.

There have been advances in methods of disrupting CSE by using mechanisms such as sexual offences prevention orders, risk of sexual harm orders and harbourers warning notices. Arrangements for statutory and voluntary agencies to share information about those who might pose a risk to children have been the subject of a recent judicial review, and there remains some uncertainty about the circumstances in which such information can now be shared.

There are some excellent recent examples of collaborative working amongst agencies in Northern Ireland relating to CSE. These can provide learning for a review of collaborative working. There are too many agencies and partnerships in Northern Ireland covering overlapping issues. When SBNI was established in 2012, there was a commitment to a planned review of the organisation, and such a review may provide an opportunity for a wider perspective.

At operational level, while there are examples of good joint working, this is often hampered by different perspectives from the organisations involved and lack of joint training on issues such as the response to children going missing.

Problems also arise from: the fact that the boundaries of HSC trusts and PSNI districts are not co-terminous (although the Inquiry understands this issue is being addressed); the lack of an information-sharing protocol for agencies; the difficulties of agencies having different systems, manual and electronic, to facilitate information sharing; lack of consistency in terminology, information gathering and analysis; and impressions that the contribution of voluntary agencies is undervalued.

There are a number of services to help promote recovery from CSE, but they need to be joined up in a strategic approach to ensure equality of access. Help should also be provided for adults abused as children, in part because the impact of this can impede their ability to support and protect their children from CSE.

The law should be strengthened in a number of ways, in particular, with a view to ensuring that protection is extended to all children up to the age of 18, in line with international standards. The definition of grooming should be strengthened, as well as some legal provisions about who has to prove the age of a child when a sexual offence has been committed.

Recommendations

The Inquiry made 17 key recommendations and a further 60 supporting recommendations.

The 60 supporting recommendations add substance and detail to the key recommendations listed, including the issue of children going missing from home or care. They address issues relating to disability, ethnicity and sexual orientation. They recommend a joint approach to the problem of underage drinking, including education and enforcement. A need for further collaboration with the Republic of Ireland is identified in terms of information sharing. There are particular recommendations directed at the issues of forced marriage and private fostering. A number of recommendations relate to the particular role of schools and one is aimed at strengthening child protection in non-statutory education settings.

The recommendations promote further support for residential workers, foster carers and vulnerable young adults.

The key recommendations are:

Key Recommendation 1: In response to the reality of CSE identified in this report, the Department of Health Social Services and Public Safety (DHSSPS) should direct the Public Health Agency to undertake a public health campaign on CSE-related issues. This should complement the work being undertaken by SBNI.

Key Recommendation 2: The Inquiry encourages the PSNI to pursue its commitment to strengthening relationships with communities and with young people as a priority in the context of the current climate of austerity.

Key Recommendation 3: The DHSSPS, in conjunction with DOJ, should develop guidance for parents and carers, including foster carers and residential workers, on how best to capture information and/or evidence when a child returns from a period of being missing or is otherwise considered to be at risk of CSE.

Key Recommendation 4: SBNI's developing plan for data collection should include a commitment to collation and analysis of the data in a way that will facilitate a strategic response to CSE.

Key Recommendation 5: The DHSSPS should explore the benefits of amending or adding to standards for inspection of children's homes to ensure that they:

- a) promote a culture conducive to respect for the best interests of the child; and
- b) take account of the specific needs of separated and trafficked children and those affected by CSE.

The DHSSPS should issue a circular and associated guidance stating how these issues should be taken forward.

Key Recommendation 6: The DHSSPS, along with the HSC Board and HSC trusts, should consider how "safe spaces" could be developed for children and young people at risk of, subject to, or recovering from CSE. This development should take account of models of best practice and the views of young people, and should respect international human rights standards.

Key Recommendation 7: The Northern Ireland Assembly, through the Office of the First Minister and Deputy First Minister, should re-affirm its commitment to strategic, long-term and sustained funding of services for prevention and early intervention.

Key Recommendation 8: The Department of Education (DE) should conduct a review of youth services that takes into account the views of young people and aims to ensure that such provision is attractive and appropriate.

Key Recommendation 9: The DOJ should establish an inter-agency forum, drawn from across the criminal justice sector and third sector stakeholders, to examine how changes to the criminal justice system can achieve more successful prosecutions of the perpetrators of CSE. This must be informed by the experiences and needs of child victims.

Key Recommendation 10: The DHSSPS should ensure that the forthcoming, planned review of SBNI should consider streamlining joint working arrangements to make them more realistic, efficient and effective.

Key Recommendation 11: The DHSSPS should ensure that there are clear reporting pathways, 24 hours a day, seven days a week, for reporting concerns about children and young people, including CSE, with appropriate feedback provided to the individual or agency making the report.

Key Recommendation 12: The protocol for sharing information amongst agencies being developed by SBNI should be concluded as a matter of priority.

Key Recommendation 13: SBNI and its member agencies should seek to ensure that there is delivery of professional training, both multi-agency and profession-specific, and that this is based upon a clear, agreed and shared definition of CSE.

Key Recommendation 14: The DOJ should lead on a project to examine legislative issues highlighted in this report and bring forward proposals for change. These include:

- a) Ensuring compliance with international standards by extending protection to children up to the age of 18, specifically, the Child Abduction (Northern Ireland) Order 1985 and the Sexual Offences (Northern Ireland) Order 2008.
- b) Providing for a recovery order under the Child Abduction (Northern Ireland) Order 1985, on the model of that in section 69 of the Children (Northern Ireland) Order 1995.
- c) Replacing all references to child “prostitution” with “child sexual exploitation”.
- d) Extending the offence of “grooming” to include “enticing”.
- e) Reversing the rebuttable presumption in the Sexual Offences (Northern Ireland) Order 2008 in relation to “reasonable belief” as regards the age of a child.
- f) Whether recent legislation in England and Wales relating to hotels, guest houses and bed and breakfast accommodation would be helpful in addressing CSE in Northern Ireland. These are contained in the Anti-Social Behaviour, Crime and Policing Act 2014.

Key Recommendation 15: The DHSSPS should lead the development of a regional strategy to prevent, identify, disrupt and tackle CSE. It should involve the DOJ and DE and should:

- a) Be informed by the experiences and views of children, parents and carers.
- b) Recognise parents and carers as partners in preventing and tackling CSE, unless there are strong indications that they are involved or complicit.
- c) Recognise the support and training needs of frontline workers in all agencies in relation to CSE.

- d) Reflect the particular role of schools in raising awareness and identifying concerns about CSE.
- e) Acknowledge the role of health workers in early intervention, prevention and reporting of CSE, which should be made more explicit in policies, guidance and training.
- f) Recognise agencies operating in the voluntary (non-statutory) sector as equal and valued partners.
- g) Equip communities with the information, support and confidence to identify and report concerns about CSE.
- h) Link into, and build upon, existing work in relation to child trafficking as well as strategies tackling known vulnerabilities for CSE, such as alcohol, drugs (including “legal highs”), sexual health and domestic violence.
- i) Explore the potential contribution to this issue of strengthening a statutory duty to co-operate among stakeholder agencies.
- j) Establish a process for promoting and monitoring implementation of the recommendations of this report.

Key Recommendation 16: The HSC Board should adopt a strategic approach to the provision of support services for those who have been subject to CSE, to ensure equality of access. This should build on current, good practice examples.

Key Recommendation 17: The HSC Board should ensure that accessible and appropriate support services are made available for adults who were abused as children.

PART A: INQUIRY INTO CHILD SEXUAL EXPLOITATION

CHAPTER 1: INTRODUCTION

1.1 Background

On 10 September 2013 representatives of a number of agencies and organisations attended a ministerial summit on the theme of Child Sexual Exploitation in Northern Ireland. Edwin Poots, Minister for Health, Social Services and Public Safety, welcomed representatives to the summit and presentations were made by Barnardo's Northern Ireland, by the Police Service for Northern Ireland (PSNI) and by the Health and Social Care Board (HSC Board). The presentation from the PSNI made reference to Operation Owl, an investigation of allegations of child sexual exploitation in Northern Ireland which had resulted in a number of adults being interviewed and subsequently some having been arrested on related charges. The summit ended with a short statement from David Ford, Minister of Justice outlining key messages in respect of CSE in Northern Ireland.

On 25 September 2013, Minister Poots, made a statement to the Northern Ireland Assembly about child sexual exploitation. He outlined a range of actions which had been taken by the Department of Health, Social Services and Public Safety (DHSSPS) and the health and social care (HSC) sector to strengthen the protection of children and young people in Northern Ireland, namely:

- Establishment of the Safeguarding Board for Northern Ireland (SBNI) in 2012 to support and promote effective interagency cooperation in safeguarding children, which had identified child sexual exploitation as a priority and was developing an action plan to address it.
- Initiation of three joint round table meetings with the Minister of Justice and key stakeholders to consider how to improve the outcomes and lives of vulnerable children and better protect them through the effective use of early authoritative intervention.
- Continued partnership working with PSNI and social services in tackling all forms of child abuse, to include child sexual exploitation.
- Development of the co-located team of police and social workers currently investigating child sexual exploitation.
- Investment in the Early Intervention Fund by several governmental departments.
- Additional investment into specialist services. For example, in the establishment of the Sexual Assault Referral Centre and extension of existing services targeted specifically at children and young people including Child and Adolescent Mental Health Services and Drug and Alcohol services.

The Minister Poots' statement described three separate actions:

- An ongoing PSNI investigation focusing on a number of children and young people from care. The investigation had identified a group of 22 young people, aged between 13 and 18, who may have been abused.
- The commissioning of a thematic review of the 22 cases that had triggered the PSNI investigation in order to identify the learning from the management of those cases to inform and improve future practice. This would be undertaken by the SBNI.
- The commissioning of an independent expert-led inquiry into child sexual exploitation in Northern Ireland commissioned by the Minister for Health, Social Services and Public Safety and the Minister of Justice. This would be supported and facilitated jointly by the Regulation and Quality Improvement Authority (RQIA) and the Criminal Justice Inspection of Northern Ireland (CJI). The Minister of Education agreed that the Education and Training Inspectorate (ETI) would enjoin the Inquiry in relation to schools and the effectiveness of the statutory curriculum with respect to CSE. The Inquiry was to focus on both children and young people living at home in the community and those living in care.

On 5 November 2013, the Minister for Health, Social Services and Public Safety made a further statement to the Northern Ireland Assembly, following appointment of the Inquiry Lead, Kathleen Marshall. This is the report of that Inquiry.

1.2 The Inquiry Team

In November 2013, the Minister for Health, Social Services and Public Safety made a statement to the NI Assembly to announce the terms of reference and his appointment of Kathleen Marshall, former Commissioner for Children and Young People in Scotland, as the Inquiry Lead.

The Inquiry Team was established in November 2013, with:

- Sheila Taylor, Chief Executive, National Working Group (NWG) Network for Child Sexual Exploitation, United Kingdom
- Glenn Houston, Chief Executive, RQIA
- Noelle Buick, Chief Inspector, ETI
- Derek Williamson, Inspector, CJI
- Fiona Smith, Children and Young People's Advisor from the Royal College of Nursing (RCN), joined the Team in December 2013

Details of our respective professional backgrounds are set out in Appendix 2: Inquiry Board Biographies.

The Inquiry was managed and supported by the Senior Project Manager and Administrative Team Supervisor from the Reviews Directorate in RQIA.

As the Inquiry progressed, supplementary support in specific pieces of work was also provided by staff from RQIA, ETI, CJI and NWG.

1.3 Terms of Reference

The Terms of Reference of the Inquiry were to:

- Seek to establish the nature of child sexual exploitation (CSE) in Northern Ireland and a measure of the extent to which it occurs.
- Examine the effectiveness of current cross sectoral child safeguarding and protection arrangements and measures to prevent and tackle CSE.
- Make recommendations on the future actions required to prevent and tackle CSE and who should be responsible for these actions.
- Report the findings of the Inquiry within one year of its commencement.

In addition, the Inquiry should:

- Consider specific safeguarding and protection issues for looked after children, taking into account the ongoing thematic review by the Safeguarding Board for Northern Ireland (SBNI).
- Seek the views of children and young people in Northern Ireland and other key stakeholders.
- Engage with parents to identify the issues they are facing and seek their views on what needs to be done to help them keep their children safe from the risk of CSE.

Exclusions

The Inquiry was not to focus on the circumstances and/or responses to the 22 children who were part of the ongoing police investigation known as Operation Owl. This would be the focus of a separate thematic review being undertaken by the SBNI. However, available learning generated from the thematic review would be taken into account.

1.4 Operation Owl

PSNI advised that Operation Owl arose as a result of the internal review of public protection arrangements. When examining the particular area of missing persons, it was noted that a small number of children were going missing a significant number of times. In particular, 13 children accounted for 10% of all missing persons' reports, while 40 children had been reported missing more than 25 times in 16 months.

As a consequence, a senior investigating officer was appointed to scrutinise these particular missing children's cases. This resulted in the establishment of Operation Owl in May 2013, to further examine these issues, reduce harm and give assurances of the policing response.

Operation Owl was subject to joint protocol arrangements between the police and HSC sectors and an operational group was established, involving a range of disciplines and agencies.

The Inquiry was advised that the risk of CSE had already been identified as a key issue for most of the young people involved in Operation Owl. The significance of Operation Owl was that it allowed a fresh look at cases where young people had gone missing, to reconsider the issues raised, map any patterns relating to offenders and seek to ensure that appropriate action had been taken.

1.5 Context and Focus

Public concern about child sexual exploitation has been heightened in recent years by a number of reports and inquiries including the Rochdale Report¹ and, more recently the Rotherham report². The OCC also published a series of reports as part of its Inquiry into CSE in Gangs and Groups³. There is an increasing understanding and a wealth of associated recommendations about CSE, which are available as a compilation, produced and maintained by the NWG Network, many of which reflect the conclusions of this Inquiry⁴. There are, however, particular Northern Ireland dimensions to them which we have sought to address.

1.6 Past Work on CSE in Northern Ireland

There have been reports about CSE in Northern Ireland going back a number of years. At policy level, Include Youth, a charity working with young people, produced *Out of the Shadows* in 2001, making a number of recommendations, many of which are still pertinent.

More recently, Barnardo's Northern Ireland published some ground-breaking research in 2011, which explored the nature and scale of CSE in Northern Ireland. It made six recommendations, which have been partly implemented⁵.

¹ Report of the Independent Reviewing Officer in Relation to Child Sexual Exploitation Issues in Rochdale Metropolitan Borough Council During the Period 2006 to 2013:

<http://www.rochdale.gov.uk/pdf/2013-20-05-Final%20Report%20of%20IRO%20into%20CSE%20issues%20v2.pdf>

² Jay, A. Independent Inquiry into Child Sexual Exploitation in Rotherham (August 2014). http://www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham

³ <http://www.childrenscommissioner.gov.uk/info/csegg1>

⁴ Contact NWG Network: www.nwgnetwork.org or network@nwgnetwork.org

⁵ Beckett, H., *Not a World Away: The sexual exploitation of children and young people in Northern Ireland*. Barnardo's NI (2011).

At operational level, there have been a number of cases and inquiries into what would now be called child sexual exploitation but which, at the time, tended to be referred to as small-scale child abuse.

We have taken note of cases of organised or potentially organised abuse going back to the early 1990s. Some of these related to abuse that had been going on since the 1960s. Seven or eight relate to abuse within communities and two to abuse within families. A case in 2006 related to a children's home where it was recognised that organised abuse had taken place. This led to a number of reviews and reports.

These cases tended to result in changes to protocols or procedures, but many of the problems identified still exist and are reflected in this Inquiry report. This information supports the assertions of the trusts that CSE is not new to them.

Whilst the Inquiry believes a pan-Northern Ireland strategy is required to address CSE, this will have very limited impact if it is not informed by the experiences of children, young people and parents, and associated with a change in culture and attitudes. The strategy should aim to give an initial impetus in terms of awareness-raising and response to CSE, but the aim should be to integrate it into existing strategies, processes and training. These matters are addressed later.

1.7 How we Approached our Task

When the Inquiry Team was established in November/December 2013, roles and responsibilities were agreed, as well as a schedule of meetings. The Inquiry was managed using PRINCE2 project management methodology.

The methodology incorporated:

Engagement with Children, Young People and Parents

We commissioned well established organisations that already had a presence in Northern Ireland, to undertake several discrete pieces of work, namely:

- engagement with children and young people who live at home by Children in NI (CiNI) via Participation Network
- engagement with children and young people in care by the Voice of Young People in Care (VOYPIC)
- engagement with children and young people in education by ETI
- engagement with parents by Parenting NI
- engagement with parents who had children in education by ETI
- others came forward to meet with us to share their experiences of CSE as children, young people and parents

From the outset, we explored the idea of forming a group of young people to inform and advise the Inquiry. This culminated in the commissioning of Include Youth who brought together a group of 19 young people. The group was drawn from a range of organisations from across Northern Ireland which had been involved in the earlier engagements.

The Working Group came together over a number of days in the summer of 2014 in order to share ideas, consider the challenges of addressing CSE and to respond to questions raised by the Inquiry. A DVD of the work was produced and presented at the stakeholder event in September 2014.

The full reports of the CiNI, VOYPIC, Parenting NI and Include Youth work can be accessed on the RQIA website at: www.rqia.org.uk.

Engagement with Stakeholders

Meetings and focus groups were held throughout the Inquiry with the voluntary and community sectors, criminal justice sector, education sector and HSC sector, when the terms of reference were examined. Individuals from frontline practitioners to chairs and chief executives spoke with us and shared not only their experience of working with CSE, but also their personal experiences. Engagements in England, Scotland and the Republic of Ireland also took place.

Three stakeholder events were held in June 2014 and September 2014, when participants came together to share their expertise in how arrangements for identifying, tackling and preventing CSE could be improved in Northern Ireland. These events were also used to validate earlier findings from the Inquiry and to ensure that all avenues of investigation were covered.

A Call for Evidence

A call for evidence was launched on 11 December 2013, with a closing date of 18 March 2014. Forty-one submissions were received by the closing date. The content of these submissions allowed the Inquiry to identify and follow up relevant issues.

The Inquiry continued to receive submissions up to mid-October 2014, resulting in a total of 50 submissions. These came both from organisations outlining their policy and practice in relation to CSE, and from individuals. Some of the individual submissions related to professional experience and insights and some were about personal experiences, or the experiences of a family member. Oral evidence sessions were also held with several individuals to clarify details contained in their submissions.

A list of those who contributed to the call for evidence, and who consented to be named, is outlined in Appendix 4: Contributors to the Inquiry.

This call for evidence was followed up with a targeted engagement in June 2014, when the Inquiry Lead contacted a wide range of royal colleges and professional associations, requesting that they disseminate information to all members.

Engagement with the Criminal Justice, Education and Health and Social Care Sectors

The three inspectorates, RQIA, CJI and ETI undertook comprehensive engagement via three workstreams:

- **Criminal Justice Workstream**

This was established in March 2014 and included validation of submissions to the Inquiry and semi-structured interviews and focus groups with frontline and management staff from organisations such as:

- Department of Justice (DOJ)
- Northern Ireland Courts and Tribunals Service (NICTS)
- Northern Ireland Prison Service (NIPS)
- Probation Board for Northern Ireland (PBNI)
- PSNI
- Public Prosecution Service (PPS)
- The Judiciary
- Youth Justice Agency (YJA)

- **Education Workstream**

This was established in March 2014 and included validation of submissions to the Inquiry and a Thematic Survey. The Thematic Survey comprised engagement with Year 10 and 11 pupils from 20 post-primary schools and four special schools, engagement with parents and carers of Year 10 and 11 pupils in post primary schools who responded to parental questionnaires, engagement with parents in special schools and meetings and focus groups with frontline staff and management from schools.

Cluster group meetings were also held with staff from:

- Alternative Education Providers Group
- Child Protection Support Service for Schools (CPSSS)
- Department for Employment and Learning (DEL)
- Education and Library Boards (ELBs)
- Education Welfare Service (EWS)
- Educational Psychology Service
- ETI Associate Assessors and Safeguarding Panel
- Further Education Student Support Manager Forum
- Independent Counselling Service for Schools (ICSS)
- Primary Schools
- Teacher Training Institutions

The full report of the ETI Thematic Survey can be accessed on the ETI website at www.eti.org.uk or the RQIA website at: www.rqia.org.uk.

- **Health and Social Care Workstream**

This workstream was established in March 2014 and included validation of submissions to the Inquiry and engagement with frontline and management staff across the HSC. It comprised a self-assessment questionnaire completed by five Health and Social Care (HSC) trusts, as well as meetings and focus groups with staff from the HSC trusts.

Further engagements included meetings and focus groups with:

- Child and Adolescent Mental Health Services (CAMHS) unit at Beechcroft
- Children and Young People's Strategic Partnership (CYPSP)
- DHSSPS
- Fostering NI Network
- HSC Board
- Northern Ireland Ambulance Service Trust (NIAS)
- Northern Ireland Guardian Ad Litem Agency (NIGALA)
- Northern Ireland Sexual Assault Referral Centre (SARC) at the Rowan
- Northern Ireland Sexual Health Improvement Network
- Public Health Agency (PHA)
- SBNI

Visits to two children's residential homes also took place and 42 children's residential care homes across Northern Ireland completed an online survey.

As the Inquiry moved into engagement, both an Ethics Strategy and a Protocol for Rules of Direct Engagement with Individual Young People via External Agencies were agreed and utilised.

In order to ensure access to the Inquiry, a website was launched in December 2013 and a dedicated email address set up. The RQIA Twitter account was also used to tweet key messages. A Post Office Box for anyone who wished to contact the Inquiry, to include those who wished to submit information anonymously, was also provided, from June 2014.

We met with, and heard from, many people - too many to name individually and a list of those contributors who consented to be named is included in Appendix 4: Contributors to the Inquiry.

Full details of the Inquiry's methodology are set out in Appendix 3: Inquiry Methodology.

1.8 Structure of this Report

The report explores the nature of CSE, following through the types previously identified in Northern Ireland and elsewhere, but with a particular focus upon the Northern Ireland dimension. This is followed by an examination of the vulnerability factors for CSE. The Terms of Reference tasked the Inquiry to seek to establish a measure of the extent to which CSE occurs.

We have accessed available information and gathered evidence from those working with children and young people.

Chapter 5 looks at safeguarding issues for young people who are looked after by the HSC trusts. These children are sometimes referred to as being in care or as LAC (looked after children).

Chapter 6 examines some issues specific to young adults aged 18 to 21 who were formerly looked after, or are disabled.

Chapter 7 looks at how the system in Northern Ireland seeks to prevent and tackle CSE. This addresses the issue of cross-sectoral working referred to in the Terms of Reference.

Chapter 8 moves on to address the services required to promote recovery from CSE.

Chapter 9 is an analysis of human rights and international standards relevant to CSE, with a particular focus on the UNCRC. It is placed at the end, not because it is the least important dimension, but because the significance of these rights becomes more evident when the full spectrum of issues has been explored. Nevertheless, the report references these rights at points throughout the report where it seems particularly appropriate to do so.

Chapter 10 draws together the conclusions of the Inquiry and is followed by a full list of recommendations. These are accompanied by the Inquiry's view on who should be responsible for taking action to implement them.

The Inquiry gained many insights from the information provided. We did not want to lose these, but neither did we want our critical, and often strategic, recommendations to become lost within a large number of particular recommendations. We have therefore prefixed our recommendations with **Key Recommendation** or **Supporting Recommendation**, each with its own numbering sequence. This allows the key recommendations to stand out as a broad picture of what the inquiry seeks to achieve.

Threaded throughout the report are quotes from children, young people, parents and professionals. Where we have set out quotes from individuals, especially children, we have been careful to do so in a way that protects their identity. When we have described particular cases, we have changed names and identifying details to preserve anonymity.

Case studies are realistic, but may be composite, drawing from different cases.

CHAPTER 2: THE NATURE OF CHILD SEXUAL EXPLOITATION IN NORTHERN IRELAND

2.1 Introduction

This chapter explores what is meant by child sexual exploitation and the need for a shared understanding. It refers to types of CSE identified in research and what the Inquiry has learned about what is currently happening in Northern Ireland. It also identifies the conditions and predisposing factors that may increase the risk of CSE occurring. Whilst media attention has focused on victims within the care system, this chapter discusses how children and young people from any background can be affected.

2.2 What do we mean by Child Sexual Exploitation?

The first difficulty with CSE is identifying what it means. Much energy has been expended on developing definitions that capture the core elements as well as the wide variety of forms of CSE.

CSE can range from the type of planned or systematic activity uncovered in Rochdale and Rotherham to relationships between underage girls and men who are perhaps a few years older, which neither of the parties, certainly at that time, regard as exploitative. It includes party houses where drugs and/or alcohol may be provided free in the first instance, but which the young people enticed to the venue are later expected to pay for with sex. It can be a relationship that starts off looking like a consensual one but develops into an expectation that the young person has sexual activity with the partner's friends and associates. It may involve the young person being transported from place to place. Money may also change hands. Increasingly today, children and young people can be exploited through the internet and social media, through grooming that may or may not lead to face-to-face contact, or through the generation and sharing of indecent images of the young person (sexting), which can become the focus of bullying and/or blackmail. CSE can affect both males and females, but young men are less likely to disclose or to be identified as victims.

The working definitions of CSE attempt to identify elements common to all of these activities. The earliest definitions are now regarded as too complex and outdated. The most recent definition, published by SBNI in October 2014 (adopted from the CSE Knowledge Transfer Partnership NI) defines CSE as follows:

“Child sexual exploitation is a form of sexual abuse in which a person(s) exploits, coerces and/or manipulates a child or young person into engaging in some form of sexual activity in return for something the child needs or desires and/or for the gain of the person(s) perpetrating or facilitating the abuse.”

The Inquiry is aware that this is also regarded as an interim definition that may be further refined.

The history of the definitions of CSE reinforces the perception that CSE is a confusing concept. Some argue that these behaviours should be classified simply as child abuse. But here too there are grey areas. A young person aged 16 is over the age of consent. If a 16 or 17 year old has a sexual relationship with someone a few years older, and there is a power imbalance, some would say they have made an unwise choice, but would have difficulty identifying the point at which this crossed the line into an exploitative relationship in which the young person had little or no choice.

CSE is also a difficult concept to communicate effectively, in a way that causes people – young and older – to consider its relevance to them.

The report of the consultation with young people in care told us that using the word ‘child’ and ‘sexual’ together seems to make young people uncomfortable.

A young person said they would not pick up a leaflet about CSE:

“You would be embarrassed to pick it up because of what it says on the front.”

The use of ‘child’ also enables some young people to dissociate themselves as they do not consider themselves as children even though they are under 16. Young people suggested that the term CSE should be reviewed and changed. One young person said:

“A child is an eight year old – maybe it should just be called sexual exploitation.”

This is a helpful insight that should inform awareness-raising information for young people. However, for information for professionals, it can be helpful to reinforce the fact that, in terms of international law, anyone aged under 18 is a child with a right to be protected.

Parents told us that they would not pick up leaflets on child sexual exploitation because they did not think it was relevant to them. However, after some discussion about what it involved, they concluded that it may be relevant to them and their families after all. The ETI, as part of their fieldwork, issued a confidential questionnaire to parents and, of those that responded, 78% had no prior knowledge of CSE.

If the term child sexual exploitation encourages people to think it does not apply to them, or puts them off from accessing information, this will make any awareness-raising messages less effective. The consequent lack of understanding will contribute to under-reporting by young people, parents and those in the community.

Supporting Recommendation 1:

All agencies involved in awareness-raising should ensure that language used is meaningful to the target groups.

2.3 What does Child Sexual Exploitation look like in Northern Ireland?

2.3.1 The Barnardo's 2011 Report

The Barnardo's report repeatedly acknowledged the difficulties in quantifying the extent of CSE and in identifying clearly defined categories. It recommended systematic collation of data to allow for a more accurate picture. However, on the basis of the information collated, the report identified 147 cases of known or suspected CSE. These were classified into seven categories, on the understanding that there was some overlap between them. The categories are listed below in order of the number identified amongst these 147 cases:

1. Party house scenario, where a young person is exploited by more than one individual (63).
2. Sexually exploitative relationships in which the young person believes the abuser to be their boyfriend/girlfriend (35).
3. Abuse through prostitution, including all cases where sex was exchanged for money, goods or the discharge of a debt (24).
4. Sexual exploitation by other individual in the community, where the abuser was not perceived as a boyfriend/girlfriend (18).
5. Internet grooming/exploitation, involving cases that were started on-line, but not including many cases under other categories that involved use of social media, etc. (4).
6. Forced Marriage Protection Order (2).
7. Trafficking from abroad for the purposes of CSE (1).

This classification was refined in the light of discussions with professionals and young people and case file reviews. The abuse through prostitution category was divided into prostitution for third party gain and those cases that identified no third party. The third parties organising the prostitution could be individuals or groups, some with links to paramilitarism. Peer exploitation emerged as a serious issue.

The Inquiry explored these different forms of exploitation with agencies and individuals and concluded that child sexual exploitation takes many forms in Northern Ireland. These often replicate what is happening elsewhere in the United Kingdom, but there are particular Northern Ireland dimensions to them.

The following sections set out what the Inquiry learned about the nature of child sexual exploitation in Northern Ireland.

2.3.2 Organised or Not?

In our early discussions with the Trusts, we often heard the statement, "It's not like Rochdale." We were told that, while there had been examples of organised abuse in the past, and there had been a time when taxis and unknown cars were turning up to collect young people from children's homes in ways that aroused suspicion, this was less evident now.

Others reflected that this might not mean that the danger to these young people had lessened, but that young people and abusers had become better at covering it up. The taxis and cars might be less evident, but they could be waiting around the corner from the children's home. Trust staff often recognised that they might not be getting the whole picture. In a submission to the Inquiry, a school related concerns about pupils spending protracted periods of time away from their residential facility in the company of unknown older adults and, according to reports from staff, being returned in private cars or taxis.

The general message from statutory agencies was that there was no evidence of organised child sexual exploitation in Northern Ireland today. It was portrayed as largely a case of opportunism. There may be loose groupings of adults who knew each other, but these did not constitute organised gangs.

We asked the PSNI: Is there evidence of organised groups involved in CSE in Northern Ireland? Their response was:

“In terms of links between offenders, Organised Crime Groups type links have not been noted, although there are links between some of the offenders who have committed crimes across a number of victims. These links appear to be based on relationships surrounding a number of forms of criminality, for example, drug use, burglary etc.”

The HSC Board told us there was “no evidence of gang involvement” in Northern Ireland.

However, the closer to the grass roots we moved, through contact with community organisations and individuals familiar with particular cases, the more concern was expressed that there was a level of organisation in some types of CSE. Even within one statutory agency – PSNI - we found that the response teams working in the communities were more likely to identify a level of organisation than those working at a little more distance such as the Police Public Protection Units (PPUs).

Representatives of voluntary organisations questioned what was meant by references to organised exploitation by those who said this was not currently happening:

“Is having a house party and making drink available organised? It's not an organisation, but it's organised. Who is paying for the drinks and the taxis?”

It became clear that there are, and have been, a number of labels used in relation to activity involving more than one perpetrator or unrelated victims: organised crime, small or large scale abuse, complex child abuse. Each brought with it its own set of procedures and resources. Whatever one calls it, the Inquiry considers that it is important to identify what levels of organisation exist in order to pursue appropriate responses to them. Accordingly, within this report, we will use the term organised to indicate that there is a level of organisation as this is the ordinary sense in which people used it when speaking to us.

The Child Exploitation and Online Protection Centre (CEOP) has an international perspective on this issue. It was established in 2006 to tackle online offending both within the United Kingdom and abroad.

In October 2013, it was absorbed into the National Crime Agency (NCA) which has restricted operation in Northern Ireland. However, PSNI reported that they continue to work with CEOP, particularly around overt and covert technical issues around indecent images of children. In their submission to the Inquiry, the NCA said the remit of CEOP Command was to prevent and tackle CSE in both the online and offline environments, through adding value to law enforcement agencies across the United Kingdom. The NCA declined to comment on the nature and extent of CSE in Northern Ireland, referring the Inquiry to PSNI for that detail. However, its annual CSE Threat Assessment of Child Sexual Exploitation and Abuse gives an interesting insight into the United Kingdom picture, particularly in relation to the online dimension and trafficking, which have the potential to extend beyond Northern Ireland's borders.

CEOP's Threat Assessment of Child Sexual Exploitation and Abuse (2013) observes:

"In the majority of its forms, both online and offline, child sexual exploitation and abuse ... remains a largely solitary crime, albeit one often exacerbated by the effects of group dynamics. Often where true group offending does occur, this shares few of the characteristics traditionally associated with organised crime."

The implication of this is that one should not assume, from official references to lack of evidence of organised crime in relation to CSE in Northern Ireland, that there are not groups of people acting together to exploit children and young people.

Some of those who spoke to us referred to what was happening as opportunism. There are plenty of opportunities in terms of young people's vulnerabilities. Perpetrators may not start off with a plan, or as part of a gang, but can be drawn together around the young people and the places where they gather, and then coalesce into a group.

Both CEOP and the Office of the Children's Commissioner (OCC) Inquiry in England distinguished between gangs and groups. The OCC report used the following definitions:

Gangs are relatively durable, predominantly street-based, social groups of children, young people and, not infrequently, young adults who see themselves, and are seen by others, as affiliates of a discrete, named group who (1) engage in a range of criminal activity and violence; (2) identify or lay claim to territory; (3) have some form of identifying structural feature; and (4) are in conflict with similar groups.

Groups are two or more people of any age, connected through formal or informal associations or networks, including, but not exclusive to, friendship groups.⁶

In this context, we consider gangs to be pre-existing entities, whilst groups would be individuals who might coalesce around CSE.

⁶ *If only someone had listened*: Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report, November 2013.

The consensus from those who spoke to this Inquiry was that street gangs of children are not a Northern Ireland phenomenon. The label of gang tended to be attached to adult groups associated with paramilitarism and to some emerging groups of immigrants.

2.3.3 Trafficking

Trafficking is one manifestation of organised abuse of children. It occurs when people of any age are moved, harboured or received for the purposes of exploitation or where such actions are facilitated. It is the subject of both international and national law. The Sexual Offences Act 2003 criminalises trafficking into, out of and *within* the United Kingdom. This means that a person may be trafficked: from abroad into Northern Ireland; within the United Kingdom; or within Northern Ireland itself. The offence of trafficking is committed when the intent to exploit is there – whether or not it was actually put into effect. Trafficking may be conducted for purposes other than sexual exploitation (domestic servitude for example), but some trafficked children will also be victims of offences listed in the Sexual Offences (Northern Ireland) Order 2008. Known numbers for trafficking from abroad are small, but a number of people we spoke to were able to give examples.

Much of the discussion was around internal trafficking and the fact that many of the models of CSE could involve transporting children within Northern Ireland and would therefore fit the definition of trafficking. A briefing by Barnardo's in 2013 said this had become increasingly visible in Barnardo's work across the United Kingdom⁷.

There are particular protections for child victims of trafficking. Home Office Guidance says:

“Any child who is recruited, transported or transferred for the purposes of exploitation is considered to be a trafficking victim, whether or not they have been forced or deceived. Even when a child appears to have submitted willingly to what they believe to be the will of their parents or accompanying adults, it is not considered possible for a child to give informed consent.”⁸

The National Referral Mechanism (NRM) is a framework for identifying victims of human trafficking and ensuring they receive the appropriate protection and support. NRM statistics show the numbers referred to be low. From October to December 2013, there were seven referrals of children from Northern Ireland. Four were given a positive decision (recognising that they had been trafficked), two were withdrawn and the other was, at the time of writing, still in process. Six of these related to trafficking cases originating within the United Kingdom. Six, including the four positive decisions, related to the sexual exploitation of females. Two of the four successful cases involved young people aged 12–15 and two were aged 16-17. No children were referred to the NRM in the period January to March 2014, the latest period for which figures are available.

⁷ Webb, M.A., and Devlin, J.M., *Safe Choices: Responding to the changing nature of child sexual exploitation in Northern Ireland*. Barnardo's NI (2013).

⁸ Home Office: National Referral Mechanism – Guidance for Child First Responders: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/244697/NRM_First_Responder_Guidance.pdf

PSNI advised the Inquiry that:

“Between 1 April 2012 and 24 July 2014, they referred 23 potential victims of human trafficking under the age of 18 to the NRM. Eighteen of these referrals were in the year 2013-14 and arose largely out of the PSNI Operation Owl. Ten of the 23 referrals were for sexual exploitation (the others related to unknown exploitation) and 10 involved British or Irish young people.”

The National Society for the Prevention of Cruelty to Children (NSPCC) which operates a Child Trafficking Advice Centre across the United Kingdom, advised that:

“In 2012-13, they received three queries about children identified as potential victims of trafficking and responded to seven calls and eight e-mails from professionals concerned about children and young people in Northern Ireland.”

The NSPCC noted that, while trafficking was a small but emerging issue, the fact that Northern Ireland was the only part of the United Kingdom with a land border might be used to exploit children.

Parents involved in the Parenting NI consultation gave different perspectives:

“Three of the focus groups referred to trafficking. In Group A, one parent was aware of trafficking of young people for sexual purposes in Northern Ireland while other parents expressed surprise that this issue exists here. Participants in Group D felt that some prostitute rings in the city included young women who were there against their will. Participants said that they believed police know about these, but appear to be doing nothing about it. There are websites which are used to book into these venues.”

The Inquiry asked PSNI whether trafficking legislation could be used more effectively to tackle CSE. They advised that:

“As our knowledge and understanding of Child Sexual Exploitation has grown, Trafficking, as an offence, is being considered by officers where there is information a child has been moved from one location to another for the purposes of Child Sexual Exploitation. This had been reflected in service instructions.”

PSNI also advised that almost 4,000 officers had completed a 60 minute e-learning course on human trafficking.

Some say we should use the trafficking legislation more for internal cases, whilst others point out the disadvantages in that approach. The benefits of using trafficking legislation are that it provides a ready-made framework built on the principle that the victim should not be blamed. The disadvantage is that the label of trafficking may divert attention from the fact that this is essentially child abuse. Trafficking legislation is not intrinsically linked into protective mechanisms such as the Sex Offenders Register. This means it will be important to ensure that any prosecutions for trafficking also pursue any sexual offences associated with it.

Trafficking is an area under development in terms of law and policy. In May 2013, the Minister of Justice published the first Human Trafficking Action Plan for Northern Ireland. A progress report published on 12 May 2014, noted collaboration with authorities in the Republic of Ireland and a number of awareness raising and educational initiatives.

Furthermore, the ETI survey showed that some of this had found its way into a small number of the schools they visited. The Minister's progress report identified targets for wider engagement and referred to an event hosted by the Belfast Policing and Community Safety Partnership in January 2014 involving council staff, the hospitality sector, landlords and estate agents and taxi drivers. This is a welcome development and of interest to the Inquiry as these are people who are also likely to be able to help identify, disrupt and report broader concerns about CSE. The report also refers to the Justice Department's work with Lord Morrow to agree amendments to the Human Trafficking and Exploitation (Further Provisions and Support for Victims) Bill, which is currently before the Northern Ireland Assembly.⁹ The Inquiry understands that the DHSSPS has also been working with Lord Morrow on this Bill, particularly with reference to the introduction of child trafficking guardians.

2.3.4 Party Houses

Young people have always had parties and have indulged in behaviours that their parents would not approve of. It would be wrong to demonise parties as such. This generation of parents, in common with those who went before, will try to help their children make wise decisions about where they go, who they associate with and what they do with them. This is nothing new. What is new is that social media allows young people to make contact with a much wider group of people unknown to their parents, and allows unknown persons, some with malicious intent, to make contact with children. Another factor is the increasing sexualisation of society and the impact on young people's expectations and culture. This is explored further below.

The party house scenario generally involves the availability of drugs and alcohol, and exploitation of a young person by more than one other person. To a young person, often aged 13-15 according to reports made to us, it might seem on the face of it just to present the prospect of a good night out. However, once under the influence, they may lose control and will not know the details of what has happened to them. Girls may go there with someone they believe they are in a relationship with, but end up being passed around a number of people for sexual activity. They may also be told that they have to engage in sexual acts to pay for the drugs and alcohol they have consumed.

“Girls are given drugs to induce them into sex and are then told it's payback time.” [Individual]

Sometimes there are older adults at these parties who know each other. Nevertheless, those we spoke to were often reluctant to classify what was happening as organised abuse, preferring to refer to loose associations of adults and an element of opportunism.

⁹ <http://www.niassembly.gov.uk/Assembly-Business/Legislation/Current-Non-Executive-Bill-Proposals/Human-Trafficking-and-Exploitation-Further-Provisions-and-Support-for-Victims-Bill/>

Others pointed out that sometimes there did appear to be some organisation involving the supply of drugs, alcohol and transport. Some gave examples where there appeared to be very specific organisation, such as where an older adult organised the parties and allowed young people to stay over.

Some venues remain party houses for some time, but others come and go. One HSC trust said they worked well with police who would disrupt them by issuing harbourers warning notices and getting them closed down.

We believe it is reasonable to conclude that there is a wide spectrum of levels of organisation associated with the party house scenario, involving varying levels of vulnerability, manipulation and exploitation of young people.

Party Houses were frequently referred to by HSC trusts, police, community organisations and individuals as occasions for CSE. The VOYPIC report picked up on the party scene and its link to CSE.

“All young people identified drugs and alcohol as a feature of this scene and how it is used to build trust, friendship and dependence leading to vulnerability. Peer pressure and not wanting to lose status at the party scene also feature. Local party venues are widely known amongst young people.”

Young people described experiences of parties and the availability of drugs and alcohol:

“Sometimes you bring your own but usually everyone shares and I don’t have to do anything in exchange for them, just good times.”

“If you are under the influence you are more likely to go to a party with people you don’t know.”

“There are always parties going on and everyone knows where they are.”

Some young people consulted by VOYPIC recognised the scenario in which drugs and alcohol are initially supplied free but later something is expected in exchange. They gave examples of ways in which friends or acquaintances had been exploited both at party houses and other places. Worryingly, whilst they could see the dangers in this kind of scenario, they did not acknowledge their own vulnerability.

“Young people are oblivious – they don’t realise it’s happening – even if their mates say, they just think they’re jealous.”

The risk assessments that formed the basis for the Barnardo’s report, and the VOYPIC consultation commissioned by the Inquiry, both related to young people already known to social services. However, exploitation at party houses can affect young people living at home, in care and across all social classes. The Safe Choices Service operated by Barnardo’s specialises in work with children who are being sexually exploited or are at risk of it. The Service told us that, in their experience, the party house scenario had become normalised amongst many young people the service works with.

Parenting NI reported that some parents were very aware of the dangers of party houses and others were not. They did not feature significantly in the consultation with parents. Professionals gave examples of parents expressing concern and/or taking action. One described a case in which the parents went to the party house to retrieve their daughter and found her unconscious and in a compromising state. Another parent we spoke to described her frustration at attempts to get help to keep her daughter safe.

Taxi drivers said they were very aware of the existence of houses where parties sometimes went on for days, attended by 14 - 15 year old girls and large numbers of men and boys. We were also told that taxi drivers regularly buy alcohol in response to requests and deliver them to customers' homes where they are reimbursed. It may not be clear to them until the point of delivery that the customer is underage, or that the premises are hosting a party involving underage children.

It is difficult to assess the extent of CSE related to the party house scenario because those attending often do not see the dangers and are unlikely to report it. This is a very difficult area where normalised behaviour by young people (which may in itself be an issue) leaves them vulnerable to escalation into CSE in a way that can quickly get out of control.

2.3.5 Other Locations

Other locations were referred to as places where young people could be vulnerable to CSE. The VOYPIC young people cited: outside discos, at late night fast food outlets and car parks where groups congregate especially when drinking or drunk. Trust staff identified hospitals, train stations and shopping malls as places where young people congregate.

We heard from a few sources about line-ups in parks and other public spaces where girls are expected to perform sexual acts on groups of boys. In England, the OCC report linked this kind of activity with organised gangs but, as indicated, those we spoke to in Northern Ireland felt there was no similar street gang culture in Northern Ireland, just loose groupings of young people.

Bars and clubs were referred to as places of vulnerability even for children under 18. We were told that it is very easy for underage young people in Northern Ireland to get access to licensed premises. At a meeting with young people, we were told that there is not a lot for young people to do:

“Teen discos are okay till you’re 12. Age 13-16, there’s nothing to do. Once you’re 16, you get fake ID and go to clubs and bars.” [Young person]

Some respondents told us that licensing laws could be more forcefully enforced. There was a strongly held view that there were deficiencies in the policing of licensed premises, particularly those they believed to be frequented by people with paramilitary links.

A group of parents involved in the Parenting NI consultation that included taxi drivers, expressed concern about lack of enforcement of licensing laws:

“Group D was concerned about the lax interpretation of licencing laws by licenced premises and off-licences in their city. Underage young people gaining admission to adult night clubs was a particular concern, as was the specific vulnerability of these young people to predatory adults.

Participants described certain premises that stay open and continue to serve alcohol after 2 am when they are supposed to be closed - despite CCTV cameras. Nothing happens to stop this. Further risks on the premises include availability of a wide range of drugs and the possibility of having drinks spiked. Participants gave examples of rescuing young people from risky situations on the streets including potential sexual assault, extreme intoxication and distress, resulting in having to bring children home or to A&E.

Another source of concern was the availability of alcohol from off-licences, via adults who buy drinks for children and young people. Participants were also aware of certain taxi drivers who deliver alcohol to houses for underage young people. Taxi drivers in Group D said that they sometimes collect young people who are already drunk before they go out to the night clubs. Furthermore, for many young people the night does not stop after the bar/club closes as they proceed onto parties or party houses.

Taxi drivers in Group D also reported bringing young people to school on Monday morning who smell of drink. They expressed concern about the impact this might have on schooling.”

Young people can be particularly vulnerable if they are denied entry to or thrown out of pubs or clubs because they are underage, or under the influence of drink or drugs. They will be alone and vulnerable on the street. This contrasts with an example of good practice cited by young people regarding an alcohol-free club for 13 to 17 year olds. If a young person arrives under the influence, they are supervised until a family member comes to collect them.

Supporting Recommendation 2:

PSNI should take action to strengthen enforcement of licensing laws and especially those concerning the supply of alcohol to young people. Police and Community Safety Partnerships should lead localised approaches to address the issue.

2.3.6 Internet and Social Media

In recent years, there has been publicity and awareness-raising about the dangers presented by the internet and the possibility of grooming by adults posing as young people. A recent phenomenon is sexting, whereby a young person sends an indecent image of themselves to another person, often on the understanding that it will be visible only for a short time.

The ETI report commented that in the schools visited:

“There is recognition in most schools that all pupils are at risk of sexual exploitation through the use of communication technologies and they try to ensure that their pupils are taught about online risks and how to recognise unsafe contacts. There is, however, variation in the capacities of pupils to use technologies safely.”

During the Inquiry’s consultations with young people, they reported that they did receive messages at school about keeping safe online. There are already some useful resources for children about internet safety, such as Thinkuknow on the CEOP website. Some young people said they were “possibly more educated about online exploitation,” but “not aware that it happened outside the internet.” Some admitted that they didn’t pay attention to what information there was, as they didn’t think it would happen to them and added that they were not taught how to handle it if it did happen.

A school reported that it had identified six cases of online grooming over the past four years. All of these had been identified before abuse took place. A therapeutic facility reported that referrals for online abuse had increased from five in 2008 to 22 in 2013. Ten were male and 12 female. Barnardo’s observed that, over the past two years, there had been an increase in referrals relating to young people living at home being groomed over the internet, with no obvious vulnerability factors.

Many of the parents consulted by Parenting NI were aware of the work being done by schools. Like their children, they reported that the focus tended to be on stranger danger and internet safety rather than the broader dimensions of CSE.

The internet, in its broadest sense, was the focus of discussion largely in relation to access to sexual information or pornographic material. Lesbian, gay, bisexual and transgender (LGBT) young people reported that sex education at schools rarely addressed same-sex relationship issues. Research suggests this can lead to young people to looking to the internet for information, with the potential of bringing them into contact with risky people and dangerous situations.¹⁰ For young people in general, their expectations of what a normal sexual relationship involves can be coloured by what they see on-line. It is easy to access pornographic material and there can be peer pressure to replicate the sexual behaviours depicted. A social services team reported an increase in young people from middle class families becoming involved in CSE via pornography over the internet. Children as young as nine or 10 were exposed to pornography, both accessing and sending sex images. This made it easier for predators to groom and exploit them. We were also told of growing numbers of primary children watching pornography on smart phones – not understanding what they saw and then acting it out.

However, it was the social media dimension of the internet that featured most widely in the discussions – a fast-moving world of new applications and possibilities for networking and grooming. Young people discussed the grooming process and how easy it is for people to lie about their age.

¹⁰ Smeaton, E. (2013) *Running from hate to what you think is love: The relationship between running away and child sexual exploitation*. Barnardo’s London. Quoted in Barnardo’s NI *Policy and Practice Briefing No. 16. Safe Choices: Responding to the changing nature of child sexual exploitation in Northern Ireland (October 2013)*. PSNI advise that they are not aware of same sex CSE issues in relation to the internet.

It became clear that mobile phones and social media are used to advertise party venues. The VOYPIC report cited an example of a young person using social media as a way to find someone to give her a lift home:

“Usually a boy pops up offering a lift for sexual favour.”

Parents had a general awareness of the threats internet and social media can pose to their children’s safety, but considered themselves ill-equipped to recognise and counter them. Nevertheless, 93% of the respondents to the Parenting NI online consultation said they did try to keep their children safe by explaining the dangers of the internet. Substantial proportions of these parents also referred to specific actions, such as checking their child’s internet history, placing restrictions on what and when they can access the internet and checking texts and mobile phone contacts, although some felt uncomfortable about the ethics of such monitoring.¹¹

A number of parents said there was a need for education classes for parents and grandparents about keeping children safe online.

Mobile phones featured strongly in discussions around CSE. Care staff spoke of young people being settled for the night, then receiving a text message and leaving the facility without permission. Staff had adopted various strategies to deal with this, including confiscating phones, insisting or agreeing that they be handed in at night, and replacing smartphones with basic phones, sometimes with restricted telephone numbers available for communication. However, young people seemed to be able to circumvent these protective measures. New phones would be provided by family or by unknown persons. A young person might have a number of phones or a number of SIM cards for the same phone.

Parents were, in general, confident that they knew how many phones their child had, although after discussion they began to see that they might be unaware of the existence of additional SIM cards. Despite the risks associated with mobile phones, parents, young people and carers also valued them as a protective measure, enabling them to keep in contact with children. Phones were also important to young people for more general, social reasons:

Jennifer was 14 when her foster carer discovered that she had been sending indecent images to an older man. Her phone and tablet were taken by the police for forensic analysis. This was at the beginning of the school summer holidays. Without the phone, she did not have contact details for her friends. She felt isolated and, with little to do, she spent the time going over in her head what had happened to her.

¹¹ It should be noted that this result might be influenced by an element of self-selection as these parents were able to complete an on-line survey.

Developments in social media allow young people to make and share indecent images of themselves, generally on the understanding that this will be kept private by the recipient. However, even when the method used is supposed to provide privacy or a short term exposure, there are often ways to capture and share the image. This can then become a focus for bullying and/or blackmail. This sexting was described by a voluntary organisation as being epidemic in schools. ETI reported:

“In most of the schools visited, the staff are dealing with on-going incidences of sexting and the sharing of inappropriate images.”

Sexting is an illegal activity. It sometimes occurs, or at least starts, within a boyfriend/girlfriend relationship, but it can be initiated online by a stranger or someone with a false identity. Young people are often unaware that they may be committing an offence by sharing an indecent image – even if it is their own.

Within the education sector, the CPSSS expressed strong concerns about the misuse of social media and reported that they have evidence that indicates sexting is on the increase, and starts at a very young age, with examples of children in primary schools sharing inappropriate images. They see the need for more consistent approaches to e-Safety across the education sector. This should include training for parents by quality assured providers and consistent use of key keeping safe messages across the phases of education. They also expressed concerns at the increasingly complex roles being undertaken by designated staff in schools without the opportunity for professional support, in line with the clinical supervision provided to social workers and counselling staff.

Many reports to CEOP are initiated by a young person having confided in a parent or other trusted adult about having sent an indecent image of themselves to an offender. Thirty-five percent of the cases known to CEOP involve 13 and 14 year olds, 26% are aged 11 or 12, and 22% are aged 15 or 16. Eighty percent of known victims are female. Most of the images show domestic backgrounds such as bedrooms or bathrooms. CEOP considers that most of the images were generated freely by the young people, but a smaller number will have been the result of deception or coercion or will go on to be used for other purposes. Within Northern Ireland, interviews with police PPU staff identified notable numbers of investigations involving the sharing of indecent images amongst young people.

The Barnardo’s report in 2011 observed that, during their research, few references were made to the commercial production and distribution of images. It considered this was something that required further investigation as it was unlikely that Northern Ireland would be immune from that form of abuse. We asked about this during various engagements with stakeholders but were given no indication that this was a known problem. In particular we put the question to PSNI who responded as follows:

“Throughout our investigations our Child Protection Internet Team regularly come across people who distribute indecent images. This is captured and dealt with and, if possible, an intelligence pack created regarding the person who has received the images. This is subsequently forwarded to the local Public Protection Unit for their investigation. The Child Internet Protection Team has not come across any person or business within Northern Ireland that have been distributing/supplying abusive images of children for financial gain.”

We agree with Barnardo's that, despite the absence of hard evidence of this happening in Northern Ireland, authorities must remain vigilant about this possibility.

CEOP's 2013 Threat Assessment of Child Sexual Exploitation and Abuse noted a development in online grooming techniques across the United Kingdom. Earlier models had focused on the gradual grooming of a child:

"The restrained influencing of a child over several months has been largely replaced by rapid escalation to threats, intimidation and coercion. Both features are a symptom of the availability of thousands of potential victims online at any one time."

In more than two-thirds of the attempts reported to CEOP in 2012, vigilance by the potential victim prevented escalation into full offending. However, CEOP adds that it is not possible to establish how many vulnerable young people have fallen victim to this kind of scatter-gun approach by offenders.

Within Northern Ireland, e-safety is a strategic priority for SBNI, as evidenced by its Business Plan.¹² This includes research to evaluate current internet safety messages. It has also established an e-safety forum and associated task groups.

2.3.7 Abuse through Prostitution

The OCC has published the conclusions of its inquiry into CSE, including an Accelerated Report in July 2012 which recommended that:

"All references in Guidance and Regulation to 'prostitution' when speaking of children should be amended to 'child sexual exploitation'."

We fully endorse that recommendation and have received no objections to that proposal when we have raised it in discussions in Northern Ireland. All references to prostitution in this report should be read in the light of that recommendation.¹³

The wide definition of prostitution, in line with the legislative definition, manifests links with party houses (where sex may be demanded in return for availability of drugs and alcohol) and the kind of case referred to previously, where a young person reported a transaction of sex in return for a lift home. This is not an isolated incident. We have heard numerous references to payment of taxi fares by the performance of sexual acts.

We asked PSNI for information about the prevalence of child prostitution. Their response emphasised that they did not refer to these children as prostitutes and that they consider them to be victims. They supplied the following information about sexual exploitation offences against children:

¹² SBNI Business Plan September 2013 to March 2015:

<http://www.safeguardingni.org/sites/default/files/sites/default/files/imce/08.01.14%20SBNI%20Business%20Plan%202013%20-%202015%203.0%20FINAL%20COPY.pdf>

¹³ It should be noted that the Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland, (2013) uses the term "children abused by commercial sexual exploitation" rather than "prostitution".

“There is no intelligence to suggest the organised prostitution of children. Sexual offences classification 71, Abuse of Children through Prostitution and Pornography, is available in our published annual bulletin (Table 2.2). The data series for this classification started in 2008-09, although no offences were recorded in that financial year. Since then the numbers recorded are:

2009-10	1
2010-11	4
2011-12	5
2012-13	2
March 2013 to February 2014	5 (provisional)”

We were advised that there had been no reporting on boys or young men as sex workers, and limited reporting on girl minors working in the sex industry in Northern Ireland. The main nationalities of female sex workers were Romanian and Chinese.

Despite this, we believe that there will be more of what might be regarded as traditional prostitution that does not come to light. Certainly, individuals who have spoken to us about their experiences of exploitation as children have often been convinced that money has changed hands.

Karen had been abused by her father. When she was 16, she was befriended by Harry, an older man and eventually moved in with him. Harry began to offer Karen for sex to men who came to the house. She became aware that money was changing hands. Karen was moved from town to town and sometimes across the border into the Republic of Ireland to have sex for money. This happened from one to several times a week.

2.3.8 The Boyfriend Model

The HSC trusts told us, largely with reference to young people in residential care, that the dangers they had identified did not relate so much to organised abuse as inappropriate relationships between young girls and men aged perhaps a few years older. This is sometimes referred to as the boyfriend model, although it can apply to both genders. It was acknowledged that not all relationships with an age difference are exploitative, a point made also by young people but, given what we now know about power dynamics and practices associated with grooming, the existence of a significant difference in age should at least prompt us to ask questions. Worryingly, young people told us it could be seen as cool to have an older boyfriend/girlfriend.

“A young fella with an older girl is way cool – you’d be jealous.”

Moreover, we were told that the boyfriend model could be the way into other types of CSE and that younger men were often used to recruit girls into sexual activity through introducing them to party houses and/or wider networks of friends or associates. Sometimes the exploitative nature of the relationship is clear:

James was 14 when he met John, who was 31. James had a troubled background and John said he would protect him. He kept a knife in the kitchen and said he would use it on anyone who came near him. It became clear that he would also use it to attack James if he didn't do as John said.

At other times, the nature of the relationship is less clear. The problem is that many of the characteristics of grooming involve activities that one might expect of the beginning of a normal relationship, such as giving gifts and expressing affection.¹⁴ This raises the question of how young people, parents, professionals and communities can be helped to understand and reflect on what makes one relationship suitable and another questionable.

Young people's awareness of the possible risks must be raised, but it would be an unhelpful consequence of the legitimate focus on CSE if young people were encouraged to distrust anyone or any romantic overture. Young people and parents told us that it was important to raise these issues in a way that didn't scare young people.

2.3.9 Sexual Exploitation by Other Individuals in the Community

This refers to situations in which a young person may have some sort of attachment to the abuser, but does not understand the relationship as being a romantic one. It is also the fall-back category where a case does not seem to fit neatly into other classifications. It can be difficult to separate this out from the boyfriend model because there is an element of subjectivity in it. It depends on the perception of the young person. Children who have been abused may have different ideas of the norm in terms of human relationships than the rest of society and may view a relationship quite differently from onlookers. But young people with no history of abuse can also be subject to this kind of exploitation. A young adult with no experience of the care system described to the Inquiry how she had been groomed by a respectable older male. She commented:

“If I had known that a paedophile was not just some old guy behind a computer, things would have been different.”

¹⁴ Article 22 of the Sexual Offences (Northern Ireland) Order 2008 makes “grooming” a specific offence where it is followed up by a meeting, or intended meeting with the victim. This is also discussed at Para. 6.6 of the Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland, (2013).

We also heard of cases involving army personnel, both in the past and in recent times. The cases in the past related to alleged actions by the security forces during the Troubles and were described to us as part of a whole spectrum of abuse of power by those who had it at that time. Those who spoke to us recounted movingly the impact this had had on their lives.

We received verbal information about more recent cases and followed these up with the relevant HSC trusts and the Ministry of Defence, requesting information about any such cases within the past three years. It was confirmed that there had been two separate incidents, involving two different barracks, in which girls had been smuggled into the barracks and sexual activity had taken place. Investigations had taken place, involving the HSC trusts, the PSNI and the Ministry of Defence in relation to the specific incidents and as to whether there was any connection between them. It was concluded that the incidents were not linked. None of the young people involved made a formal complaint to the PSNI. The investigations led to disciplinary procedures in relation to some army personnel, and tightened security at the barracks to prevent further unauthorised entry. The information we received from the HSC trusts indicates that the army is responsive to concerns and engages in collaborative working. The Ministry of Defence confirmed that they take allegations of this nature extremely seriously and work closely with PSNI to ensure that allegations are dealt with thoroughly, and as promptly as possible.

2.3.10 Powerful Individuals

The Barnardo's 2011 report referred to the involvement of organised groups, some with links to paramilitarism¹⁵. As the Inquiry progressed, it became clear that the paramilitary dimension was regarded by some as a very serious issue, but there were different perspectives on it. PSNI, in their response to the Inquiry, observed that:

"Organised paramilitary involvement in Child Sexual Exploitation has never been established. However, as with all perpetrators of sexual abuse, they do come from all walks of life. "

Police officers interviewed by the Inquiry tended to reinforce that view, commenting that, whilst there were probably some individuals involved who were associated with paramilitaries, there was no evidence of organised paramilitary activity related to CSE. HSC Board also told us there was, "no evidence of paramilitary involvement in Northern Ireland" in respect of CSE. Nevertheless, many others painted a worrying picture of what was happening in some communities. This was confirmed by some of the discussions we had with the Trusts.

A number of individuals expressed an ardent plea that the Inquiry should speak up about the paramilitary dimension to CSE. They gave examples of the kinds of things that are happening, but no-one gave names or identified locations. It is important to say this because some told us very explicitly that they feared for their lives if it became known that they had spoken to the Inquiry about this, especially if they had given details.

¹⁵ Barnardo's 2011 *supra*, paras. 6.4.1 and 7.2.

In setting out the information that follows, the Inquiry is aware that some will challenge us to provide hard evidence. Our evidence is the testimony of the witnesses who shared their insights and experiences with us. In our view, this evidence was powerful and persuasive.

It is clear that the peace process has brought great benefits to Northern Ireland and much has been achieved. However, we were advised that, while de-militarised in political terms, some of the structures of paramilitary authority remain and now focus on criminal activity for personal benefit at a local level. This understanding is confirmed by successive Independent Monitoring Commission reports on the state of the paramilitary ceasefires. The most recent report, presented to parliament in July 2011, observed:

“Members and former members of all paramilitary groups remain very active in non-terrorist types of crime – a bequest from the Troubles which will dog Northern Ireland for years and will require a substantial continuing effort from law enforcement agencies.”

“...we returned repeatedly to the point that the active involvement of paramilitaries made the organised crime threat markedly worse than it would otherwise have been.”

“Some members and former members of all groups remain heavily involved in a wide range of serious crime, exploiting the contacts and expertise they acquired during the Troubles and thereby presenting a challenge to law enforcement which is significantly more serious than it would otherwise have been.”¹⁶

These gangs are involved in drug dealing, and, we are told, sometimes co-operate across the traditional community divisions in Northern Ireland in pursuit of this activity.

No-one who spoke to us identified CSE as a targeted activity of paramilitary organisations, although some described how it could be associated with organised drug dealing. More commonly, it was a case of individuals who were, or were believed to be, members of, or linked to, paramilitary groups who used that authority and the fear it engendered to exploit children and young people. These individuals have access to alcohol, drugs, guns and violence. They were described as people to whom you cannot say no. They regard themselves as beyond the law and, to the affected communities, it appears that they are. Blighted communities feel abandoned. In their view, the police are reluctant to get involved. Some believe that others in authority also know what is going on but take no action. A regular comment was:

“The dogs in the street know what is going on.”

We cannot say whether that is true. PSNI rejects the assertion that police are reluctant to get involved, and state that no-one is above the law. What is clear is that these communities believe they are being left to look after themselves. There are some very committed and courageous people taking on that role.

¹⁶ Twenty-sixth and Final Report of the Independent Monitoring Commission:
<http://cain.ulst.ac.uk/issues/politics/docs/imc/imc040711.pdf>

We were told very clearly that paramilitary influence where it is apparent may cause and facilitate CSE and this undoubtedly makes it difficult for people to report it to the statutory authorities. Within communities, it can build upon loyalty and fear and sometimes a mixture of both. Girls may feel they can gain status through co-operating with these powerful individuals and this may be tolerated by some families. Others fear threats to their families if they do not succumb to the abuse, or if police visit their homes in response to a reported concern. Parents may resist reporting to PSNI for similar reasons. They may also fear reporting to social services in case their children are taken from them.

“Adults are afraid to name – so what chance has any child?”

We also heard that some young men look to these powerful individuals as role models and aspire to be like them.

For some parents, it is a particularly painful issue when they have experienced similar abuse themselves. During the Troubles, individuals in some communities felt they could not take their complaints outside their communities. We were told of families that had endured generations of exploitation. Mothers said they found it difficult to deal with their children’s abuse because they had not been helped to come to terms with what they themselves had suffered.

We were told that paramilitaries in some communities will punish those who exploit children and young people, and close down “party houses.” The offenders disappear from their communities but are free to abuse elsewhere, as there is no official record of their abusive behaviour.

Paramilitary influence is not restricted to urban areas. Whilst many believe it is less of a problem in rural areas, we were told that there are some small villages or hamlets controlled by powerful families with paramilitary links.

It was not possible for the Inquiry team to accurately identify the prevalence of paramilitary influence. Some told us it was endemic or widespread, but it seems clear that there are also many communities that do not experience it. However, for those who do, it casts an oppressive shadow over their lives.

The kind of power such individuals exert means they may be involved in all of the types of CSE described here. However, specific to them are the pubs and clubs operated in some areas where there may be lock-ins involving young girls who get “the tap on the shoulder” to stay behind and may then get shared around.

Some people in these localities expressed the concern that police were ineffectual in tackling the issues surrounding these premises:

“In terms of pubs and bars, there are still some that PSNI won’t go near.”

“The police almost seem afraid to address the issue of underage drinking in bars - aged 13 and 14. They turn a blind eye. If you rock the boat, you will have problems at the interface.”

PSNI has told the Inquiry that they strongly refute the suggestion that there are no go areas for the police. They reject the implication that they would not act against child abuse to avoid public disorder.

A strong message came out through these engagements about the reluctance of people in certain communities to involve the police.

PSNI told the Inquiry that they rely on the community to provide information to them to ensure the safeguarding of children; reluctance to provide detail impedes their ability to investigate. It seems clear that a great deal of effort is required to build up trust between the police and these communities. Voluntary organisations working within them have much to contribute to the process. In the meantime, it is imperative that steps are taken to protect the children within these communities.

We also heard references to other powerful individuals who had in the past used their professional authority or status to abuse children, sometimes in an organised way. We did not receive enough information about this to allow us to draw conclusions but we reaffirm that no-one should be blinded to the possibility of abuse on the basis of a person's position or perceived respectability.

2.3.11 Forced Marriage Protection Order

PSNI observed, in their submission to the Inquiry:

“Child sexual exploitation may also be linked to honour-based violence and forced marriage.”

Barnardo's reported that two forced marriage protection orders had come to their attention but that no further information was available. The Inquiry confirmed that, over the past five years, one forced marriage protection order had been made in Northern Ireland, and that was in 2010.

Whilst the number of forced marriage protection orders is low, it seems possible that the scale of the problem is greater than that represented by the statistics. In order to assist in identifying the scale, it was suggested to the Inquiry that schools should be alerted to the possibility of forced marriage and there should be a mechanism for monitoring the numbers of young people who do not return after a holiday abroad.

Supporting Recommendation 3:

In order to improve understanding and vigilance, schools should be alert to the possibility that young people who do not return after holidays abroad may have been subject to forced marriage. Any concerns should be reported to the designated teacher for child protection within the school for further escalation if appropriate.

2.4 Peer to Peer Abuse

There is increasing awareness of the risks that young people can pose to each other and how this has been magnified by the development of technology and the changing cultural norms, within society generally and amongst young people. Some specialist services have been developed to deal with peer abuse.

The Young Life and Times (YLT) Survey of 16 year olds in Northern Ireland (2010) disclosed that peers were the greatest offenders in cases where a young person was taken advantage of sexually whilst under the influence of drugs or alcohol.

The Inquiry heard a lot about the problems resulting from sexting between young people, but also about rape and sexual assault. Some of this is facilitated by peer pressure. The consultation conducted by Parenting NI commented on peer pressure into doing inappropriate things:

“Some parents said that children and young people can feel pressure to conform or to join in with peer group and that this can result in CSE. One mother explained that her daughter (aged 11) has friends who already have ‘boyfriends’. One of her child’s friends recently described how her boyfriend had ‘touched’ her. This parent spoke of the quandary for her child, who obviously does not want to be left out, but is not old enough or mature enough to have boyfriends. From the parents perspective, her child is still of an age where she can enjoying playing, but her friends want to go to discos and have boyfriends.”

In England, the OCC commissioned research on young people’s understandings of consent in relation to sexual matters which disclosed a high degree of tolerance of situations in which it would appear to an external observer that the young person had little choice but to engage in sexual activity. From what we have heard, we would suggest that the same applies in Northern Ireland, particularly in communities in which there is little respect for women. This is reflected in the use of inappropriate sexualised language by young people in schools and children’s homes, which may go unchallenged.

Some of the peer abuse described to us appeared to arise out of normalisation of unacceptable behaviour, but in others it was linked in with deliberate exploitation, often with elements of organisation. Young people, male and female, may be used by adult abusers to introduce other young people to the network. The Barnardo’s report 2011 expressed concern about young people who have been sexually exploited drawing other young people into the spider’s web and commented:

“The primary focus of law enforcement agencies must be directed towards the adults who are organising and perpetrating the abuse.”

Peer abuse was raised in the consultation with the education sector. The further education colleges explained the risks they had to manage in respect of young people attending as part of rehabilitation programmes for sexual offences. They said they needed more support, collaboration and information from social services. They suggested, for example, that a child’s social worker should accompany them to college, meet their learning support officer together and assist in the transition.

The colleges report an increasing need to carry out risk assessments where students posed a risk to other learners.

We are aware that PSNI guidance on this matter specifically raises the possibility that sexual activity that appears to be consensual may nevertheless be exploitative.

We would encourage PSNI to continue to ensure that this issue is highlighted in training of police officers so that they actively consider the possibility that controlling adults may be standing behind the young people on the frontline of exploitation. This is also emphasised in the recent guidance published by SBNI.¹⁷

2.5 Gender

Recent research on CSE has focused largely on female victims. In August 2014, University College London (UCL)¹⁸ published a Rapid Evidence Assessment of the sexual exploitation of boys and young men. It confirmed that very little is known about the exploitation of young men but identified some key themes:

- males constitute a substantial minority of child sexual abuse victims, but estimates are complicated by an assumed greater reluctance of males to disclose
- males are more likely than female victims to be abused by female offenders
- males may be more likely to be abused within institutional settings
- the impact of technology in creating new avenues for abuse
- males and females may react differently to abuse

The research suggests a need for different responses to prevention, awareness-raising and support for male victims of CSE.

Many people gave us case examples of males who had been exploited, but all agreed about the lack of hard information on the scale of the exploitation. Most of these cases involved male perpetrators, but a few were female.

In response to our request about male victims of CSE, PSNI acknowledged that:

“Recognition of sexual exploitation in males is traditionally difficult to identify. While the vulnerabilities for male and female victims are very similar, the number of male victims who disclose is significantly lower. Young males may be less likely to make a disclosure as they feel that this may be damaging to their masculinity.”

This understanding was confirmed by young people consulted on behalf of the Inquiry who thought boys might lose face for seeking help and would find it hard to present themselves as vulnerable:

“No wee lad is going to go to the police and say he’s a victim.”

¹⁷ Child Sexual Exploitation: Definition and Guidance. SBNI October 2014. www.safeguardingni.org/professionals

¹⁸ In partnership with Barnardo’s and NatCen.

As a result of all of these factors, the scale of male victimhood is unknown. The Northern Ireland Sexual Assault Referral Centre (SARC), which opened in May 2013 gave the Inquiry some figures. By June 2014, they had received 502 referrals, 42% of whom were under 18. Across all age groups, 14% were male. Staff believed the males were mostly under 13, especially under nine. This seems to indicate that they are not receiving many cases related to the exploitation of adolescent males. The Barnardo's Safe Choices Service assessed that 8 – 10% of their clients were male. Both of these figures would suggest the under-reporting of cases of CSE involving male victims.

The DHSSPS advised the Inquiry that it is currently working with the DOJ to develop a joint domestic and sexual violence strategy. While the strategy acknowledges that women and girls are more often the victims of domestic and sexual violence, it accepts that men and boys are also affected. The strategy is intended to cover men, women and children and to provide protection and support for those who are victims and, at the same time, hold perpetrators to account for their actions.

2.6 Black and Minority Ethnic (BME) Communities

The 2011 census showed that 1.8% of the population of Northern Ireland (32,400) belonged to minority ethnic groups. The main groups were: Chinese (6,300); Indian (6,200); Mixed (6,000); and Other Asian (5,000).

The Department of Education (DE) also collects figures on newcomer pupils¹⁹ which show a substantial increase from 1,792 in 2001-2002 to 10,255 in 2013-2014²⁰. The most common were Polish (3,538), Lithuanian (1,654) and Portuguese (739). This indicates a change in the population profile of incomers to Northern Ireland.

The numbers of minority ethnic young people involved in the research for the Barnardo's 2011 report were too small to form a basis for conclusions.

Our discussions with the HSC trusts confirmed that the minority ethnic population was growing and diversifying. Across the region, there was relatively little contact with them in the social care arena, although one HSC trust reported a significant increase in the representation of BME families within the child protection and the looked after population. We were given a few examples of cases where the victims of CSE were from minority communities. This was often linked with what were described as cultural standards amongst some existing and immigrant communities which tolerated early marriage and relationships between young girls and much older men, and may also tolerate violence.

¹⁹ The Department of Education definition is: "A newcomer pupil is one who has enrolled in a school but who does not have the satisfactory language skills to participate fully in the school curriculum, and the wider environment, and does not have a language in common with the teacher, whether that is English or Irish. This has previously been referred to as English an Additional Language. It does not refer to indigenous pupils who choose to attend an Irish medium school."

²⁰ In order to have comparable data between 2001-2002 and 2013-2014, the figures are based on primary (including nursery, reception and year 1-7 classes), post primary and nursery schools.
http://www.deni.gov.uk/index/facts-and-figures-new/education-statistics/32_statistics_and_research-numbersofschoolsandpupils_pg.htm

There were some references to organised criminal activity amongst these communities, some with links to CSE, including accounts given to us directly by young people who had experienced CSE, or young adults who had experienced it in the past few years.

It was notable that some of the concerns about relationships in minority ethnic communities were picked up by health personnel, for example, during pregnancy appointments. This underlines the importance of helping health personnel to identify and report concerns about CSE.

The consultation with parents conducted by Parenting NI had some representation of minority ethnic communities in the focus groups and the online survey. In responses to general questions about feeling safe in their communities, some expressed fears related to racism. The possibility of racist attacks increased parents' appreciation of their children having mobile phones.

Whilst there was some minority ethnic representation amongst the groups of children and young people involved in our consultations, we did not succeed in our attempts to gain access to particular groups. In some respects, this needs to be a project on its own because the diversity of cultures now settling in Northern Ireland means that meaningful consultation, especially where there are closed communities, would involve building up relationships and consulting each community on its own issues.

Professionals in Northern Ireland are still becoming acquainted with the characteristics, needs and vulnerabilities of the emerging minority ethnic communities. They need to be encouraged to develop and strengthen these links as a route into protecting children and supporting ethnic communities to report concerns that arise within them. There is a clear role here for the education sector, given its contact with minority ethnic families, and the health sector as a universal service in a prime position to pick up concerns.

Supporting Recommendation 4:

Schools should be encouraged to engage parents with regard to the preventative curriculum, including those with literacy difficulties or for whom English is not the first language.

2.7 Disability and Special Needs

2.7.1 The Link between Disability and Child Sexual Exploitation

The Barnardo's report noted that one in six of the cases involved in the quantitative research were described as having a learning disability, and almost 3% as having a physical disability. Little is known about the link between disability and CSE but this is now becoming a focus for research. Whereas disability had been included merely as background information in the early versions of the risk assessment tool that has been used in Northern Ireland, the more recent versions include learning disability as a vulnerability factor.

The word disability was often used by those who communicated with us in a general sense, without reference to categories associated with legal or administrative processes and this is reflected in the Inquiry's use of the word.

In the past, it might have been assumed that children with disabilities of a certain level of severity were more protected than their peers, as they would rarely be unaccompanied by a carer. However, developments in communication technologies mean that it is easier for abusers to access children, even in their own homes.

Many expressed concern to the Inquiry about the vulnerability of children with learning disability, particularly where this is mild and not diagnosed. If they have not been statemented (a process whereby needs and support are identified), they do not get the same support at school or in the community. This includes some children on the autistic spectrum. The Inquiry raised this issue with HSC Board who questioned whether there was a need for a formal diagnosis before the issue of support was addressed. They pointed to the Autism Act (Northern Ireland) 2011, and accompanying strategy and action plan, as significant developments in bringing those with autism within the scope of disability discrimination legislation.

The significance of communication difficulties was highlighted to the Inquiry by the Royal College of Speech and Language Therapists (RCSLT) who informed us that language and communication difficulties affect 7–10% of all children, with rates significantly higher in areas of social deprivation. These difficulties were a predictor of neglect, exposed children to risk of harm, including rape and serious sexual assault, and made it more difficult for them to engage effectively with the justice system to pursue offenders. The RCSLT recommended early identification and support, particularly for looked after children who are an accessible group with a high incidence of the problem.

2.7.2 Children in Northern Ireland (CiNI) Report

Staff from a disabled children's project who participated in the CiNI consultation described how young people with disabilities aspire to be normal. They want to have boyfriends/girlfriends, but receive no preparation for this. The assumption by others that they will never engage in sexual relationships increases their vulnerability to exploitation.

Children with physical disabilities may receive intimate, personal care, which makes it difficult for them to learn what kind of touching is appropriate. Those with learning disabilities may have very few boundaries. They may not know the difference between love and exploitation, and are not taught how to make the distinction.

We were told that many young people with disabilities are isolated and depend on the internet for social interaction. The project had worked with the young people about abuse issues, including the internet, but felt that the young people remained unaware of the consequences, particularly in relation to sexting. Staff believe the availability of the internet means these young people can be targeted as easily as young people at discos. They believe professionals who deal with CSE need disability training – preferably delivered by young people with disabilities.

They believe that parents need to be helped to enable their children to be as independent as possible. There is a danger that parents “treat their children with kid gloves and don’t allow them to mature in an age-appropriate way.”

2.7.3 Education and Training Inspectorate (ETI) Survey

Many of the insights of staff at the disability project were corroborated by those involved in the ETI survey, which included four special schools.

Only a small number of pupils had any awareness of CSE.

The survey confirmed that parents are very protective of their children and concerned about the risk of exploitation in social situations. Parents believe they can keep their children safe whilst they remain within the family home. The survey acknowledged the isolation of many young people with disabilities. While some young people do not use the internet and social media at home, many do rely on these for social interaction. There was a concerning lack of awareness amongst parents of the dangers posed by modern methods of communication.

The category of disability covers a wide spectrum. It was noted that some young people have a good level of understanding and know how to use the internet and social media safely. However, some join with friends to play online games with inappropriate sexual or violent content. Worryingly, some parents, while aware that the games were designed for people aged 18 or over, seem unaware of the content or of how playing such games can make their children vulnerable.

A minority of the parents spoken to by ETI had, along with their children, attended external training in relation to aspects of CSE, organised by the school. Nevertheless, all of the parents agreed that there is a lack of knowledge of issues regarding CSE and, in particular how to keep children safe when using social media or the internet. Most said they would be keen to attend school events in the evening, but child-minding arrangements made this difficult. They added that, while they wanted to keep their children safe, they were aware of the need to address such issues sensitively to avoid alarming or distressing their children unnecessarily.

Schools were keen to support pupils and parents in learning about the risks related to CSE and how to keep children safe. Staff in all four schools reported that they needed further training and better and more up-to-date resources to allow them to deliver keeping safe messages confidently, particularly to children with learning disabilities. They felt that current resources were often not suitable for use with pupils with special needs and required to be adapted or better targeted to the needs of special schools. Schools felt they needed support to develop more innovative ways of engaging with parents.

The Inquiry recommends:

Supporting Recommendation 5:

The Department of Education should give guidance to schools on how they can provide flexible support sessions about CSE that are accessible for parents of disabled children.

2.7.4 Child Protection Statistics and Processes

The HSC Board advised that, within Northern Ireland, numbers of children with disabilities who are recognised as having child protection issues are low compared with the rest of the United Kingdom. They are also low in comparison with the general population. This is concerning because, according to a Scottish report on CSE, research has shown that abuse rates for disabled children are on average higher than for non-disabled children²¹.

Within Northern Ireland, disability teams sit separately from child protection teams within HSC trust structures. The Inquiry understands that, when a safeguarding issue is identified, disability teams will co-work with gateway or family support teams in assessing risk and implementing the appropriate child protection policy and procedures. It is important to ensure that staff in disability teams have the awareness and training to recognise vulnerability to CSE and other emerging child protection issues, and to respond appropriately by involving staff with more specialist child protection expertise.

Supporting Recommendation 6:

The HSC Board should ensure that child protection issues are consistently and skilfully addressed in LAC and disability settings, where these are separate from specific child protection processes.

2.8 Lesbian, Gay, Bisexual and Transgender (LGBT)

Young people from the lesbian, gay, bisexual and transgender (LGBT) communities face particular difficulties, especially within Northern Ireland. There are some good examples of support for LGBT young people. For example, our attention was drawn to an integrated secondary school which facilitates an LGBT group for pupils. However, more generally, intolerance of same sex relationships makes it difficult for these young people to learn about their sexuality and to raise concerns if they feel they are at risk.

The young gay people we met told us there was no mention of LGBT relationships or safe sex advice in their schools. As referred to earlier, this might lead them to exploring the internet for basic information with the risk of coming into contact with people who would exploit them. Other young people thought their LGBT peers would be at particular risk because of the potential for being bullied or blackmailed.

Some HSC trust personnel referred to young gay people who cannot explore their sexuality safely in their own communities. Some end up in clubs in Belfast where they are exposed to alcohol, drugs and associated dangers.

²¹ Stalker, K., et al., *Child Protection and the Needs and Rights of Disabled Children and Young People: A Scoping Study*. Glasgow: University of Strathclyde (2010). <http://disability-studies.leeds.ac.uk/files/library/stalker-Kirstens-booklet.pdf>

Supporting Recommendation 7:

The Department of Education should ensure that all young people can access more information and support on healthy relationships, including LGBT young people. This could be included within the CCEA review of Relationships and Sexuality guidance materials.

2.9 Sexualised Society

There was consensus amongst the groups we interacted with, the submissions we received and the views of young people and parents about the impact on young people of today's highly sexualised society. Statutory agencies commented that, although it was hard to evidence in terms of figures, it seemed to them that an increase in sexual activity at an earlier age, coupled with access to alcohol and drugs, meant that societal issues and cultural change were facilitating an increase in CSE.

“We are living in a society which is toxic. What children are exposed to at an early age is normalising sexual and violent behaviour.” [Health professional]

“Things have changed over the past five years - a new normality: internet, phones, sexual activity.” [HSC trust staff]

“A lot of young people think party houses, drink and drugs is just normal. Casual sex and multiple partners are seen as normal. But girls are still considered a slag if they have multiple partners.” [HSC trust staff]

The last comment reinforces issues about the cultural attitude to women, which were also the subject of comment:

“Young women accept domestic violence. It's all right to be hit and controlled by boyfriends.” [Community organisation]

Education staff commented on good practice in some schools where young men were facilitated to reflect on their views of women.

A community organisation gave examples of peer abuse and commented:

“Over the past year or three, workers have noticed more sexualised behaviour on the streets – in public – involving young girls aged around 12.”

A group of young people identified the impact of what they regarded as over-sexualised story lines in books and soap operas and an advertisement for a food product.

It is important to note here that article 5 of the UN Convention on the Rights of the Child sets out the rights and responsibilities of parents and carers to give direction and guidance to children as to how the children should exercise their rights. The UN Committee on the Rights of the Child points out that this means that children have a right to direction and guidance to compensate for their lack of knowledge, experience and understanding. Direction for young children will shade into guidance for older children in line with their evolving capacities.

What this means is that it is perfectly acceptable to have standards and expectations, and we fail children if we do not provide this. Chapter 9 of this reports explores how these standards can be set in a way that acknowledges the full spectrum of children's rights to protection and participation in decisions that affect them.

2.10 Republic of Ireland and Cross-Border Issues

The Inquiry was given a few examples of cases where young people had moved across the border in the course of their exploitation. It was suggested to us that the border was used to avoid getting caught. In particular, if young people needed urgent medical treatment, they would choose which side of the border to go to for it. This lessened the possibility of their exploitation being identified by health staff.

The NSPCC submission to the Inquiry stated:

“CSE has an interface with trafficking; an emerging issue in Northern Ireland ... Northern Ireland is the only part of the United Kingdom with a land border (which is not monitored) and this may be used to exploit children.”

The Inquiry understands that much work has been undertaken in the Republic of Ireland in relation to trafficking and separated children. We were referred to guidance on the protection and welfare of children²² which includes information about organised abuse and sexual exploitation. This confirms the impression of professionals in Northern Ireland that, while CSE is referenced, its scope is narrower than the concept of CSE that is the focus of discussion in the United Kingdom.

There are a number of cross-border working arrangements in place which would be relevant to CSE, including:

- Arrangements involving the PSNI, An Garda Síochána and PPANI (Public Protection Arrangements in Northern Ireland), particularly in the wider remit of Public Protection and information sharing.
- Cooperation and Working Together (CAWT), a partnership between the HSC Services in Northern Ireland and Republic of Ireland, which facilitates cross border collaborative working in HSC.
- The North South Child Protection Hub, an internet resource for child protection professionals in Northern Ireland and the Republic of Ireland.
- The child protection work undertaken by the North South Ministerial Council led by the DHSSPS and the Department of Children and Youth Affairs (Republic of Ireland).

Social care professionals we spoke to indicated that they had good relationships with their colleagues in the Republic of Ireland, facilitated by CAWT training, but there was no formal sharing of information about particular cases. It was suggested that an all-Ireland information sharing agreement should be explored. It has also been suggested that there should be focus on synchronising the vetting procedures for Northern Ireland and the Republic of Ireland.

²² <http://www.dcy.gov.ie/documents/Publications/ChildrenFirst.pdf>

ETI advised that inspections in a small number of independent schools identified gaps in their vetting arrangements which meant that checks on individuals who live in the South but work in the North were not as rigorous as they should have been.

The Inquiry is aware that, in January 2012, a protocol was agreed for the transfer of children's social care cases between Northern Ireland and the Republic of Ireland.²³ This is helpful, but it has limitations. It was designed to address situations in which families move across the border. The protocol applies only to cases where child protection issues have been identified or children have been assessed as requiring a family support social work service. It may not provide a firm foundation for sharing information in cases where CSE is suspected and the child is not known to social services.

The Inquiry recommends:

Supporting Recommendation 8:

DHSSPS in conjunction with DOJ should pursue an All-Ireland Information Sharing Agreements to achieve closer collaboration on CSE and related issues.

2.11 Which Children and Young People?

When CSE became headline news in Northern Ireland in September 2013, the focus was on children looked after away from home, particularly in residential care.

It is generally accepted that young people who are “looked after” are more likely to have a number of the vulnerabilities and risk factors for CSE than the rest of the population, largely because of their experiences before coming into care. Staff and young people told us that young people in care felt stigmatised by this focus upon them and wanted the picture to be more balanced. Vulnerability is not restricted to young people in the care system. Within Northern Ireland, the YLT Survey of 2010 showed that, amongst the general population of 16 year olds, one in nine had experienced grooming and one in 15 reported having been taken advantage of whilst under the influence of drink or drugs.

More recently, the Education Welfare Service (EWS), consulted as part of the ETI survey, said they have considerable experience of dealing with cases of CSE, and they find that young people are vulnerable regardless of class, ethnic culture or gender. The EWS staff often have direct involvement with alleged victims and perpetrators, or deal with cases where there are suspicions of CSE. They expressed particular concern for children who believe they are in a loving relationship but are actually with a perpetrator. They also highlighted the fact that CSE can be family-based, as children and adults become desensitised to sexual behaviours through ease of access to pornography on the internet or other media.

The lives of children in care are monitored to a greater degree than other children, so there is more information about them.

²³ DHSSPS and the Department of Children and Youth Affairs, Republic of Ireland. *Inter-jurisdictional Protocol for Transfer of Children's Social Care Cases between Northern Ireland and the Republic of Ireland*, January 2012. <http://www.dhsspsni.gov.uk/inter-jurisdictional-transfer-of-children-protocol-2011-11.pdf>

The insights from the ETI survey go some way to balancing the debate towards the general population, but there is still much that we do not know.

2.12 Conclusions

The Inquiry concludes that CSE takes many forms in Northern Ireland. These often replicate what is happening elsewhere in the United Kingdom, but there are particular Northern Ireland dimensions to them. There is a wide spectrum in terms of organisation of CSE in Northern Ireland.

Whilst different forms of CSE have been identified, it is not possible to separate them completely. They overlap in the lives of young people. While there has been a particular media focus on young people in the care system, it seems clear that this is largely because we know more about them. Further, some young people move in and out of the care system. Some will have been subject to CSE within the community before they entered public care.

The first step in tackling CSE is to recognise that it exists. This exploration of the nature of CSE shows a need for an extensive public awareness campaign based on the public health model. There is a need to raise awareness amongst parents and those who work in the community such as taxi drivers and those working in the hotel, leisure and entertainment industries. Members of the public need to know what to look out for and how to report any concerns. SBNI has embarked on a staged awareness campaign and we have heard much reference to this. However, many have suggested that more is required. Young people reference television, radio and social media as appropriate ways of raising awareness.²⁴

There was much discussion about the impact on young people of the current overly sexualised society and the easy access to pornographic material. Article 5 of the UNCRC sets out the duties of parents and carers to give direction and guidance to children in a manner consistent with their evolving capacities. Children have a right to receive such guidance.

The Inquiry recommends:

Key Recommendation 1:

In response to the reality of CSE identified in this report, DHSSPS should direct the Public Health Agency to undertake a public health campaign on CSE-related issues. This should complement the work being undertaken by SBNI.

Supporting Recommendation 9:

DHSSPS should ensure that any Public Health campaign(s) should seek to challenge cultural norms that may seem to legitimise or promote CSE.

Supporting Recommendation 10:

DHSSPS should ensure that the forthcoming revision of the guidance, Co-operating to Safeguard Children should take account of the conclusions and recommendations of this Inquiry.

²⁴ See the consultation recommendations set out in Appendix 1.

We have commented on the threats to children posed by powerful individuals linked to paramilitary organisations. We note the differing perspectives from the communities and PSNI as to whether or not police are reluctant to intervene. We also note the fear of some about police being seen to visit their homes in response to a report. Children in these communities have the same right to be protected as any other child. They cannot wait until political or cultural tensions ease.

Later in this report we make recommendations about a strategy to address CSE and who should be involved. This will go some way to opening the conversation about it, but it is a conversation that has to be progressed urgently within the communities and with the statutory authorities. It seems clear that PSNI must also do more to recognise the issue and engage with these communities. We are aware of the ongoing resource issues that might affect their ability to do this, however, we believe this should still be a priority.

Key Recommendation 2:

The Inquiry encourages the PSNI to pursue its commitment to strengthening relationships with communities and with young people as a priority in the context of the current climate of austerity.

Supporting Recommendation 11:

All agencies both statutory and non-statutory should work with local communities to identify how they can best engage together in a way that will build up trust.

Recognising the good practice of the Belfast Police and Community Safety Partnership referred to in connection with trafficking, the Inquiry recommends:

Supporting Recommendation 12:

Police and Community Safety Partnerships should seek to add value to the policing of communities by creating innovative mechanisms to hear and reflect issues of local concern. This should specifically reflect issues affecting children and young people.

CHAPTER 3: VULNERABILITY TO CSE

3.1 Introduction

This chapter sets out what we know about the risk factors for CSE and how vulnerability is assessed. It sets out the history in Northern Ireland of attempts to identify the numbers of children who go missing, as this is regarded as a key risk for CSE. It explains how episodes of going missing are responded to and how young people feel about it. It also discusses the regulation of private fostering as this is an area of potential vulnerability that lies outside the care system.

3.2 Assessment of Risk

A central component of the Barnardo's research, carried out from 2009 to 2011, was a tool designed to assess the risk of CSE amongst children and young people already known to social services. It was based on one developed, initially in Wales, as an early attempt to explore issues related to CSE. It has been refined over the years and that process is continuing with the aim of producing the first properly validated tool. The current and past tools can give no more than a general idea of the scale of the problem. The HSC trusts who have been using the tool acknowledge that, until there is a greater shared understanding of the risk assessment process by staff, there will inevitably be variations in the thresholds applied. The HSC trusts also acknowledge the importance of professional judgement by staff when completing the risk assessment tool. This was built into the interim guidance produced by the HSC Board in February 2014.²⁵

Part A of the risk assessment tool was used by social workers across the HSC trusts in relation to 1,102 children and young people, including LAC aged 12-17, care leavers aged 16 and 17 and others known to social services. The risks assessed were divided into three categories: underlying vulnerabilities; moderate risk indicators; and significant risk indicators. Lessons learned from this process about the potential extent of CSE will be discussed in Chapter 4.

3.3 Indicators of CSE

Underlying vulnerabilities identified in the risk assessment tool included: abuse or neglect within the family; breakdown of family relationships and the lack of any substitute positive relationship; family histories of domestic abuse, substance misuse or mental health difficulties; low self-esteem; and isolation from peers or social networks. The issue of bereavement is now also recognised as a potential vulnerability.

²⁵ *Interim Regional Guidance – Management of Child Sexual Exploitation Referrals*. HSC Board (February 2014).

Moderate risk indicators include: staying out late; multiple, unknown callers; use of the internet or a mobile phone that causes concern; sexual health issues; having peers or siblings who have been sexually exploited; misuse of alcohol or drugs. Young people might also exhibit expressions of despair and be disengaged from school. They may be living independently and failing to keep in touch.

Significant risk indicators include: relationships with controlling adults that may involve physical or emotional abuse; unexplained amounts of money or expensive items; frequenting party houses or areas known for sex work; or entering or leaving vehicles driven by unknown adults. Periods of going missing overnight or longer heads up the list of significant risk indicators.

The risk assessment tool and associated indicators are being used largely by social workers in the HSC trusts. It is important that the indicators become more widely known. Representatives from the further education sector report that many staff working with vulnerable young people do not fully recognise the potential risks of CSE. They identify a number of significant issues across the sector that include: 16 year old girls involved with men in their 20s; cyber-bullying; internet and social media misuse; peer pressure among the student population; and the taking and sharing of inappropriate images. Within the sector there are particular concerns in relation to key student groups including: students with learning difficulties; LAC; young homeless people; young single parents; young carers; and young people with a criminal history. They also highlight the related issue of the growing number of young people with mental health issues, and an increase in those with challenging behaviours.

In the view of youth providers consulted by ETI, the most vulnerable groups are young people: not in school and unknown to Social Services; who receive home tuition; who have a poor attendance record at school but have not yet reached the threshold for action; and young people frequently suspended or expelled from school. It is significant that most of the young people identified as vulnerable by youth workers will not be known to social services. This lack of monitoring means they will have a lower profile than looked after children because they are hidden. A recent internal audit on child protection across the youth service found that a majority of referrals made by youth workers concern neglect, followed by sexual abuse. The youth representatives state that there is currently no specific coding to track CSE within their systems.

Many people made the point that CSE is only one of a number of threats to the well-being and safety of children and young people, and they cited neglect, poverty and deprivation, and substance misuse as other dangers that affected young people more than CSE. This may be true, but these other threats also make young people vulnerable to CSE. In particular, many spoke of the threats posed by the proliferation of legal highs and the difficulties experienced by the authorities in controlling them. Legal highs are substances which produce effects similar to controlled drugs but are not regulated in the same way. They can be cheaper than alcohol and easier to access. These substances featured prominently in our discussions with agencies as a new threat to the welfare of children and young people, although some believed that alcohol was still the greater problem.

3.4 Private Fostering

Privately fostered children are vulnerable and yet hidden from the system. Children in private fostering arrangements are not looked after children, but some state regulation is provided for.

Private fostering is an arrangement whereby a child under 16 (or under 18, if disabled) receives care and accommodation continuously for 28 days or more by someone who is not a parent, does not have legal parental responsibility and is not a close relative. Close relatives are defined by the Children (NI) Order 1995 as parents, step-parents, grandparents, siblings, aunts or uncles. Such arrangements must be notified and supervised by an HSC trust under the Children (Private Arrangements for Fostering) Regulations (Northern Ireland) 1996.

Arrangements are regulated by the DHSSPS Circular on Children Living with Carers in Private Fostering Arrangements Including Children from Overseas (CCPD 1/2011). This provides some measure of oversight by the HSDC trusts, however it is essentially reactive.

According to data collected by the HSC Board, very few (less than five) private fostering arrangements have been notified to HSC trusts. Guidance issued in 2011 by the DHSSPS and PSNI noted that children who may have been trafficked, “may be found in quasi private fostering arrangements which have not been notified to the Trust.”²⁶

The Northern Ireland Human Rights Commission (NIHRC) expressed concern about the potential abuse of private fostering arrangements by traffickers and advised that the Inquiry should recommend measures to enhance the protection of children by addressing loopholes in the legislation, increasing data collection and improving inter-agency co-operation.

Supporting Recommendation 13:

The HSC Board should monitor the arrangements for private fostering to ensure that awareness of CSE is raised and to ensure identification of cases that have not been notified to the HSC Trusts.

3.5 Going Missing

3.5.1 The Significance of Going Missing

While it is clear from research²⁷ that going missing is an important indicator of CSE, not all children and young people who go missing are experiencing CSE, and some who are experiencing CSE may not be going missing or staying out late without permission.

²⁶ *Working Arrangements for the Welfare and Safeguarding of Child Victims of Human Trafficking*. DHSSPS and PSNI, February 2011, para. 2.4.

²⁷ The Barnardo's October 2013 Briefing (*supra*) cites relevant recent research as: Berelowitz et al, 2012 and Smeaton, 2013.

For example:

- Exploitation via the internet can happen without the young person ever leaving their place of residence, whether in care or not.
- We heard examples of children being abused during summer holidays or at times when young people would normally be out and about.

This confirms the statement in the Barnardo's research that:

"They can be abused while out of a unit on agreement and never even registered as an unauthorized absence."

Nevertheless, much focus has, for good reason, been placed on the issue of missing children. As indicated previously, the police investigation leading to the identification of 22 possible victims of CSE (Operation Owl) was initiated in 2013 in response to an analysis of information about missing children. According to reports, the 22 children concerned had been reported missing 437 times.

Some of those we spoke to referred to different interpretations of commonly used categories such as missing, absconding and unauthorised absence, despite the fact that the terminology is defined in the relevant guidance.²⁸ In the Risk Assessment tool, staying out late appears as a moderate risk indicator of CSE and periods of going missing overnight or longer is identified as a significant risk indicator. The confusion of terminology makes it difficult to assess accurately the numbers of children involved. The HSC Board advised that new guidance on missing children, currently in draft, will synchronise the definitions within the different sets of guidance.

3.5.2 Research on Missing or Runaway Children

Young people may go missing from the family home or from substitute care. A survey of young people in Northern Ireland in 2001 estimated that one in ten run away or are forced to leave the family home, spending at least one night away before the age of 16. Of these young people, 73% identified problems at home as a reason; 51% said personal problems; 30% identified problems at school and 12% gave other reasons. The numbers of looked after young people were too small within this research to draw any conclusions. In recent years, looked after young people have been the main focus of interest as regards going missing or running away in Northern Ireland.

The Barnardo's research showed that one in five of the overall sample of 1,102 cases had been missing overnight or longer within the previous year. This rose to three out of five for the residential care population and an even higher percentage (67.1%) amongst the 147 cases of known or suspected CSE. Taken together with the 2001 research, this would suggest that:

- One in ten young people are likely to go missing overnight from home before the age of 16.

²⁸ Regional Guidance: *Police Involvement in Residential Units/ Safeguarding of Children Missing from Home or Foster Care*, May 2012.

- One in five of young people known to social services are likely to go missing overnight or longer.
- Three out of five young people in residential care are likely to go missing overnight or longer.
- Those known to be at risk of or suffering CSE were even more likely to go missing overnight or longer.

Research in England found that the number running away from home is likely to be underestimated in official figures as many parents do not report their children as missing.²⁹ Nevertheless, looked after young people were identified in the same research as being significantly more likely to run away than young people living in family.

The debate about missing children and their vulnerability to CSE can be skewed by the fact that children in the care system are more likely than the rest of the population to have their activities recorded and monitored. This might reinforce the impression that CSE is a phenomenon largely related to children in residential care. However, it is notable that, the figures the Inquiry obtained from PSNI about reports of missing children over two 24-hour periods (discussed later), showed that, over the weekend, there were more than twice as many young people reported to police as missing from family settings as there were missing from looked after settings (including foster care).

3.5.3 Understanding of this Link in Northern Ireland

The link between going missing and child sexual exploitation has been recognised in Northern Ireland for some years but the scale of the problem has not been identified. In 2006, a report by the Social Services Inspectorate³⁰ into child protection identified the risks to young people running away from children's homes:

“Major risks and child protection concerns were evident in respect of the frequency of children and young people running away from a number of homes, their engagement in inappropriate sexual activity and the management of absconding behaviours by residential/fieldwork staff and the PSNI.”

No assessment of the numbers involved was given. The report recommended:

“where children or young people are returning to children's homes following a period of running away they are interviewed to establish their reasons for this behaviour and to establish what risks they have been exposed to during their absence. Particular consideration should be given to whether or not they have been involved in high risk behaviours such as sexual exploitation, inappropriate sexual activity and/or the misuse of alcohol or drugs. Trusts should also ensure that these children and young people have access to appropriate therapeutic and other support services, as needed. [Rec 58]”

²⁹ Rees, G., and Lee, J., *Still Running II: findings from the second national survey of young runaways*. The Children's Society (2005). Relates to England
<http://www.gmsafeguardingchildren.co.uk/417626/stillrunning2findingsfromthesecondnationalsurveyofyoungrunaways3195full>

³⁰ Social Services Inspectorate, *Our Children and Young People – Our Shared Responsibility* (2006)

In response to the 2006 report, the four area child protection committees agreed a regional protocol (2009) to support joint working between police and social services in relation to children who go missing from residential care, foster carer or the family home. Revised guidance was issued by HSC Board and PSNI in May 2012.

3.5.4 Recording in Relation to Missing Children

Incidents of residents going missing from children's homes have been recorded since 2005 but the information has not, until recently, been collated or analysed. It was not possible to get an idea of how many children ran away and how many ran away repeatedly.

The Children's Homes Regulations (Northern Ireland) 2005 required registered persons to notify PSNI and the placing authority (usually the trust) if a child absconded from a children's home. Trusts were also required to produce written procedures for response to unauthorised absences of residents of children's homes.³¹

For a while, RQIA and its predecessor collected some information on missing children. However, as there was no legal requirement for the inspectorate to be notified, the information was incomplete and a decision was made to stop collecting it.

Between December 2008 and February 2009, Michelle McIlveen, Member of the Legislative Assembly (MLA), tabled a series of questions in the Northern Ireland Assembly seeking information on the numbers of children and young people missing from care over the previous five years. The response was that the information was not collected centrally and could only be provided at disproportionate cost. Information obtained by the MLA from PSNI showed that, in 2007–08, 616 incidents of missing persons related to residents of children's homes, but it was not possible to identify how many were repeat incidents or how many children that represented.

The issue has been less regulated in relation to foster care. Regulations in 1996 required trusts to keep records of notifications from foster carers of serious incidents. The written answer to the MLA's question added: "which includes absence without permission," but this is not actually specified in the regulations.³²

Concerned at the lack of information, Michelle McIlveen tabled a motion in the Assembly in May 2009:

"That this Assembly notes with concern the failure of the Department of Health, Social Services and Public Safety to monitor and maintain baseline figures relating to the number of children who go missing from care and the number of such incidents per child; demands action to address the lack of access to specialist therapeutic support services for these children across all Health and Social Care Trust areas; recognises the pressure on police resources and time in retrieving these children: calls on the Minister for Health, Social Services and Public Safety to place greater emphasis on the needs of missing children

³¹ The Children's Homes Regulations (Northern Ireland) 2005, Schedule 1.

³² The Foster Placement (Children) Regulations (Northern Ireland) 1996.

and to ensure that his Department accurately accounts for these children in its role as corporate parent; and provides a clear strategy and resources to address the reasons for these children going missing and the risks to which they are exposed during their absence.”

In March 2010, the MLA launched a consultation paper proposing a Private Members Bill to require the formulation of a strategy on missing and runaway children and the collection of accurate statistics. The proposal was supported by Barnardo’s who said it reflected policy and legislative developments in England and Wales, however Ms McIlveen reports that she experienced a great deal of hostility from the Department and some children’s agencies for having raised the issue. The Bill was ultimately withdrawn when the DHSSPS agreed to address the matter through administrative means. Correspondence from Ministers and the DHSSPS commented on the dangers of stigmatising children in care, especially those living in children’s homes. It noted that the vast majority of children in care do not abscond and those that did often did so as part of normal teenage behaviour. The numbers who absconded and were at risk of sexual exploitation were described as a “very small minority ... very small numbers of children are affected.” In the Inquiry’s view, it is difficult to reconcile this statement with the figures that have since emerged from the Barnardo’s research.

The establishment of a single HSC Board was identified at that time as “an opportunity to achieve greater consistency in the recording and analysis of children who have gone missing from care throughout Northern Ireland.” The HSC Board, the trusts and the DHSSPS were said to be “working together to introduce a new monitoring and reporting system. A meeting between Ms McIlveen and officials on 1 June 2010, concluded with a commitment to the production of an administrative system for collection, collation and recording of quarterly statistics and the formulation of an action plan on missing children.”³³

In meetings and correspondence with the DHSSPS, the Inquiry confirmed that the DHSSPS’s position had been that legislation was not required to facilitate the collection of statistics and that this could be done administratively. They provided a copy of a letter dated 28 October 2010, in which the Minister for Health, Social Services and Public Safety updated Michelle McIlveen on a number of initiatives including:

- an interim Strategic Action Plan on Children Missing from Home or Care (August 2010)
- an intention to revise the monitoring information on children missing from care in line with their forthcoming revised practice guidance on Police Involvement in Residential Care/Safeguarding of Children Missing from Home or Foster Care
- an agreement with PSNI to ensure the information collected by each organisation is complimentary and relevant and is able to provide a comprehensive overview to assist with strategic planning.

³³ See Michelle McIlveen. Speech at VOYPIC event, September 2013.

3.5.5 Missing Children Strategic Action Plan

The HSC Board's Strategic Action Plan – Children Missing from Home or Care (2010) referred to is attached to this report as Appendix 5, along with an update of September 2013. Although referred to in correspondence as interim, it is not clear that a final version ever emerged. The HSC Board advised that this was a one-off action plan.

The Action Plan comprises a brief resume of research concerning children going missing and the risks to which they are exposed, followed by short sections on sexual exploitation and looked after children who have been trafficked from abroad. A section on Strategic Overview focuses on the need for effective joint working by agencies. The 2013 Update identified some completed actions in relation to the collection and collation of statistics and the revision and implementation of the joint protocol between police and social services.

Items identified as ongoing, include:

- improving strategic oversight, building on the more systematic collection of data
- synchronising data collection between social services and PSNI (a task now referred to SBNI)
- joint training for police officers and social workers on the revised guidance;
- review of the joint protocol, using the revised data set
- establishing arrangements within each HSC trust area to monitor police involvement in residential care units, including the response to children going missing and children at risk of sexual exploitation

In short, it appears that there have been improvements in data collection, but, until recently, this has not been accompanied by analysis and oversight to inform a strategic overview. There have been improvements in procedures, but these have not been supported by joint training and monitoring of their impact.³⁴

We understand that the action plan was not the subject of consultation and not disseminated.

3.5.6 Recent Estimates of Missing Children

The origin of Operation Owl was linked to a PSNI analysis of information about missing children.

The ability to analyse missing children data and take action on it represents a significant improvement on the situation a few years before. Michelle McIlveen was told that it was not possible to identify how many of the 616 reports of children missing from children's homes in 2007–08 were repeat incidents or how many children that represented. The establishment of Operation Owl in response to concerns arising from the analysis of more specific information shows the value of that approach and a continuing, strategic focus on the linking and analysing of such information.

³⁴ HSC Board advise that social work staff have been trained on the guidance but police have not.

PSNI advised that the arrangements that were developed under Operation Owl have continued and are now incorporated into normal business. The revised risk assessments are conducted in each PPU and any query in relation to adding the child to the at risk list, or indeed removing any child from the list, is carefully considered and, where necessary, the final decision is escalated to a Detective Chief Inspector, Public Protection.

The HSC Board advised that, since its establishment in 2009, there has been a progressive response to recording information about missing children. The HSC Board now collects information on children missing from care in two forms.

The first process gathers figures from notifications of untoward events relating to children missing from care for more than 24 hours. These can be broken down into Trust areas. Figures for the past three years across Northern Ireland show a significant increase in the most recent year:

2011-12	99
2012-13	100
2013-14	132

The second set of figures is found in the six-monthly reports from trusts known as the Delegated Statutory Function Reports. The latest available figures are shown in Table 3.1:

Period	Children	Events
April 2011 – Sept 2011	45	69
Oct 2011 – March 2012	43	96
April 2012 – Sept 2012	59	100
Oct 2012 – March 2013	34	60
April 2013 – Sept 2013	38	113
Oct 2013 – March 2014	36	53

Table 3-1: Missing Children from HSC Board Delegated Statutory Function Reports

We asked the HSC Board about the apparent discrepancy in these two sets of figures and were advised that this was a result of their sourcing from different processes and do not cover identical categories of children. They advised that they will seek to ensure that both sets of data reconcile in future returns.

The co-located team at Operation Owl also collected figures on missing children and undertook analysis to identify those going missing more than three times over a six month period. Across NI, in the period April to November 2013, 147 young people fell into this category, and 108 in the period from November 2013 to April 2014. One-third of these young people are not LAC. Whilst the time periods and criteria are not identical, this shows that, according to the HSC Board figures, from April to September 2013, 38 young people in care went missing on 113 occasions. The PSNI figures show that from April to November 2013, about 100 LAC went missing more than three times.

We asked PSNI for figures of children missing from home or care. The data provided indicated that, for the year from March 2013 to April 2014, there were 2,517 reports of children missing from looked after settings (including foster care), representing 48% of the total of 5,222 reports of missing children. These figures are significantly greater than what appears in the other data sets. It is also notable that almost half are LAC and the other half are from family settings.

It is clear that there is a need to rationalise and synchronise the ways in which reports of missing children are made and recorded.

In order to gain a more focused picture, the Inquiry sought a snapshot of children missing from children's homes across Northern Ireland over two 24 hour periods – one during the week and one at the weekend. We learned that, during the 24 hours from midday on 10 September 2014 to midday on 11 September 2014, 10 young people aged 14 to 16 were classified as whereabouts unknown. Six were female and four were male. Eight were missing for a period of one to six hours and two for six to twelve hours. The regional guidance was initiated in eight of these cases.

Over the following weekend, from midday 13 September 2014 to midday 14 September 2014, 17 young people aged 14 to 17 were classified as whereabouts unknown. Six were female and 11 were male. One was missing for less than 60 minutes. Twelve for one to six hours, one for six to twelve hours and three for one to three days. The regional guidance was initiated in 11 cases.

In cases where the guidance was not initiated, staff explained their reasons, which generally related to their assessment of the risk to the young person.

All of the children missing at the weekend had gone missing before. All but two of the children missing during the week had gone missing before.

During each period, police were also alerted by the children's homes to one young person (different young people on each occasion) whose whereabouts were known but who was believed to be at risk.

We asked PSNI for figures relating to the same two 24 hour periods. This showed that, during the weekday period, 15 children were reported missing across Northern Ireland: eight of whom were from looked after settings and seven from the community. During the weekend period, 25 children were reported as missing: eight from looked after settings and 17 from community settings.

Whilst it is difficult to reconcile these figures, they give some idea of the scale of the issue of missing children and also of the notable police response to missing episodes.

3.5.7 Responses to Missing Children

In 2012, regional guidance was issued in respect of the safeguarding of children missing from home, residential care and foster care.³⁵

³⁵ Regional Guidance- *Police Involvement in Residential Units: Safeguarding of Children Missing from Home and Foster Care* (2012).

This guidance was agreed jointly between the HSC trusts and PSNI. It set out an agreed procedure for responding to children and young people who go missing. For residential care, the guidance operates a 'traffic light' system and each young person who absconds is coded on a risk assessed basis with a green, amber or red categorisation. This codification governs the intensity and immediacy of response from both the local PSNI officers and residential staff to the unfolding situation.

This includes a high level of cooperative working with frequent and ongoing contact between the police and care home. Both agencies also undertake the active pursuit of the young person in known or likely locations to secure their wellbeing. Once a young person has been returned to the unit, the PSNI conducts a 'safe and well' interview to confirm the safety of the young person and, where necessary, attempts to ascertain details of their activities in the community for purposes of prevention, disruption and prosecution. The guidance also advises that the HSC trust should arrange for the child to have an in-depth interview with a person independent of the placement within 72 hours of their return. This would usually be undertaken by the field social worker or someone from an advocacy service, but the child should be given a choice.

We were advised that residential care staff continue to have considerable difficulties ascertaining precisely what has occurred when the young people have absconded from the unit. Most young people share little or no information with staff who have to piece together the events from a range of sources including the police, LAC health professionals and/or Barnardo's Safe Choices workers who attempt to engage the young person in the days and weeks afterwards. Safe Choices engagement is usually ongoing. Young people share in-depth information with Safe Choices staff and often maintain contact with them while they are missing. Safe Choices staff share all this information with the statutory services.

The young people involved in the VOYPIC consultation discussed occasions when they have been classed as missing but they believe they are safe. In their view, the reaction of staff is "over the top". This includes staff contacting their friends and others in an effort to locate them and have them return. This seems to be a source of irritation and frustration for some looked after young people and ineffective in changing their attitude or behaviour.

"Staff do a town search to try and find us"

They also expressed frustration at what they experience as excessive contact with the PSNI at times when they perceive the risk to be low and the behaviour not of particular concern.

"Pissed off because I am fine. I am safe but the staff are worried."

VOYPIC commented that it is clear that these responses are not effective and may result in a young person refusing to engage with support staff or the PSNI. The young people also discussed what, if anything happens in the aftermath of going missing and returning. There is a process of interview and conversation when a child or young person returns home after being missing and the level of formality depends on who carries out the interview:

"Nothing happens if we don't tell them where we went."

“Police come up to the house when we return.”

VOYPIC reported that they did not hear evidence of a standard response or process of interview following incidents of going missing. It seemed that if the PSNI were involved in bringing the young person home they would conduct a formal interview. It was not clear at what stage or how quickly this happened. When it was a staff member who brought the young person home (without PSNI involvement) the process might be more informal and the young person is:

“Just asked lots of questions about where they have been and who they have been with.”

Practitioners raised issues with us about how effectively intelligence is gathered about where the young person has been and what has happened to them. We were advised that information about the circumstances in which the young person was found may not be recorded or passed on, especially when a young person is picked up by police in one district and transferred to another for return to the unit in that district.

Individual police officers who were interviewed by the Inquiry readily acknowledged that they considered the time spent looking for and returning missing children to be a huge drain on resources. These officers clearly and commonly expressed noteworthy frustration arising from these repeated episodes.

For foster care, the procedure can be less formal. The Foster Placement (Children) Regulations (Northern Ireland) 1996 require HSC trusts to keep records of notifications from foster carers of serious incidents. These do not specify missing episodes, but Regional Guidance³⁶ sets out the procedure to be followed by PSNI when a carer notifies them that a foster child has gone missing. The traffic light system is not generally used for foster children but will be brought into play for children who go missing regularly, and there are procedures for escalating the case in response to serious concerns. In general, carers are expected to exercise the judgement that would be expected of a responsible parent. Guidance states that, where children have gone missing and police are involved, they should conduct a safe and well check, and the HSC trust should conduct a return interview. A child who has repeated unauthorised absences (where the whereabouts are thought to be known) should be given the opportunity of speaking to an independent person.

The DHSSPS has advised the Inquiry that new fostering regulations should come into operation early in 2015. These will require fostering agencies (including trusts) to notify relevant bodies, including the HSC Board and RQIA of significant events, including events relating to missing children and sexual exploitation. This will bring fostering arrangements into line with arrangements in children’s homes.

When a child goes missing who is not known to social services, police will conduct a Safe and Well Check and contact the HSC Gateway Team to discuss whether to refer the child to them. Further interviews will take place with the child, where appropriate.

³⁶ Regional Guidance: *Police Involvement in Residential Units/ Safeguarding of Children Missing from Home and Foster Care*, May 2012.

Parents could also benefit from guidance on how to preserve evidence when their child returns home after being missing or putting themselves at risk.

The Inquiry therefore recommends:

Supporting Recommendation 14:

DHSSPS should ensure the involvement of young people in any future review of the Regional Guidance on Police Involvement in Residential Units/ Safeguarding of Children Missing from Home and Foster Care.

Supporting Recommendation 15:

The HSC Board should address as a priority the provision of joint training on Regional Guidance on Police Involvement in Residential Units/ Safeguarding of Children Missing from Home and Foster Care.

3.6 Conclusions

The vulnerability factors for CSE are well known. There is a particularly significant link with episodes of going missing. There is already work being undertaken to address some of the matters identified as underlying vulnerabilities for CSE such as neglect, drugs and alcohol, domestic violence and deprivation. It is important that whatever is done in response to CSE should build upon these, rather than be seen to be in competition for time and resources. The identification of CSE as an emerging, developing and growing threat to children should give extra impetus to these existing commitments.

As it is now possible to gather figures of missing children, broken down by HSC trust, we are satisfied that, with the new processes in place, the HSC Board would be in a position to answer the question asked by Michelle McIlveen in 2008.

Given that the link between going missing and CSE was made in an official report in 2006, it is disappointing that there was a delay of some years before data were collected systematically. The commitment in the 2010 Action Plan to synchronisation and analysis of figures has yet to be fulfilled. It is still difficult to reconcile the figures that come from different sources. Some analysis commenced with the work of Operation Owl and the circumstances that led to it.

There are also gaps in approaches to gathering evidence when a child returns after a missing period.

The Inquiry recommends:

Key Recommendation 3:

The DHSSPS in conjunction with DOJ should develop guidance for parents and carers, including foster carers and residential workers, on how best to capture information and/or evidence when a child returns from a period of being missing or is otherwise considered to be at risk of CSE.

Supporting Recommendation 16:

The HSC Board Strategic Action Plan – Children Missing from Home or Care should be revised and implemented as part of the strategic overview of CSE.

Supporting Recommendation 17:

Police evidence about the circumstances in which a child was found after going missing or putting themselves at risk can be vital to protection arrangements. PSNI should review current processes to ensure that, in all circumstances, information is recorded and transmitted appropriately, both internally and to partner agencies.

Supporting Recommendation 18:

HSC Trusts should ensure that when a child returns after being missing, he or she is offered a return interview with an independent person in line with Regional guidance.

CHAPTER 4: THE EXTENT OF CHILD SEXUAL EXPLOITATION IN NORTHERN IRELAND

4.1 Introduction

This section of the report will:

- set out what data we have on the extent of CSE
- reflect upon what that tells us
- report what people have said to us about the extent of CSE
- draw conclusions including what ought to be put in place in order to get a fuller picture of the extent of CSE against which to measure progress

4.2 Learning from the Risk Assessments

Unlike Rotherham, where CSE has been a category for referral since 2001, it has not been, and still is not, a recognised category in Northern Ireland for most purposes. This means there is little hard data to assist in measuring the extent of CSE. Even where figures are available, attempts to assess extent are complicated by concerns about under-reporting and over-estimation. On the one hand, published reports on CSE consistently emphasise the likelihood that numbers are an underestimate because of under-reporting. On the other hand, the figures from risk assessment tools are regarded as in danger of over-estimation where they do not take account of professional judgement. Young people can have high risk assessment scores due to their backgrounds and other experiences but may not be considered by those who know them to be at real risk of CSE.

From June 2013, the trusts were required to use the risk assessment tool developed by Barnardo's. Neither this nor the tool used for the Barnardo's research, took account of professional judgement. With the further input of Barnardo's, a revised version was issued to the HSC trusts in March 2014 as part of the Interim Regional Guidance – Management of Child Sexual Exploitation Referrals issued by the HSC Board. The main differences between the Barnardo's tool and the revised version are that, in the later tool, learning disability was added as a vulnerability factor, and professionals were invited to contribute their professional judgement as to whether the young person was at risk of CSE. Feedback from the HSC trusts has indicated that they welcomed the addition of professional judgement which they believe has resulted in more realistic scores for the risk assessments, which are now often undertaken in conjunction with police colleagues.

The revised risk assessments are forwarded to the PPU (until recently, Operation Owl) who make a final determination on whether the young people's names should be included or retained on their list.

Information received from the HSC trusts shows that, on 30 September 2014, 120 children were identified as at significant risk. On 9 September 2014, the Operation Owl list had 97 young people's names on it.

From the information forwarded by the HSC trusts, there are still inconsistencies in the way in which the tool is being applied. It is natural that there will be some inconsistencies of approach while workers become familiar with the new system. However, there would be benefits in promoting consistency in order to allow a clearer picture to emerge of the scale and pattern of risk across the region, and to promote consistency of service to the young people.

Part B of the Barnardo's tool, which was devised purely for the research and has not been used since, asked for information on whether CSE was known or suspected in relation to children known to social services. This did involve professional judgement and resulted in the identification of 147 cases of known or suspected sexual exploitation. Some of these had not scored as at significant risk in Part A because the risk indicators in Part A only reached back for 6 months.

4.3 Other Available Data

In addition to the risk assessment information previously discussed, the Inquiry has drawn on the following data:

1. The YLT Survey commissioned as part of the Barnardo's research showed that, amongst the general population of 16 year olds, one in nine had experienced grooming and one in 15 reported having been taken advantage of whilst under the influence of drink or drugs.
2. The caseload of the Barnardo's Safe Choices Service. Young people involved with Safe Choices receive ongoing support from the HSC trusts field social workers who have referred them. Since its establishment, Safe Choices has completed its work with more than 250 children and young people. In October 2014, there were 99 open cases with a further 46 referrals being processed. Staffing for the Service has now increased from two to seven in the last 18 months and this has had an impact on the number of cases they have been able to take on. Nevertheless, it is significant that the current cases total 145.
3. CSE notifications to RQIA. HSC trusts are required to notify RQIA of known or suspected involvement in CSE on the part of children in residential care.³⁷ In 2012–13, there were 17 notifications. In 2013–14 there were 35 notifications. In the half year from 1 April to 30 September 2014, there have been six notifications. The numbers for 2013–14 were inflated by a spike in referrals in the two quarters from 1 July to 31 December. It is possible that the heightened media attention at that time had some impact on reporting.

³⁷ Under the Children's Homes Regulations (Northern Ireland) 2005, Regulation 29(1), Schedule 5.

4.4 Conclusions from Data

It is difficult to draw conclusions from the comparison of the results from the risk assessments shown previously. Staff understanding of how to use the tool will have evolved over the past years and they may be using different thresholds in different periods and places.³⁸ However, it would be reasonable to conclude that, taking account of the risk assessments and Operation Owl figures, in September 2014, 97 to 120 children across Northern Ireland were recorded as being at significant risk of CSE and 145 children were considered appropriate for a service from Safe Choices. It is important to note that this assessment relates to risk, not confirmed cases, but also that the assessments were done only in cases of those known to social services. So, the total number at risk across Northern Ireland is likely to be significantly higher.

4.5 Impressions of Extent

We asked professionals and people in the community how widespread they believed CSE to be. The most common response was that what is known about it was likely to be “the tip of the iceberg.” No-one suggested that it was not a problem.

Individual police officers interviewed by the Inquiry also commonly commented that there was a gap in the collective knowledge surrounding CSE and also, consequently, the response to it.

A HSC trust staff member observed:

“We won’t know the full extent until awareness goes wider into health, education, families.”

HSC trusts emphasised that there could be children experiencing CSE that may never come to their attention. Agencies have been telling us that CSE is a growing issue, especially amongst young people with no obvious vulnerability factors.

Impressions of this as a growing problem were confirmed by information from the education sector. A school advised the Inquiry that, when they had looked at historical data, they were able to identify likely cases of CSE. The evidence from the cluster group meetings held by ETI highlighted the difficulty in attempting to put a precise figure on the number of children at risk of CSE, or who may have been sexually exploited. However, the DE Independent Counselling Service for Schools (ICSS) coordinator identified CSE as a growing issue over the last two years. They have worked with a small number of young people where one of the issues emerging has been CSE. Representatives from Education Other Than At School (EOTAS), the Education Welfare Service (EWS), the CPSSS, and further education colleges, were able to identify clearly that some of the young children with whom they worked had been victims of sexual exploitation and had been traumatised as a result. However, the lack of a clear definition of CSE meant that many of the other professionals who met with ETI were still developing their understanding of CSE and its signs and symptoms.

³⁸ This was a clear concern in the notes from an interdisciplinary workshop held in January 2014.

A further problem was that currently there is no agreed format for recording incidents of CSE across the education sector. The nature of CSE means that much of it remains hidden. Many adults find it a difficult topic to discuss and it is often linked to many other related issues. While CSE is not regarded as a new problem, it is considered by educational professionals to be a growing one, with new and emerging technologies playing a key role in enabling the perpetrators of CSE to make contact with their victims more easily, with little fear of identification.

Staff from the CPSSS also say that CSE is not a new phenomenon; previously it was referred to as organised abuse. They receive only a very small number of calls from staff in schools raising concerns about CSE. Referrals in the first instance tend to be about sexual abuse, with CSE generally identified at a later stage. The CPSSS has evidence to show that there is an increase in the number of children suffering from self-harm, mental health, and neglect issues. They have strong concerns about the misuse of social media and have evidence that indicates sexting is on the increase and starts at a very young age, with examples of children in primary schools sharing inappropriate images.

4.6 Conclusions

As awareness increases, more cases of CSE will be identified. It is likely to be an evolving picture. CSE must be regarded as a significant and growing threat to the welfare of children and young people. However, it is important to avoid a panic that leads to an unhealthy repression and limitations on young people's lives, and expectations of human relationships.

We received several comments from parents and young people about the need to avoid scaring children about the possibilities of exploitation. Young people were adamant that the response should be largely about empowering young people rather than giving adults more power to control them. The response to the growing threat of CSE must be targeted and proportionate.

The report of the ETI survey concluded:

“It is difficult to gauge the full extent of CSE due to a number of factors including: a lack of a shared and agreed definition of the term; the limited awareness among those who work within the education sector; children and young people not recognising that they are being exploited or being reluctant to make a disclosure for a variety of reasons; and sensitivities around the topic area within schools and at home. The view of educational professionals is that it is a growing problem, closely linked to other related issues, and that communication technology increases the risk.”

In their submission to the Inquiry, the SBNI acknowledged that the full extent of CSE was unclear. They indicated that they were committed to taking steps to assess its scale and nature. SBNI commented that they can only do this with the cooperation of their partner agencies to collect and provide the data which, to date, has been problematic.

It is the Inquiry's view that available figures can only give a rough idea of the extent of CSE and it is likely to be a significant underestimate. We will not be able to be more precise unless and until:

- there is a clear, shared understanding of what CSE is
- there are clear and accessible pathways for reporting concerns about CSE
- people are encouraged to report because they are confident that it will result in action that will protect and support victims and/ or hold perpetrators to account
- information is collected in a way that allows the extent of CSE to be measured

These issues will be addressed later in this report. As far as the current situation is concerned, we agree with the following comment:

“There's lots of impressions, but not enough evidence. It's prevalent in society, but people are not open to talk about it.” [Statutory agency]

The Inquiry recommends:

Key Recommendation 4:

SBNI's developing plan for data collection should include a commitment to collation and analysis of the data in a way that will facilitate a strategic response to CSE.

Supporting Recommendation 19:

SBNI should periodically audit that all statutory agencies record details of CSE in a consistent manner.

CHAPTER 5: SAFEGUARDING LOOKED AFTER CHILDREN

5.1 Introduction

The Inquiry's Terms of Reference include consideration of specific safeguarding and protection issues for looked after children. This chapter identifies the numbers of looked after children in the context of the Northern Ireland population, explores issues of care and control, including resort to secure accommodation and restraint, and looks at the impact of living in residential and foster care. It also discusses the use of unregulated placements for some young people in the care system.

5.2 Statistics

According to DHSSPS statistics³⁹, in March 2014, there were 432,015 children living in Northern Ireland of whom about 26,000 were known to social services. Of these, 2,858 were looked after children in the care of the HSC trusts; 75% of these were living in foster care, 12% were with parents, 7% (around 200 children) in residential care and 5% in other placements. Of those in foster care 40% were in kinship placements, that is, with one of their own family or friends. Those in residential care were living in one of the 47 children's homes in Northern Ireland, which are currently active on the RQIA register – 39 of which were in the statutory sector and 8 in the independent sector.

The number of looked after children is the highest recorded since the introduction of the Children (Northern Ireland) Order 1995. According to the DHSSPS report, this may in part be due to the impact of a legal judgement about 16–17 year olds who present as homeless and are now classified as looked after.

There is a significant crossover between young people who are looked after and the youth justice system. The report of the Review of Youth Justice in Northern Ireland (2011), noted “the over-representation of looked after children, particularly those in residential care, entering the justice system and ending up in custody.” Looked after children are known to accumulate offences while in care for situations that would not result in the criminalisation of other young people.

In terms of known or suspected involvement in CSE, the Barnardo's report identified CSE as an issue of concern for 33% of those involved in the youth justice system, compared with 10% of those with no involvement. In terms of assessed levels of risk, the report estimated that 54% of young people involved in the youth justice system were at significant risk of CSE as compared with 12% of those not involved.

³⁹ DHSSPS Information Analysis Directorate, *Children's Social Care Statistics Northern Ireland 2013/14*, published 16 October 2014: <http://www.dhsspsni.gov.uk/child-social-care-13-14.pdf>

5.3 Care and Control

Whilst the risk assessment tools feature a list of indicators, most attention has been placed on the relevance of children going missing. Some have warned against an unhelpful conflation of these categories. It is necessary to look at the reason for a child going missing to identify links with the potential for CSE. The pull factor of the control exerted by the abuser may be reinforced by the push factor of an unsatisfactory family or care placement. Conversely it is widely acknowledged that a trusting relationship between a young person and parents, or care staff, is a protective factor against CSE.

We know that young people go missing from home and all kinds of substitute care, but the discussion has focused largely on children's homes. This section of the report sets out what people have said to us about care and control in children's homes and compares this with comments about family homes and foster care.

It is important to record at this point that many young people do have a good experience of residential care. They experience stability of placement, and they do not go missing or become exploited. Staff told us that many young people in care had felt stigmatised by the media publicity surrounding the revelations of CSE in September 2013.

There is a perception amongst some members of the public, and the police, that staff in children's homes are unable to do anything to stop a young person from leaving the unit and that this disempowerment leaves young people unprotected. It can feel like an unequal battle in which those who wish to exploit young people have more control over them than care staff can exert. That control may take the form of fear of the consequences of not complying with the exploiter's instructions, or the desire to be with people who can provide something the child needs or wants, whether that is material or emotional. Sometimes it is a mixture of both. The interaction of push and pull factors was exemplified to the Inquiry by a young adult who had been exploited while living in a children's home. She described the chaos that seemed to her to reign in the unit, where she felt unprotected. Going back to her abusers was a more attractive option:

"I just wanted out of it all because it's this madness."

This highlights the fact that care and control need to be considered together. Young people are more likely to be influenced by those they believe can give them care and protection, whether they be staff, family or abusers.

Care staff we spoke to, and their managers, were well aware of this. They spoke consistently of the need to build trusting relationships with the young people in their care. Each HSC trust had adopted a therapeutic model of care that focused on building these relationships. However, for some young people, this does not work. One young person told the Inquiry that she had experienced almost 100 placement moves during her years in care, involving a large number of foster carers and movements between different facilities. Asked what would help, she replied:

"Stop moving us."

Individual police officers interviewed by the Inquiry, generally expressed a view that there was no control in children's homes. In their view, young people could just walk out the door at any time of day or night with no consequences. They felt frustrated that they were left to pick up the pieces, spending what they presented as inordinate amounts of time looking for young people who had been reported missing and taking them back, only for them to leave again shortly after. This was also the view of some other professionals and members of the public we spoke to.

Young people in care also believed staff called in the police too readily.

"Staff over-react and call the police when you don't come back when you were supposed to. A parent wouldn't call the police if you didn't come back straight away, so why is it different for young people in care?"

"Staff lack of confidence leads to PSNI being called prematurely."

"Staff don't have confidence which is why police is phoned."

Care staff described their strategies for stopping young people leaving the unit inappropriately through persuasion, using the power of their relationship with the young person, and through diverting them to attractive activities. Staff readily conceded that this did not always work. If a young person did leave, they would, if at all possible, follow them, even stopping buses or trains to get them off. If this did not work and they had no other options, or if the risk was sufficient to trigger reporting to the police, this was their next action, in accordance with agreed reporting arrangements. Police officers were often sceptical about this. In their view, staff reported young people at the earliest opportunity, in order to pass the risk to the police.

The risk aversion dimension was also referred to by young people, during a discussion about the differences in the ability of parents and staff to exercise control:

"Parents don't worry so much, because they know you."

"Your parents care about you. Staff just care about themselves."

Frontline police officers, media and other commentators often ask why care staff cannot physically restrain young people attempting to leave inappropriately. They suggest that, if young people consistently put themselves at risk, they should be held in a secure place to keep them safe. The implication is that this is what caring parents would do. However, any further exploration of that leads to an acknowledgement that, if a young person is determined to leave the family home, parents have no real ability to control that either. The advantages parents have are – less fear of the consequences if they try to bar the door and the young person gets physical, and the potential for greater emotional authority.

"Parents can stand in front of the door, hold, hug, say "I love you." Staff are disempowered." [HSC trust staff member]

Within foster or kinship care, carers will have the advantages of parents to the extent that they have succeeded in making the young person feel they have an investment in a safe, family unit. This will vary according to the length, stability and quality of the placement and the young person's ability to engage with it.

The VOYPIC consultation report set out young people's views on the implications of the dynamics in different care settings:

"For some young people the response and intervention by foster carers to risky behaviour is effective. They discussed how foster carers use discipline to establish boundaries and resolve difficulties. They described a process where boundaries are discussed and agreed between the foster carer and the young person. Talking calmly and continuously with one carer and addressing the issues with the young person were significant features. Some young people felt that the PSNI do not seem to be called immediately or automatically and there was no sense of an over-the-top reaction to risky behaviour.

Young people who had experienced living in a children's home said that this approach can be more difficult in a group living situation.

"There is too much change in staff and you can't build relationships."

This more measured response allows the young person to talk through issues with the foster carer and address their behaviour together in a reasonable way."

Young people talked about what would help and what would not help in terms of care and control.

What would not help:

"Sometimes workers work against young people instead of trying to work with them and this can get their back up."

What would help:

"Carers should have more time to build relationships, the child shouldn't feel like they're just another number."

"More one-to-one support would be useful, setting boundaries together and having some sort of reward system."

Young people commented on the differences between living at home with your parents and living in care:

"At home your parents spend time with you and they don't go off for hours to do admin."

Staff also referred to the administrative burden and, in particular, the need to fill in a number of forms to notify different agencies in response to a single incident. They asked that consideration be given to having one form that could be used for all agencies.

Supporting Recommendation 20:

DHSSPS, in conjunction with the HSC Board, should review the notifications that residential care staff make following an incident, with the aim of producing a single form that will act as the response to all agencies who have to be notified.

5.4 Restraint

Behaviour management in most children's homes is informed by the model known as Therapeutic Crisis Intervention (TCI). Children's home staff in Northern Ireland have been trained in this method since 2001. The model is intended to equip staff to prevent crises from occurring and to de-escalate them when they do occur. It includes methods of physical restraint in response to acute physical behaviour by the child, which is likely to result in immediate harm to self or others. The DHSSPS informed the Inquiry that restraint measures "are not designed to be routinely used as a preventative measure, e.g. to stop a child from leaving a Children's Home without permission." The DHSSPS advised that use of the model of TCI would be reconsidered on completion of a literature review being undertaken by HSC Board, on the effectiveness of methods of managing aggression (including restraint), in use across the United Kingdom.

Homes for children with disabilities, and respite care homes, use alternative models known as MAPA or Respect.

Whilst some have suggested that staff should physically restrain children attempting to leave children's homes without permission, many others have advised that this is likely to be ineffective and in fact to be counter-productive. If a young person is determined to leave, they will find a way. The experience of restraint can also damage the relationship between staff and the young person, and it is this relationship that is acknowledged as the most effective tool in safeguarding young people. Staff also need to be mindful of the child's background and possible experience of abuse and how this will impact on their experience of restraint.

We were advised that the act of restraining can be dangerous and potentially harmful because of the difficulty in controlling it safely. Staff have to be adequately trained and consider the risks associated with their actions. These should comply with the young person's individual crisis management plan and with the assessment that the physical restraint is less risky than the child's behaviour.

5.5 Secure Placements

Secure placements allow young people's liberty to be restricted. Within Northern Ireland, young people may be held securely in Lakewood Regional Secure Care Centre or Woodlands Juvenile Justice Centre.

Young people may be admitted to Lakewood only if they meet the criteria in the regulations.

They cannot be kept there for more than 72 hours without a court order⁴⁰. Young people may be admitted to Woodlands by the courts, either on remand or on a sentence or under Police and Criminal Evidence provisions, usually overnight or for the weekend, until they appear in court.

Whilst we encountered some opinion that children at risk of CSE or going missing from residential care should be locked up for their own safety, others recognised that this is not an effective long term response. PSNI told the Inquiry that it recognised that placing children and young people in secure accommodation is not a means to resolving issues around child sexual exploitation and may in fact lead to a breach of rights under the UNCRC. However, they noted that there are children, albeit a few, who are clearly placing themselves at risk of serious harm. They conclude that, unless residential care staff have the ability or power to safeguard those children, secure accommodation is probably the only means of ensuring their safety.

There has been a longstanding concern about the over-representation of looked after children (LAC) within Woodlands Juvenile Justice Centre. The 2011 Review of Youth Justice (referred to earlier) noted that 37% of admissions to Woodlands were LAC compared with 27% in England and Wales. It recommended that, “Looked after children should no longer be placed in custody where this would not have been an outcome for children in the general population.” The HSC Board advised that an action plan following the report cites initiatives being taken forward, including collaborative work between the HSC Board and the Northern Ireland Housing Executive (NIHE), to develop alternatives to custody.

In December 2013, a progress report by the CJI showed that there had been limited progress in the implementation of this recommendation of the Youth Justice Review. Nevertheless, the proportion of LAC admitted on remand had, at that time, fallen from one-half to one-third of the total number of remands. Unfortunately, this positive trend appears to be going into reverse.

Despite the demonstrable commitment presented by officials to the CJI in relation to keeping LAC out of custody, the HSC Board figures now show an increase in the number of LAC detained in Woodlands from 137 in 2012 to 226 in 2013, largely for breach of bail conditions or remand, and in relation to offences for which a custodial sentence is highly unlikely. Official documents acknowledge that bail conditions imposed on LAC are likely to be more onerous than for the general population and are often unrealistic or even unachievable and therefore more likely to be breached. For example, a bail condition might require a young person to abide by the rules of the children’s home and/or not leave the home without permission. Given the delays within the youth justice system, young people will be subject to bail conditions for an average of three to four months, and any breach can result in detention. This makes criminalisation even more likely for those young people enticed from children’s homes by those who control them. For some young people, choices are restricted:

“Punishment by society is easier to manage than being out in society.”
[Professional]

We were given examples of young people ending up in the juvenile justice centre as a result of acting out their trauma linked to CSE.

⁴⁰ See the Children (Northern Ireland) Order 1995, Article 44, and the Children (Secure Accommodation) Regulations (Northern Ireland) 1996.

In one case, we were told, bail was refused because the young person was at risk of CSE. A professional expressed the opinion that young people might be admitted to the juvenile justice centre in circumstances when the secure facility, with a child care focus, would have been more appropriate. This person linked this to the fact that there were fewer bureaucratic barriers to admission to the justice facility than the care facility.

Officials are aware of these difficulties. In July 2014, the DOJ and the DHSSPS jointly hosted a workshop for representatives of the statutory sector to discuss the issue and identify a consolidated action plan against which progress could be measured.

We were told that most young people dislike secure accommodation but some do like the boundaries and clear expectations that help them to feel safe. We were told that, in relation to Woodlands:

“The girls almost come in for a rest.” [Staff]

The same applied to Lakewood:

“Young people like secure and will do things to get back in. It’s a revolving door. If they can’t get into secure, they will get into the JJC [Woodlands Juvenile Justice Centre].” [Voluntary organisation staff]

Even in a secure placement, it can be difficult to keep young people safe. A voluntary agency told us of cases of self-harm by young people in secure facilities:

“The idea of secure is to keep them safe physically, but it exposes them to other young people at the same risks. They condone each other’s behaviour. It keeps them contained rather than safe.”

Once young people are released, they have to face the challenges that freedom brings. The VOYPIC consultation noted young people’s view that secure accommodation is not effective because you return to the same environment. We were given information about a case in which a young person had made it clear to staff at the secure unit that she was afraid to leave because of the environment she would be returning to. A young person explained to the Inquiry:

“It’s okay in secure. It’s rearing someone in captivity. You know where to go, what to do. But then you get released into the wild, and it’s f***** wild out there.”

The challenge for society is to provide the kind of structure, safety and quality of care that these facilities provide without depriving young people of their liberty and of the opportunity to develop into individuals who can cope with freedom. Children need a safe space, and it may be possible, with their help, to identify a model that feels safe without restricting their liberty. For example, the Inquiry’s attention was drawn to a model in the Netherlands and to a four-way risk assessment that involves examining the internal, external, geographical and environmental implications of a building.

For some young people, a period in secure accommodation may be a temporary answer but it cannot be a long term solution. Certainly, young people should never be criminalised in response to criminal acts committed against them.

5.6 Impact of Living in Residential Care

Young people may enter the care system with a pattern of CSE or of going missing already established. However, we heard many concerns about the possibility that the group living and peer pressure of a children's home could render children more vulnerable. Those who wish to abuse children would find it easy to locate children's homes and may target them. We heard some evidence about this. Some believe this no longer happens:

“It's difficult for homes to be targeted now because they are under so much scrutiny. Staff are more proactive – following young people, taking names and car numbers. Since September, police have been more proactive about disruption.” [HSC trust staff]

However, on the basis of information we have received, we believe it is more likely that this activity is still happening, but is now just less obvious.

We asked about the processes for choosing a placement for a young person entering the care system. Trust staff explained the processes for assessment and matching a young person to a unit. Choices might be limited due to lack of availability. One HSC trust had experimented with an all-girls unit, but they concluded that it was better to have a vulnerable unit for small groups of mixed gender and to be careful who you placed in it.

“The Resource Panel will look at the mixture of young people in any home. There is a risk in introducing new young people. Their older boyfriend will have access to other vulnerable young women.” [HSC trust staff]

“The danger is that you put a young person where there is a place. We are trying to manage that at the moment. It's difficult because, if all the young people have the same vulnerabilities, they can reinforce each other.” [HSC trust staff]

Staff at a unit that now primarily accommodates older males explained how they had arranged a transfer out of a young girl because the mix of young people had changed, and they feared the girl would be put at risk.

The HSC Board explained that, as part of the review of residential child care, they were seeking to commission smaller units with more specific statements of purpose and also to place an emphasis on relationships.

5.7 Occupancy and Staffing Levels of Children's Homes

The snapshot survey of children's homes already referred to asked about the numbers of beds available in children's homes, the numbers occupied on the relevant dates, and the reasons for any unoccupied beds.

Children's homes can accommodate from two to eight residents, with most having between six and eight beds. The return showed occupancy rates of 70% on the weekday and 73% at the weekend.

Reasons for empty beds included situations in which a young person was temporarily absent from the unit and the bed had to be maintained, recent discharges, the complexity of the needs of current residents and/or the risk they might pose to other young people. Only four responses stated that there had been no requests for placements. The HSC Board advised that, whilst units may have eight beds, agreed occupancy levels may be five or six in keeping with the commitment to having smaller units. Admissions will also need to reflect the statement of purpose and function for the unit, as well as the background of a young person being considered for admission and current mix of residents.

It is important to ensure that levels of occupancy allow for choice in placements and an appropriate response to young people with complex needs or risky behaviour. The Inquiry would encourage HSC trusts to maintain sufficient beds to allow for choice in placements.

The survey also asked about the numbers of staff on duty on different shifts, their pay band and qualifications. There was an average of 7.6 staff per home during the week, 82% of whom were permanent staff. This contrasted with the weekend period when there was an average of 6.1 staff per home, 65% of whom were permanent staff. Staff grades ranged from Band 2 to Band 8a, with most being Band 6. The same general pattern applied at the weekend, although with fewer staff. Where this is the case, we were advised that it is due to the absence of managerial staff at weekends, some of whom will be available on call. All staff members had some qualifications or training relevant to work in this setting.

On both nights, 78% of those on the night shift were permanent staff. Most had two members of staff on at night, some had three and one home had four members of staff on the weekend night shift. Two homes reported that they had only one member of staff on the weekend night shift and a few did not record an answer to that question.

In the Inquiry's view, the band levels of staff seem to be appropriate, and all had received some relevant training. However, it is concerning that:

- There is a greater reliance on temporary and bank staff at weekends, as this is when more young people are likely to go missing.
- Staffing levels at night in most homes would make it difficult for a staff member to follow or search for a young person without leaving the unit in charge of a single staff member.
- In two homes, there was only one staff member on the weekend night shift.

5.8 Foster Care

Three quarters of looked after children live in foster placements and two-fifths of these are in kinship placements.

There is a tendency to view those in foster care as at a lesser risk of CSE or of going missing. However, we spoke to a small group of foster carers who were dealing with serious cases of CSE. In their view, they had not received adequate training or guidance, and experienced varying levels of support.

The foster carers we spoke to acknowledged that not all foster carers would be dealing with CSE, but felt it was more widespread than people realised, and that raised awareness would identify more cases. This had already started to happen as a result of recent publicity about CSE. They said there were no policies or procedures for foster carers on how to deal with CSE. Sometimes, through their own efforts and experiences, foster carers knew more about CSE than the social worker assigned to the case. There were varying experiences of support from police and social services, positive and negative. One carer expressed her appreciation of the support she received from the trust's 16 plus team. High turnover of social work staff was considered to be a problem.

While LAC nurses are not restricted to residential units, some of the carers reported a lack of dedicated support for the health needs of their young people, including lack of availability of LAC nurses. They felt that all health intervention was initiated by them as carers.

Carers commented on the lack of good chronologies of a young person's personal history on taking up the placement. They felt there was not enough multi-agency working and no structure to address the needs of the child. It was not standard practice to involve carers in risk strategy meetings.

The trusts and the HSC Board advised the Inquiry of the kinds of guidance and support they provided to foster carers, with some reference to health support. In the Inquiry's view, there is a need to audit what is being provided across the region to ensure equality of support for foster carers and their young people.

Supporting Recommendation 21:

The HSC Board in conjunction with HSC Trusts should ensure that adequate support is available for foster carers (including kinship carers) and foster children, including health support through LAC nurses.

5.9 Unregulated Placements

A number of placements for young people aged 16 plus, including some LAC, are classified as unregulated. These include:

- Jointly commissioned (NIHE and HSC Trust) young adults supported accommodation projects. These arrangements are governed by DHSSPS standards and are subject to annual inspection by RQIA, but remain classified as unregulated for reporting purposes.

- Supported lodgings (jointly commissioned by NIHE and HSC Trusts). DHSSPS standards are currently being developed to govern this model which will be subject to RQIA inspection in the future.
- Relatives and friends who have not been approved as foster carers.
- Hostel accommodation.
- Single tenancies.
- Bed and breakfast accommodation. (It is stipulated that this arrangement should only be used as a last resort and for the shortest possible time.)
- Temporary accommodation provided by the NIHE.
- Other arrangements.

The HSC Board advised the Inquiry of circumstances that might lead to this kind of placement:

- Planned transition and step down from care placement in keeping with the pathway plan.
- Crisis of homelessness and where a mainstream care placement is not available or is deemed unsuitable due to assessed needs/risks.
- Unplanned moves from mainstream care placement due to escalation in behaviours that puts other children at risk, e.g. drug/alcohol related behaviours.
- Determination by young person that he/she no longer wishes to reside in mainstream care placement.
- Breakdown in a series of more suitable placements. Jointly commissioned accommodation options due to high risk behaviours which culminate in a placement in a bed and breakfast or generic hostel as a last resort.
- Young people on remand in Woodlands who require accommodation to facilitate a discharge. In these circumstances the young people are children in need and require accommodation, however associated behavioural and bail conditions often exclude a placement in mainstream care placements.

The HSC Board has advised the Inquiry of the reporting arrangements in place which require HSC trusts to complete and submit unregulated notification reports. These apply only to 16 and 17 year olds. The HSC Board reviews these reports and monitors unregulated placement arrangements. For the period 1 September 2013 to 31 August 2014 a total of 66 such placements were notified to HSC Board. Eighteen related to young people aged 16, and 48 to those aged 17.

There were slightly more males than females. During the period from 1 September 2013 to 31 August 2014, the majority of moves from care placements into unregulated settings were into jointly commissioned supported accommodation, followed by placements in bed and breakfast and generic hostels.

Table 5-1 shows the range of placements and numbers of young people placed in them:

Type of Unregulated Living	Number of Incidents
Unregulated - Hostel	11
Unregulated - Bed and Breakfast	12
Unregulated - Friend or Relative	4
Unregulated - Hotel	4
Unregulated - Single Tenancies	4
Unregulated - Supported Accommodation	30
Unregulated -Women’s Aid Refuge	1
TOTAL	66

Table 5-1: Number of Unregulated Placements per type of unregulated living accommodation

The HSC Board has assured the Inquiry that processes are in place to identify and review inappropriate placements.

It is of concern that some young people are still being accommodated in hostels, hotels and bed and breakfast accommodation. However, we learned about some particular concerns related to supported accommodation projects. These are recently developed hybrid projects which, depending upon their individual statements of purpose, accommodate LAC moving towards independent living, young people who are over 18 and have left care, young homeless people, or a mixture of these. The providers are all voluntary organisations, with beds being commissioned by the HSC trusts.

There are 16 such projects but this number is expected to increase over the next two years. They can accommodate from two to 25 young people. Only one accommodates the maximum figure of 25. One accommodates up to 18, one accommodates up to 16, and the remainder accommodate 10 or less. The minimum age of admission is 16 and the maximum stay is two years. The upper age limit for some projects is 21. The length of stay depends on a number of issues, such as their readiness to move out on their own, their behaviour whilst in the project and the length of time they have been in the project.

These facilities were described as a positive development to the extent that they are an alternative to the previous greater use of bed and breakfast accommodation. They are inspected by RQIA as a matter of good practice rather than a matter of law. There are no regulations for supported accommodation projects, but RQIA inspections utilise the standards for leaving care services in Northern Ireland (DHSSPS, September 2012) to inspect the trusts and the standards for young adults supported accommodation projects in Northern Ireland (September 2012) for the projects themselves.

We have been advised that some of these projects are working with high risk young people and that their placement in the project may not be the most suitable for them.

There is also a concern that HSC trusts are not passing on all the required information to the projects during the admission process or when reviews are completed in relation to young people. Levels of staffing and training may not always be sufficient for the challenges staff have to face. They are being asked to work with complex cases, which may involve CSE, and with young people who some believe, should be in a children's home. However, we were advised that most project staff are carrying out their role to the best of their ability.

These projects do not have to notify incidents to RQIA although, in terms of DHSSPS standards, they are required to report untoward events and serious concerns both to the NIHE and the HSC trusts.

Supporting Recommendation 22:

The HSC Board, in conjunction with the HSC trusts, should assess the appropriateness of existing unregulated placements to ensure that the assessed needs of young people in these placements are being met.

Supporting Recommendation 23:

DHSSPS should consider bringing forward regulations to require supported accommodation for young people under 18 to be registered by RQIA.

5.10 Conclusions

The number of children in residential care is relatively small. The welfare of this particularly vulnerable group needs to be a priority. We heard a lot about the police time and resources expended on looking for missing children and returning them. It would be a better use of public resources if we could make children's homes places where children wanted to be. We are aware that there are some very good children's homes where the culture is positive and the standard of care is high. We heard a lot about the importance of building trusting relationships with young people as the most effective way of protecting them from CSE. We are aware that the HSC trusts have adopted therapeutic models to support their relationships with young people and that the policy is to move towards smaller units.

Good relationships can withstand an element of challenge. This was the approach of one professional working in a residential setting with young people:

“We care enough to say no.”

We are aware of the difficulties staff face in balancing the rights of young people to care and to control. In Chapter 9, we set out an analysis of these issues in terms of children's rights. In that discussion, we note that children have a right to be protected and that this will be most effectively secured, if their views are taken into account about how matters of care and control should be addressed.

The young people consulted by VOYPIC, suggested that children and young people should be involved, with care staff, in developing strategies to respond to those who are in danger of being exploited.

They believed this would ensure an effective and meaningful response. We agree that young people's participation will help ensure that strategies and rules are practical and informed by their experience. This does not mean that the young people's views should always be determinative. There is a responsibility on adults to keep children and young people safe.

We noted that some believe there should be greater resort to physical restraint and secure accommodation in order to keep children safe. We are firmly of the view that these must not be regarded as everyday responses to situations in children's homes. There will be some situations in which these are justified.

We reported how some young people appreciate the feeling of safety within secure facilities, whether it be a care facility or youth justice. We believe there is an important message here about what we need to provide, to keep young people safe during vulnerable periods. However, it is unacceptable for children to be placed in a justice facility for their own safety. Even in care settings, deprivation of liberty can feel like a punishment. We believe young people with experience of CSE should be involved in discussions about what a safe space would be like. We understand that there are some international models, in the Netherlands for example, that can be looked to as a starting point for discussion. A safe space may mean different things depending upon place and need. It could be a daytime resource, a small residential unit with safety features agreed with the residents, or something else that arises out of conversations with the young people who need protection.

The HSC trusts reported to us their confidence in the training and skills of staff in residential units to respond appropriately to challenging situations. We believe this should be backed up by a strong commitment by management to support staff where they have acted on the basis of sound and informed judgement. It is a management responsibility to ensure their staff are well qualified, trained and supported and it is right that they should be accountable for that.

If it is the relationship between carers and children that is important, then the staff who are significant to young people should be available at the most critical times – at evenings and weekends. Their administrative burden should be lessened to give them more time to spend with the young people.

Outside residential care, we note the challenges faced by some foster carers and those running establishments providing unregulated placements for young people.

The Inquiry recommends:

Key Recommendation 5:

The DHSSPS should explore the benefits of amending or adding to standards for inspection of children's homes to ensure that they:

- a) promote a culture conducive to respect for the best interests of the child; and**
- b) take account of the specific needs of separated and trafficked children and those affected by CSE.**

The DHSSPS should issue a circular and associated guidance stating how these issues should be taken forward.

RQIA previously operated a peer review process for inspections of residential child care. This has been discontinued. The Inquiry agrees with the suggestion by VOYPIC, in their submission to the Inquiry, that RQIA should consider its reintroduction.

Supporting Recommendation 24:

RQIA should consider re-introducing the involvement of young people as peer reviewers in inspections of children's homes.

Key Recommendation 6:

The DHSSPS, along with the HSC Board and HSC trusts, should consider how "safe spaces" could be developed for children and young people at risk of, subject to, or recovering from CSE. This development should take account of models of best practice and the views of young people, and should respect international human rights standards.

Supporting Recommendation 25:

HSC Trusts should endeavour to provide stability by minimising the movement of both children and staff throughout residential and foster care settings.

Supporting Recommendation 26:

The HSC Board should consider the development of region-wide guidance about care and control in residential units. This should involve input from both young people and residential care workers.

Supporting Recommendation 27:

HSC Trusts should take responsibility for ensuring that frontline staff in residential facilities are helped to feel confident that they will be supported by management if something goes wrong when they have done their best. They should also feel confident about speaking up if they feel young people are in danger and they cannot keep them safe.

CHAPTER 6: 18 TO 21 YEAR OLDS

6.1 Introduction

In recognition of the vulnerability of many young people over 18, the Inquiry agreed to define child as including any young person up to the age of 21 who had been looked after by social services or had a disability. This is in line with the definition of child in the remit of the Commissioner for Children and Young People in Northern Ireland (NICCY).

The social care system already recognises the vulnerability of some of these young people through its extended fostering and leaving care arrangements. For example, the Going the Extra Mile (GEM) scheme seeks to promote continuity of living arrangements up to the age of 21 for young people who are in foster or kinship care placements when they reach 18. Carers are given financial support so that they can continue to meet the care, accommodation and support needs of the young people.

6.2 Formerly Looked After Children

6.2.1 Statistics

In 2012-13, 263 young people aged 16–18 left care in Northern Ireland. Eighty-one percent left because they had reached the upper age limit of 18. A further 14% left to return to their parents. Forty-five per cent were in foster care at the time, including kinship foster care. Seventeen percent were in residential accommodation, a further 17% in independent living, 12% with parents, and 9% in the Other category, which included hospital, young offenders' centres, shared care and assessment centres.

Table 6-1 shows where young people went to live on leaving care⁴¹.

Location	%
With former foster carer	32
Independent living	23
With parents	22
Supported accommodation	14
With friends	5
Residential accommodation, custody and other placements	4

Table 6-1: Where young people went to live on leaving care

⁴¹ DHSSPS: *Northern Ireland Care Leavers Aged 16 – 18: Statistical Bulletin 2012/ 13*.

Sixty-six percent of care leavers were in education, training or employment when they left care. Eighteen percent were unemployed. Others, whose circumstances are recorded, were either sick or disabled, or were parents or carers.

While some care leavers were thriving, as a group they were statistically more likely than the general population to have been subject to a statement of special educational needs, and to have no qualifications or employment. Amongst children in care, those from foster care tended to fare best.

HSC trusts remained in contact with 98% of 19-year-old care leavers. Social services were in contact with 80% of this group at least once a month. Sixty-nine percent of these young people were in education, training or employment. As shown in Table 6-2, the accommodation arrangements of 19 year olds show a different pattern from the 16-18 year old care leavers, with more in independent living and fewer living with former foster carers.⁴²

Location	%
Independent living	37
With parents, relatives or friends	31
With former foster carer	12
Supported lodgings	12
Other, including custody	7

Table 6-2: Where 19 year old care leavers were living

6.3 Disability

It has long been recognised that young people with disabilities experience difficulty in the transition to adult services at the age of 18. In 2012, NICCY published a scoping exercise commissioned from the Queen’s University of Belfast on transition arrangements for young people with learning disabilities in relation to education, training, employment and health and social care which identified a range of inconsistencies, weaknesses and gaps in existing arrangements.⁴³ One of the recommendations was for age appropriate, tailored sexuality and relationships education.

A professional from the education sector commented that:

“Transition is not well managed. They move from a cosseted environment into adult care.”

The consultation undertaken by CiNI for the Inquiry referred to the natural aspiration of young people with disabilities to be normal. This heightens the vulnerability of these young people where the new normal, referred to previously, shades into exploitative behaviour.

⁴² DHSSPS, *Northern Ireland Care Leavers Aged 19. Statistical Bulletin 2012/ 13.*

⁴³ Lundy, L et al., *Review of Transitions to Adult Services for Young People with Learning Disabilities.* NICCY, Belfast 2012. http://www.niccy.org/uploaded_docs/2012/Publications/NICCY%20Transitions%20Report%20-%20final%20Sept%202012.pdf

A voluntary organisation advised:

“When disabled young people reach 18, some think they can make their own decisions. They can be offered a personal assistant but they don’t want social services in their life.”

In some instances these young adults let their houses be used as party houses. They may also be targeted on dating sites. Young adults with mild or undiagnosed learning difficulties were repeatedly identified as a group at particular risk of CSE.

Many of those who spoke to us referred to these difficulties and the fact that the definition of vulnerable adult was too narrow to support many young adults who were in great need of support:

“The vulnerable adults category is very restricted. A lot of young people have undiagnosed mental health or learning difficulties. Once they reach 18, they don’t fit easily into criteria for special support for disability or mental health.”

The DHSSPS report, *Adult Safeguarding in Northern Ireland (2010)* defines vulnerable adult as:

“a person aged 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.”⁴⁴

The Inquiry understands that the DHSSPS will consult on a new adult safeguarding policy in November 2014. In place of vulnerable adult, a definition of adult at risk will be introduced which is likely to be more extensive than the definition cited earlier.

6.4 Other Vulnerable Young Adults

Reference has been made earlier to the overlap between young people who are looked after and those involved in the youth justice system.

Young people who leave the juvenile justice facility at Woodlands may have supervision after release. However, parents of young people involved in the youth justice system say that support falls away once a young person reaches 18.

More generally, the discussion about unregulated placements noted that these placements also accommodate young people aged 18-21 who may have a range of vulnerabilities. The HSC Board advised that all will be known to social services and be subject to assessment and pathway/ support planning.

⁴⁴ DHSSPS, *Adult Safeguarding in Northern Ireland (2010)*: http://www.dhsspsni.gov.uk/asva-march_2010.pdf

6.5 Conclusions

We acknowledge the support provided to young people leaving the care system in terms of current arrangements. It is notable that a number of young people leaving care appear to move swiftly from supported placements into independent living and informal settings. For some, this may be a positive move.

Many contributors to the Inquiry referred to the potential for support for vulnerable young adults under the vulnerable adults category, but they considered that category to be too narrow to accommodate many of those in need of help. The Inquiry therefore recommends:

Supporting Recommendation 28:

DHSSPS should take the findings of this Inquiry into account in its review of the definition of vulnerable adult to ensure that it is capable of accommodating young people who are vulnerable to CSE.

CHAPTER 7: PREVENTING AND TACKLING CHILD SEXUAL EXPLOITATION

7.1 Introduction

The perspectives of young people and parents and the role of the community are central to all of the discussions that follow about: awareness raising; prevention and early intervention; identification and reporting; child protection processes; the operation of the criminal justice system; disruption techniques; collaboration between agencies and the adequacy of the law.

7.2 What Young People Said

Children and young people want to know more about CSE and to be empowered to resist it. They want support from caring adults who can spend time to build up the kind of trusting relationships that can both act as a defence against the approaches of those who would exploit them, and also allow them to talk about early fears or actual incidents of exploitation, without experiencing shame or disbelief. These are some of the things young people said about CSE and what can be done to help themselves and other children keep safe:

“Nobody knows about this. I’m going to warn my friends.”

“Younger kids need to know about this too – we need to tell them what could happen. They won’t hear it in school.”

Young people were concerned that parents should be made aware of CSE:

“Someone needs to tell parents about the dangers – they could make sure parents have heard about it and know what to do.”

“Parents should be doing stuff like we are doing with you now.”

Young people talked about how they might try to deny what was happening to them, both to themselves and to their parents:

“They would get used to nice things and not want to admit what was going on.”

“The person is nice to them and makes them feel wanted.”

“They could tell themselves that they are doing the exploiting ‘cos they get the stuff.”

“They’d put a show on so their parents wouldn’t start asking questions.”

If they did want to report, there were barriers in the way of them telling about what was happening to them:

“You’d be too ashamed to let on to anyone.”

In particular, they would be reluctant to approach the police:

“A lot of young people have had bad experiences with the police and would be afraid to go near them.”

“The police don’t believe young people.”

“Maybe made up some stories before and the police won’t listen.”

“They have bigger issues to deal with.”

Some might also have to live with fear of their abuser:

“He might kill you to stop you giving evidence.”

7.3 What Parents Said

It is clear that parents are the first line of defence against the exploitation of their children. The Parenting NI survey identified the responsibility of the family as key to the safety of children. Parents recognised their lack of knowledge about CSE and expressed their eagerness to take advantage of opportunities to address this. They recognised the critical role of schools in supporting both them and their children in learning about, and guarding against, CSE. Some parents commented upon how much they had learned just from participating in the Parenting NI survey:

“I think this survey has shown me that I am very ill informed about the issue. My children are at the younger scale of the survey but I need to increase my awareness as they grow older.”

Parents were asked if there were any reasons why they might not seek advice and support when they had concerns about CSE. Almost two-thirds of online respondents said there would be no barriers to seeking help. For the remaining one third of online respondents the main reasons for not seeking support included potential trauma to the child or fear of losing their child. Parents in the focus groups, who had a slightly different profile from the online group, said the main reason parents may not contact the authorities is a lack of trust in them. One parent said she:

“... knew from experience that this would not be handled properly and that the perpetrator would get away with it.”

A number of parents said they would specifically not contact the police due to the poor relationship between police and their community.

Two parents who recounted their experiences independently to the Inquiry said they were not taken seriously when they first tried to get help to protect their children.

Once they were listened to, they were made to feel like suspects rather than partners. It seemed to them that they were the ones who had to join all the dots together to manage their child's case. We cannot claim this is representative, as parents are unlikely to approach the Inquiry to recount a good experience, but it is confirmed by experience in England. Parents Against Child Sexual Exploitation (PACE), an organisation working in England, made a submission to the Inquiry in which they referred to YouGov research highlighting that there is still a common perception and attitude among professionals that parents are in part responsible for the sexual exploitation of their child and that parents are disempowered by statutory intervention.⁴⁵

7.4 The Role of the Community

We repeatedly heard strong statements about the role of members of the public and those working in communities in preventing, identifying and reporting concerns about CSE. Statutory services point out that it is unrealistic for their services to assume the whole responsibility for this. Children and parents agree. Some taxi drivers who took part in the Inquiry's consultations expressed their willingness to take on a role, but needed support in terms of awareness raising and provision of clear pathways for reporting and feedback.

7.5 Cross-Sectoral Working

The Terms of Reference require the Inquiry to examine the effectiveness of current cross sectoral child safeguarding and protection arrangements and measures to prevent and tackle CSE. Cross sectoral working is a challenge across the United Kingdom. It is common for Inquiries such as this to conclude that agencies need to cooperate more closely and share information more appropriately.

It is not surprising therefore that the need for more effective inter-agency working and information sharing was a constant theme as our Inquiry progressed. This chapter of the report explores the inter-agency and information-sharing concerns as an integral part of its consideration of how CSE is prevented, identified, disrupted and tackled in Northern Ireland. The next chapter will look at how victims are supported to recover from their experiences.

7.6 Awareness-Raising

CSE will not be prevented and tackled if those who come into contact with it do not know what they are looking for. Victims are unlikely to report CSE, so parents, interested individuals and professionals will have to be prepared to identify it. This is not just an issue for social services and police. Health and education workers, across the whole range, from head teachers and hospital emergency department staff, to caretakers, caterers and nursing assistants, need to know what to look for.

⁴⁵ YouGov Report. *Are parents in the picture? Professional and parental perspectives of child sexual exploitation.* (Autumn 2013) - <http://www.paceuk.info/what-we-do/publications/parents-picture/>

Some of these will have direct contact with children and parents, and children and parents will often feel freer to talk to those lower down the official hierarchy than those at the top. However, those at the lower end of the hierarchy may not feel able to address the issue. A young person with experience of CSE explained:

“Some people listened but didn’t have the power to act. People who had the power to act didn’t listen. They nod their heads, but don’t act.”

Ambulance drivers come across situations that give rise to concerns and they need to be helped to think these through and report them where appropriate. Taxi drivers, hoteliers, those running fast food outlets and leisure facilities, etc., all need to be alert to the signs that a child is being exploited. Hairdressers have also been mentioned as the likely recipients of relevant information. Children and parents need to be alert to what is happening or what might happen if a situation gets out of control.

General awareness raising is important. It will help members of the community to be alert to the dangers to their own children and their neighbours’ children. It will help people on the front line of community life, such as shop keepers, landlords, hotel owners, taxi drivers and hairdressers, to identify the significance of what they see or hear as a first step to doing something about it. It will impact on professionals who have received no specific training. And, importantly, it will inform those members of the public called for jury service.

ETI held cluster group meetings across the education sector which showed that levels of awareness amongst education professionals varied considerably. It was highest amongst the statutory educational support services and in teacher education, and significantly lower for teachers, staff and leaders in schools and other education and training providers, and amongst staff working in the voluntary and community sector. Primary principals stated that most teachers in their schools have only a basic awareness of CSE and, in particular, they have limited understanding of the dangers associated with the use of social media.

Those in contact with the Inquiry commented that awareness had increased since the media attention following the revelations in September 2013 and this publicity helped to raise awareness, as did the establishment of the Inquiry and the Inquiry’s work. The SBNI had already identified CSE as a priority and, during the course of the year, produced leaflets and launched the first stage of an awareness raising campaign⁴⁶. Publication of the Rotherham Report gave awareness a further boost. Nevertheless, whilst awareness of the term child sexual exploitation or CSE seems to have grown, this does not mean those acquainted with them have a full understanding of what it involves and its relevance to their own lives or work. Young people need to hear about CSE from sources that are meaningful to them.

The VOYPIC report on the consultation with young people from care commented:

“All of the young people talked about the value of learning from their peers and hearing real- life stories. Peer education should be a key component of any awareness raising strategy.”

⁴⁶ Further details of SBNI activities can be obtained from their website: <http://www.safeguardingni.org/>

7.6.1 The Role of Schools

Young people, parents and professionals all identified a key role for schools in raising awareness amongst pupils and parents and in identifying concerns about CSE. This has the potential to reach out to the wider community of young people who are not in the care system. A key finding of the ETI survey was:

“Schools are well placed to teach pupils how to develop healthy relationships, and to make informed choices in their lives so that they can protect themselves from sexual exploitation.”

The survey concluded that the most effective schools took a proactive approach to the personal development programme, helping children make positive choices in a range of situations. This contrasted with less effective practices where schools were more reactive to single issues such as CSE.

Most pupils said CSE was not explicitly discussed at school although aspects such as human trafficking and sexting were addressed. Pupils identified variation in the delivery of relationship and sexuality education because of the capacity and lack of confidence of some of the teachers to deliver the programme. A parent reported:

“My daughter says this lesson is frequently changed to a revision session (on other subjects). The male teacher appears embarrassed by some topics and the girls don't respect him. My daughter tells me she "knows it all already" (*she doesn't) so doesn't listen. I think dedicated teachers would be better able to get the necessary messages across.”

Some schools currently use – and value – the contribution of external agencies in delivering Keeping Safe messages but, because they are unregulated, it is difficult for schools to assess the quality and appropriateness of what they provide. Pupils valued the input of external agencies and, in particular, singled out the PSNI programme, Chat, Share, Think, which they believe is up-to-date, relevant and delivered by those with first-hand experience of the issues. A parent also commented on the value of the programme.

The Educational Psychology Service identified girls transitioning from primary to post-primary as a group at particular risk, due to their lack of self-esteem, early sexualisation and desire to be one of the group. In recent years they are seeing more children and young people with relationship or attachment issues and in need of nurture support. They emphasised the need to develop the confidence of children to say no to an adult and to develop self-protection strategies.

Most of the parents who responded to the ETI survey had no prior knowledge of CSE. Most said they would like more information on the school's approach to personal development and the strategies used to keep children safe. The ETI survey concluded that most schools do not engage well enough with parents or carers in developing a holistic, preventative curriculum:

“There is a need for parents to be involved more in developing the personal development curriculum in schools and for them to be supported so that they can help keep their children safe outside of school hours.

To assist with this, and to further improve the development, quality and relevance of the preventative curriculum, there is a need for further guidance and support from DE [Department of Education] and for a review of the guidance materials which underpin the statutory personal development curriculum, in addition to the review of the guidance materials underpinning the Relationships and Sexuality Education, by CCEA. Consideration needs to be given to the development of a coherent, progressive and preventative, personal development curriculum from primary into post-primary.”

Independent schools in Northern Ireland undergo inspection regarding their child protection procedures on a voluntary basis. This is something that needs to be considered in the light of the rights of all children to be protected, without discrimination (Article 2 of the UNCRC).

The Inquiry recommends:

Supporting Recommendation 29:

The Department of Education should ensure that there is provision for parents, carers and other educational professionals to improve their knowledge and skills in relation to modern methods of communication and to keep up-to-date on developments in social media.

Supporting Recommendation 30:

The Department of Education should work with other departments to ensure that there are appropriate safeguarding arrangements for children in all non-statutory education settings.

Supporting Recommendation 31:

Schools should ensure that Relationships and Sexuality Education is delivered by people with the skills and confidence to do so.

Supporting Recommendation 32:

The Department of Education should develop a central register of quality assured external agencies and/or programmes that schools could access to source appropriate specialist support to deliver the preventative curriculum.

Supporting Recommendation 33:

The statutory personal development curriculum should specifically reference CSE, with a clear focus on progressively developing the confidence, self-esteem, resilience and personal coping strategies of all children and young people in schools.

Supporting Recommendation 34:

School staff and wider education professionals should receive training on CSE with the aim of integrating it into general safeguarding training.

Supporting Recommendation 35:

The Department of Education should ensure that schools receive additional, regularly updated training and resources to support them in educating pupils and parents on how to use social media and online resources responsibly, and how to keep their pupils safe.

Supporting Recommendation 36:

The Department of Education should give further guidance to schools on CSE and in its review of Relationships and Sexuality Education guidance for schools, CCEA should consider specifically referencing CSE.

Supporting Recommendation 37:

The Department of Education should explore the possibilities for peer education and mentoring as a way of informing and supporting young people about CSE.

The ETI survey noted that there was a variation in practice across schools in their record-keeping in relation to child protection issues, including CSE. The Inquiry recommends:

Supporting Recommendation 38:

The Department of Education should provide schools with clear, consistent guidance on recording, storing and handling of child protection records including CSE.

7.7 Training

There was much comment across all sectors about the need for those working with children and young people to receive the kind of training that would allow them to prevent, identify and report CSE. Some training has been introduced recently and we experienced a willingness to expand training opportunities. However, there will be a need to invest in training for the trainers themselves to meet this demand.

All trusts gave lists of training and training opportunities, but it is not clear how many staff have been trained on CSE and how in-depth that training is. The PSNI list of training made some reference to attendance at CSE courses. It said police officers were invited to attend Level 1 CSE training delivered by Barnardo's, which has been available since 2003. PSNI advised that police, both uniformed and CID, regularly attend these events, but participation levels are unknown because Barnardo's does not record details of attendees. They were able to confirm that 112 specialist officers had attended the relatively new National Centre for Applied Learning Technologies (NCALT) public protection course, which covers missing persons and CSE. A further development is the two hour lesson on child protection that has been included in the new student officer training programme. CSE and child abduction are specifically covered in it. These are promising developments but will take time to become embedded in practice. During interviews for the Inquiry, police officers confirmed that most had received no training on CSE and many professed to have little knowledge or awareness of it.

Within the education sector, the ETI survey reported that the principals, governors and staff in most of the schools demonstrate high levels of commitment to ensure that the safety and wellbeing of their pupils is paramount.

However, in a significant minority of schools, the boards of governors and principals reported that they were not sufficiently well trained or confident in managing what they consider to be high risk or sensitive areas such as CSE. In the schools where the provision is less effective, leadership and management is reactionary to serious incidents rather than having an embedded approach.

While designated governors are encouraged to attend CPSSS training designed to support them in their role, it is currently not mandatory for them to do so. School staff indicated that they would require further training and better, more current and more specific resources to build their capacity and confidence to deliver keeping safe messages to pupils, particularly those with learning disabilities. A range of other education professionals also identified a need for training. The two local teacher training universities reported that the lecturers delivering teacher education programmes had high levels of awareness of child protection and CSE. They stated that CSE was not a new phenomenon and has been a feature in the lives of some young people going back many years. Both of the universities represented had a safeguarding team, with designated and deputy designated staff members, but recognised that more work needed to be done internally. For example, all of the staff in the universities need to have child protection/safeguarding training and awareness raising, not just the designated team. This is important as the academic staff will be the initial point of contact for all student teachers.

A youth organisation said it was important that training covered normal sexual development for young people as well as abuse and exploitation. This was also the view of the Independent Counselling Service for Schools (ICSS) who said there was a need for a greater understanding of how children develop sexually; normal patterns versus abnormal patterns of sexual development. The youth service, in its engagement with ETI in the cluster group meetings, identified the need for more training and greater awareness of CSE amongst staff at all levels, including the high number of youth volunteers. They said there was a need for: a clearer strategic direction across all ELBs and sectors with an action plan and more effective joined-up working; a better defined referrals processes and CSE procedures; more youth service resources which are current and relevant to young people; a consistent programme of e-Safety for all; and a more proactive approach to engaging with young people. They expressed the opinion that the role of the youth worker in schools had been very effective in the past, but had declined due to financial constraints and that a review of the role should be considered.

Training is required also for health workers, voluntary and community organisations, foster carers and those involved in the justice system. Taxi drivers and security staff in shopping centres should also be trained to recognise and report concerns about CSE.

Training programmes often lag behind critical issues and have to catch up on recent concerns. It was notable, for example, that almost 4,000 police officers had received some training on trafficking. This is a welcome development. We believe that more training on trafficking for all sectors would be appropriate. We recognise the demands on professionals that compete with time for training. We believe that, in the long run, training on CSE should be integrated into general child protection training. In the short term, there is a need for a real push for awareness-raising on CSE across the sectors, with more in-depth training for those most involved.

The SBNI advise that their Education and Training Committee has approved a Learning and Development Strategy for 2014-2017, which will be circulated for consultation.

The Inquiry recommends:

Supporting Recommendation 39:

Schools should ensure that all school governors have child protection awareness training which includes reference to CSE. The designated governor for child protection should have additional, enhanced training.

Supporting Recommendation 40:

The Department of Education should ensure that youth workers, whether paid or voluntary, should receive training to help them to inform and support young people who may be at risk of CSE, and to identify and report safeguarding issues appropriately.

7.8 Prevention and Early Intervention

There is a strong commitment to early intervention practice in Northern Ireland. An Early Intervention Transformation Programme has been established, which is underpinned by a £30m, Fund. The Fund is made up of contributions from the Executive's Delivering Social Change Programme, led by Office of the First Minister and Deputy First Minister (OFMDFM), a collective of five other government departments (DHSSPS, DE, DOJ, DEL and DSD) and Atlantic Philanthropies. The programme is intended to transform the way we interact with children and families. The Fund will continue until 2017-18. The DHSSPS advised that a key requirement for projects/services funded by the programme is that they are sustainable in the longer term. Further, a series of roundtable discussions was co-hosted by the Ministers for Health Social Services and Public Safety and of Justice between May 2013 and February 2014 to identify what needs to change, to improve longer term outcomes for vulnerable children and families. A summary report and action plan arising from these events is being finalised.

This programme is welcome, as is the commitment to sustainability. It is the Inquiry's view that transformational change is unlikely without a commitment to long term funding. Clearly, it will be important to tackle known vulnerabilities related to CSE, including neglect, drugs and alcohol, domestic violence and deprivation. CSE prevention cannot stand alone. It links into all of the existing early intervention and prevention strategies. Some suggested that, despite falling within an investment programme, current initiatives were not joined up. It is clear that the health sector has a very important role to play throughout the process of prevention, identification and reporting, which is often not recognised by other services. Health staff also felt constrained by resources:

“Constant cuts to services mean that early intervention is very difficult.”

This was also reflected in the perspective of staff from the CPSSS consulted by ETI:

“The CPSSS representatives raise concerns about cuts in services; and report that there are now fewer staff with less time to reflect on issues and therefore there is an increased risk of developing more reactionary approaches to support. In their view, cuts in social services result in longer response times, the raising of thresholds, and variation in responses. This is often due to high staff turnover and frequent changes in staff.

They report that there is increasing pressure on the training provided by the CPSSS for schools, for example, they have to cover more topics within the same period of training.”

The Educational Psychology Service raised concerns about the short-term funding of a significant number of initiatives, with no real opportunity for embedding the work. Student services staff from further education colleges state that they are under-resourced and that pastoral support is not seen as a high priority for funding. They also report that a minority of lecturing staff do not accept their responsibility to provide pastoral support for children and young people.

Schools have a critical role to play with regard to prevention and early intervention. Almost all of the post-primary and special schools visited by ETI as part of its survey had good quality personal development programmes that address risky behaviours, but links to CSE need to be more explicit. Primary principals state that they have to carefully balance the implementation of the preventive curriculum with concerns raised by parents in relation to schools unnecessarily frightening their children.

We also note the development of Family Support Hubs as an opportunity for embedding early intervention in communities.

In terms of prevention, we received comments from young people and adults about the lack of appropriate youth facilities and activities for young people who need alternative avenues of challenge and excitement. It was suggested that youth facilities needed to be updated, taking into account the views of children and young people:

“What do we have to offer our young people after school? The world has moved on so much. The Youth Service of Northern Ireland has huge resources at their disposal, but I am not sure how these are being used. The buildings in this area are just sitting there. It still works on a 1970s model.” [HSC trust staff]

“Youth services need to be used much more effectively and be relevant.”
[Statutory agencies event]

“There is a real need for youth programmes for young people. Nothing is being resourced that is interesting or exciting.” [Education staff]

“Youth services are shocking. Young people don’t want to go to them.”
[Community organisation]

Key Recommendation 7:

The Northern Ireland Assembly, through the OFMDFM, should re-affirm its commitment to strategic, long-term and sustained funding of services for prevention and early intervention.

Key Recommendation 8:

The Department of Education (DE) should conduct a review of youth services that takes into account the views of young people and aims to ensure that such provision is attractive and appropriate.

7.9 Identification and Reporting

The ability to identify cases of CSE is clearly linked to levels of awareness, which was discussed previously.

What became clear in discussions with members of the community (including taxi drivers), and with some professional workers, is that, even where someone believes they may have identified a case of CSE, they do not know where to take that information in order to get a response that will help the young person. The lack of any feedback where they do find their way to reporting a concern, makes them feel that nothing has happened in response to their report, or that it wasn't taken seriously. This reduces their confidence and willingness to report in the future.

Education staff identified inconsistency of response to reports made to social services and a lack of meaningful feedback. School staff said they would welcome joint training with social care staff to enhance their awareness and facilitate appropriate reporting. In the Inquiry's view, this could lead to a better shared understanding and facilitate a more consistent response.

Some professionals at the frontline, such as ambulance drivers and other health staff, commented that they did not have a lot of time to interact with a young person, but may nevertheless pick up some concerns. They suggested that a trigger tool be developed, in partnership with frontline staff, to help them identify and report with confidence. This could be a shortened version of a risk assessment as these staff would not have the time, nor would they feel they had the competence, to engage in a lengthy assessment. Such a tool could be useful for other frontline staff, including response police officers.

Health staff gave many examples of how their colleagues could identify cases of CSE if appropriately informed and supported. A health professional described a scenario at an appointment to discuss a pregnancy, where the dynamics between the male and his young female partner aroused her suspicions about the nature of the relationship. The male did all of the speaking and the health professional was unable to get the woman alone to ask about this. The health professional now believes this may have involved CSE. This suggests a need for assistance to frontline staff in identifying cases of CSE.

Current risk assessment tools have not been targeted at health staff, although we discovered that some health staff were using them. One HSC trust advised that it had provided CSE awareness sessions for staff in family planning services, Genito-Urinary Medicine (GUM) clinic services, paediatricians and the emergency department. This has included an understanding of the interim regional guidance – Management of CSE Referrals. Health staff have reported that they have found the guidance and the risk assessment tool helpful in identifying the elements and risks associated with CSE. We were also advised that the mental health facility (Beechcroft) and the Juvenile Justice Centre (Woodlands) had availed of the CSE training.

In recent years, the role of school nurses has changed with more emphasis on immunisation and with less possibility for proactive work with young people. Northern Ireland has fewer school nurses per child than other parts of the United Kingdom.

Consideration should be given as to whether this role should be expanded, taking into account the views of young people. Northern Ireland also needs more LAC nurses to allow them to be more available, especially to children in foster care and foster carers.

The PHA described its one-stop shops for young people across Northern Ireland, which provides another opportunity for identification of CSE if staff are trained appropriately and there are awareness raising resources for young people.

The police too could play a greater role in identification of cases of CSE. It became clear through interviews with police officers that police systems do not routinely link, analyse and assess CSE risks.

The Inquiry recommends:

Supporting Recommendation 41:

The HSC Board, in conjunction with the SBNI, should work with frontline workers including the ambulance service, to develop a simple “trigger” tool to help them to identify potential cases of CSE. This could build on existing models within the United Kingdom.

Supporting Recommendation 42:

HSC Trusts should explore the potential for school nurses to play a wider role in safeguarding issues, including CSE.

7.10 Child Protection Processes

The Barnardo’s report said that, of the 147 known or suspected cases of CSE they had identified, Joint Protocol Investigations had been initiated in respect of 42.8% of cases and child protection case conferences were convened in respect of 52.6% of cases. Whilst the small numbers in each category did not allow for significance testing, it seemed to the authors of the report that these formal processes were initiated more frequently in certain types of cases (i.e., sexual exploitation by other individuals in the community) than others. The report considered that this merited further investigation.

The Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse (April 2013) sets out the circumstances in which a joint investigation should take place, and those in which the investigation should be undertaken by only one of the partner agencies. It allows that a police only investigation may be appropriate where there are no child protection concerns and the alleged offender is not known to the child or the child’s family, classifying this as stranger abuse. If a decision is made not to hold a child protection case conference, the reason for that should be recorded.

The Inquiry received information from the eight PSNI districts about the numbers of Joint Protocol investigations in relation to relevant cases over the period from 1 April 2013 to 31 March 2014 and the numbers of those that proceeded to case conferences.

From the information supplied by PSNI, we could see that some of the Joint Protocol cases that did not proceed to case conference related to children from families where the family was not the source of the threat and were regarded as supportive. This seems to indicate that, in practice, child protection processes tend to focus on danger within the family rather than danger from outside. A HSC trust described a case in which child protection processes had been used even though it “didn’t fit.” The child had a very supportive family and the danger came from outside. Nevertheless, they said the family went along with it as they would have done anything that might help their daughter.

Other cases that did not proceed to a case conference involved LAC. We were informed that, in a bid to avoid submitting young people to dual process, child protection issues were addressed within LAC reviews. Some expressed concern about this, believing that this tended to dilute the child protection element:

“A child protection case conference requires a quorum of people not required for a LAC review. Sometimes the child protection issues are not even addressed in a LAC review.” [Professional]

As discussed and addressed in Chapter 2, there is another separate process for children with disabilities.

7.11 Prosecution

There has been a longstanding concern about the low rates of reporting, prosecution and conviction in relation to sexual offences. The CJI published a document entitled *Sexual Violence and Abuse* in July 2010 and a follow-up in October 2013⁴⁷, the foreword to which states:

“Tackling the significant under-reporting of sexual abuse and violence cases so that more incidents can be successfully investigated and prosecuted should be a priority for the criminal justice system and wider government. Dealing effectively and appropriately with offenders and supporting victims through their trauma should be both a legal and moral priority for the whole of society.”

“The importance of the issue is now recognised in the Programme for Government 2011-2015 and the opening of The Rowan is a significant achievement providing Northern Ireland with its own sexual abuse referral centre. Victim and Witness Care Units (WVCU) are being established across Northern Ireland and their full potential is also being developed.”

“This report found that significant progress has been made by the PSNI and the PPS, not only in terms of their partnership approach to investigations, but in the critical area of the care and treatment of victims and witnesses. However, we acknowledge that it will take time for the overall situation to improve, and it is only when you hear from victims and examine case files that you can accurately assess whether an improvement in outcomes has been achieved. To that end I intend to conduct a full thematic inspection of this issue in 2015.”

⁴⁷ <http://www.cjini.org/CJNI/files/d1/d1c3dab5-25f3-45a4-9e19-4f7ed8a0c9fc.pdf>

The following Table 7-1 from PSNI shows sexual offences against children as a total of all sexual offences over a period of one year:

Sexual Offences	2009-10	2010-11	2011-12	2012-13	Latest 12 months March 2013 to February 2014²
Victim aged 12-17 ¹	626	613	583	575	646
Victim aged under 18 ¹	1,003	1,050	989	1,058	1,235
Total where victim age known ¹	1,732	1,864	1,796	1,890	2,069
Age unknown / not applicable	66	64	32	42	55
Total number of sexual offences	1,798	1,928	1,828	1,932	2,124

Table 7-1: Sexual Offences in Northern Ireland by Age of Victim

¹ Figures in the rows 'Victim aged 12-17' and 'Victim aged under 18' are each a subset of the row 'Total where victim age known'.

² Figures from 1st April 2013 are provisional and will be subject to change.

PSNI recorded crime statistics for September 2013 to September 2014 identify 2,105 sexual offences reported to them, whereas, in 2013, there were 216 convictions for sexual offences. This represents a conviction rate of around 10%.

7.11.1 Barriers to Prosecution

It is acknowledged by all that the number of convictions relating to CSE is low. It is difficult to estimate how many convictions are CSE-related because CSE is not a specific crime but may involve a whole range of crimes. The main charge may not identify it as involving CSE.

But even before we reach that stage, there has to be enough evidence to justify a prosecution. There are a number of barriers in the way of securing sufficient evidence including:

- victim reluctance
- lack of analysis of information
- evidential issues

7.11.2 Victim Reluctance

Victims of CSE often do not identify themselves as victims. As shown earlier, they may also be reluctant to report their exploitation because of lack of trust in the statutory authorities and/or lack of trust in the justice system to treat them fairly.

Some of these barriers are common to victims across the United Kingdom, although the issue of lack of trust in statutory authorities is more pronounced in some communities in Northern Ireland. This was clear from a number of sources, including the views expressed by parents in the focus groups run by Parenting NI.

There has been a tendency in the past to halt an investigation where the victim was not willing to cooperate. We were assured by PSNI that third party complaints are now taken seriously. Others cited the good practice of Operation Owl in this regard. The Director of Public Prosecutions also acknowledged the possibility of a case proceeding on this basis, but emphasised it was important that the PPS was given as full a picture as possible by the police.

This flagged up another issue relating to the quality of files submitted to PPS by the police. The quality of case files, and the evidence contained in these, is a critical issue in the delivery of justice. It is an area which has recently drawn unfavourable comment and at the time of writing was the subject of an inspection by CJI. Whilst the PPS provides PSNI with prosecutorial advice and pre-charge advice in terms of section 31(5) of the Justice (Northern Ireland) Act 2002, the issue of the independence of both the PSNI and the PPS continues to present challenges to a closer working relationship. This contrasts with the Scottish approach in which the investigation is directed by the prosecution service.

A number of people raised with us the issue of young people involved in criminal behaviour associated with their exploitation. As shown earlier, this is an issue also identified by young people. This might relate to use of drugs and alcohol, which are vulnerability factors for CSE, or to bringing other young people into the exploitative situations, or even to abusive behaviour against other young people. Fear of being treated as offenders might be a barrier to reporting their own exploitation, and this fear can be used by exploiters who might deliberately involve young people in offending in order to silence them. There is a need to look beyond the young people to identify whether there are others controlling them.

We recognise that the lives of some young people subjected to CSE are complex and chaotic. They may act out the trauma of CSE through behaviour that brings them into conflict with the criminal justice system and renders them less credible in the eyes of jurors.

In the context of trafficking, there is a commitment to avoid blaming the victim for criminality associated with their abuse. This is not so formalised in cases of CSE. We discussed this with PSNI who assured us that victims of CSE would be treated as victims first. There was no desire to criminalise young people. But they could not offer a guarantee. There would have to be a balance between the interests of the young person and the public interest. If a young person had been exploited and was then exploiting others, decisions would have to be made on a case by case basis. The Director of Public Prosecutions advised that the fact that a perpetrator was also a victim would be a mitigating factor for the court to consider.

This is an important issue, given the perception that many of the perpetrators are only a few years older than their victims and may also be young people with vulnerabilities. It was suggested to us that, in these cases, a purely criminal justice response might not be appropriate.

Another barrier might be a lack of trust in the justice system to treat them fairly. This is linked with the perception that young people involved in CSE might be seen as not being credible victims or credible witnesses, from the first point of contact with the police, right through to the conclusion of a court process. A parent told us that their daughter, who was a victim of CSE, dropped allegations of rape because she was made to feel like a criminal. The case proceeded on the grounds of grooming, but the court case was cancelled five times, putting enormous stress on all involved. This finding has been repeated in successive CJI reports including that on the care and treatment of victims and witnesses in the Northern Ireland criminal justice system (2010).

We also heard from other sources about the impact of delay on young people's willingness and ability to participate in a trial. In 2011, the report of the Review of the Youth Justice System in Northern Ireland described the problem of delay as endemic in the Northern Ireland Justice system and recommended a number of measures to address it within youth justice, including the introduction of statutory time limits. Whilst the whole system needed to tackle delay, it said priority should be given to the youth justice system. It would seem reasonable to extend this priority to cases within the adult system where young people are victims and witnesses. We understand that the Minister of Justice announced in February 2012 his intention to introduce statutory time limits in the youth court.

Other reports across the United Kingdom have commented on the failure of frontline professionals to take CSE seriously and a tendency to regard young people's behaviours as lifestyle choices. This was not so evident in our discussions in Northern Ireland, but what people said to us may have been influenced by the condemnation of this approach by recent high profile reports. Certainly, senior managers expressed commitment to taking CSE seriously. We did encounter dismissive attitudes amongst some individual police officers who had possibly received no training on the subject, although others took it very seriously. We previously set out some concerns expressed by officers in relation to their responsibilities to search for and return missing children. However, we also experienced some lack of knowledge and understanding of the nature and effects of CSE by some officers. Professionals should be much better informed, but in some respects, this represents the same attitudes and misunderstanding of many in society.

We were also advised that some legal personnel remained to be informed and convinced of the dynamics of CSE (and indeed of child abuse generally in some instances), and that juries tended to be uninformed, so that the lack of credibility, as they saw it, of the witness tended to carry greater weight than the credibility of the allegation. Young people who have suffered CSE may have difficulty giving detailed evidence because they were under the influence of alcohol or drugs at the time of the offence and this lack of detail impacts on their credibility. We were told that juries often do not understand grooming and why a young person would return to their abuser. The lack of signs of distress will impact negatively on juries and the lack of medical evidence can be perceived as an obstacle to conviction.

We received some comment about the reluctance of judges to give directions to juries, in comparison with practice in England and Wales, where the Bench Book gives guidance to judges on directions to juries on matters such as consent, vulnerability and trauma.

Judges in Northern Ireland were said to exercise a lesser degree of control over the court process than in England and Wales, where it is easier for judges to stop defence lawyers from wearing witnesses down. Some legal personnel expressed the opinion that a case management system would be very useful. We understand that the Lord Chief Justice issued a Protocol on Case Management in the Crown Court in 2011 and a Protocol on Case Management in the Magistrates' Courts in 2012. However, CJI has now recommended statutory case management in a number of reports. There has been some progress in that it is included in the Justice Bill 2014, which was introduced to the Northern Ireland Assembly in June.

Comments were made about the lack of support for young people giving evidence. The contribution of the NSPCC Young Witness Service was acknowledged, in terms of information and support, but some believed more was required to promote the best interests of the child and lessen the impact of the very adversarial process. This relates to the whole structure and principles of the Northern Ireland justice system which it would be beyond our remit and capacity to address. There is a lot of research and information available about measures that would make it easier for young witnesses to give evidence. This would lead to fairer outcomes that would protect society in general and other young people from predators, through getting better evidence from young people and facilitating more convictions.

We understand that the DOJ is currently piloting a registered intermediary (RI) scheme, in line with the provisions in the Criminal Evidence (NI) Order 1999, to assist vulnerable and intimidated witnesses (both for the prosecution and the defence) to give their best evidence in criminal proceedings.⁴⁸ The RCSLT advised that the number of requests made for this service clearly evidences that there are a number of children and young people with communication difficulties who require assistance in giving best evidence. The DOJ advised that, by 26 September 2014, there were 142 referrals for children under 18 (out of a total of 233 referrals) as follows:

- 45 for ages 13 – 17
- 20 for ages 10 – 12
- 77 for those aged 10 and under (the youngest being two years old)

PSNI identified a number of measures that would, in their view, best protect the welfare of child victims in the process leading to a prosecution:

“This may be achieved by diligent evidence gathering, including from partner agencies; prompt turn round of key evidence required to secure a disposal (i.e. medical, forensic & digital media evidence); legislative and procedural changes to incentivise early guilty pleas in appropriate cases (i.e. legal aid fee structure, PE/PI process, case management procedures); revised protocols between the PSNI & PPS to introduce proportionate case file demands similar to the Director Generals guidance in England & Wales, thereby freeing capacity to focus on cases of threat, harm and risk; a good intelligence picture; focusing on the offender and offence; use of appropriate experts and practitioners along the way, for example, staff at The Rowan, registered intermediaries, counsellors, court service NSPCC Young Witness Service; post trial support.

⁴⁸ The defendant scheme is provided for by the Criminal Evidence (NI) Order 1999 as amended by the Justice Act (NI) 2011.

To further help and support young victims of crime to give their best evidence at court the PSNI ensures effective and early identification of the need for special measures and most appropriate method, including maximising the benefits of remote video link evidence.

The recently established VWCU supports young crime victims by allocating a single point of contact for them. This is very positive both from a communications point of view and in the context of the unit being able to conduct detailed need assessments of the young witness at set stages within the prosecution process. Communication with young crime victims is through the parent/guardian and where possible by their preferred means, i.e., letter, phone, text and email.

Young crime victims (and parents/guardians) are benefiting from a named contact point within the VWCU. The officer assigned to the case will keep the victim updated with significant information as the case progresses. This includes details of where bail is granted or varied in respect of any accused, the decision to prosecute and the outcome of the case. The officer is also able to discuss and offer additional support and information to the young victim and where appropriate refer them (with consent) to services provided by NSPCC.

The unit has rolled out across Northern Ireland and is now providing information and support to young crime victims across all criminal courts.

Independent Sexual Victim Advisor/Advocate (ISVAs), not currently available in Northern Ireland, would assist in this process as well. The DOJ has been considering the introduction of ISVA's for some time."

Some suggested to us that there should also be an advocate for parents within the justice system, which would be an extension of the support referred to earlier.

A young person with experience of CSE described to the Inquiry how they had been reluctant to give a statement for fear of the process that would follow, which was described as scary.

"The nightmare scenario was to be in court, with people quizzing you about your private life and everyone looking at you – even if it was through a television link."

The justice system is beginning to respond to these issues in terms of policy and procedure. For example, the PPS expressed its commitment to building cases around the credibility of the offence rather than of the victim. However, without further action, it will take some time before this filters down into practice.

The Inquiry recommends:

Key Recommendation 9:

The DOJ should establish an inter-agency forum drawn from across the criminal justice sector and third sector stakeholders to examine how changes to the criminal justice system can achieve more successful prosecutions of the perpetrators of CSE. This must be informed by the experiences and needs of child victims.

Supporting Recommendation 43:

PSNI and criminal justice partners in the Prosecution Service and Court Service should continue to develop their approach to responding to victims of CSE in a way that treats them fairly and sensitively and avoids blaming them for offending behaviour associated with their abuse. This involves attitude, not just policy or process.

Supporting Recommendation 44:

The Department of Justice should continue to seek to develop and improve the experiences of young witnesses, taking into account research and learning from other countries. This should include consultation with stakeholder groups and with young witnesses.

Supporting Recommendation 45:

PPS should ensure that prosecutors dealing with sexual offences against children continue to receive training at regular intervals on the dynamics of child abuse, including CSE.

Supporting Recommendation 46:

Awareness-raising about the dynamics of child abuse and CSE in particular should be available for all legal personnel and should be mandatory for all legal professionals dealing with child abuse cases. This should be made the responsibility of the PPS for its own legal staff, the Northern Ireland Bar for its staff and the Judicial Studies Board for Judges.

Supporting Recommendation 47:

While we acknowledge the work already undertaken by the Department of Justice in order to avoid delay, robust case management is necessary. The DOJ should ensure that both statutory case management and statutory time limits are introduced in Northern Ireland. Both have already been the subject of clear recommendations by the Criminal Justice Inspection in Northern Ireland.

7.11.3 Lack of Analysis of Information

Interviews with individual police officers identified a consistent theme indicating a patchy approach to the collection and analysis of information and intelligence. This included the proactive and strategic analysis surrounding the risks and perpetrators of CSE. However, the inquiry was also briefed regarding planned developments within the PPU which could, if fully implemented, go some way to addressing the need for a more proactive focus.

PSNI informed the Inquiry of developments associated with Operation Owl, including:

- searches for drugs
- triaging of phones and submission of the intelligence arising from this
- highlighting suspects and geographical areas of concern to police districts to build an intelligence picture around child sexual exploitation
- continuing to develop and improve upon the current offender scoring tool, to assist in identifying the high risk suspects

They also advised us of resource issues associated with forensic examination. There was a significant backlog of exhibits requiring forensic examination in relation to indecent images of children, with some taking over a year from submission. HSC trust staff informed us that forensic examination of computers is long and detailed. Other stakeholders doubted whether items suitable for forensic examination, such as clothing, phones and IT were even being gathered. On the other hand, one police district described their approach to forensic evidence gathering for CSE as 'pants and phones'. PSNI advise that forensic strategies are considered in each and every case and that the seizure of underwear and telephones are key forensic opportunities.

In Chapter 4, we made a recommendation about the need for a commitment to gathering and analysing information. We would further recommend:

Supporting Recommendation 48:

PSNI should conduct a review of resources and operational delivery in respect of digital evidence examination to ensure that any evidence of CSE is provided to investigators in a timely manner, and to avoid delay in the courts.

7.11.4 Achieving Best Evidence

In January 2012, the DOJ published detailed guidance on Achieving Best Evidence in Criminal Proceedings (ABE)⁴⁹, which includes an extensive section on planning and conducting interviews with children. This document is referred to in chapter 3 of the Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Abuse Northern Ireland, April 2013. Some police officers have commented that it is difficult to access trained social workers in their area who are able to assist with this. The Inquiry therefore recommends:

Supporting Recommendation 49:

HSC trusts should consider how best to address the appropriate availability of social workers for Achieving Best Evidence interviews.

7.12 Perpetrators

We heard repeated expressions of concern that there was too much focus on the behaviour of the victims, resulting in calls to restrict their liberty, rather than punishing and locking up the perpetrators. The failure to hold perpetrators to account was identified as a significant issue, not just for reasons of securing justice, but because it constituted a further barrier to reporting, because people would ask – what's the point?

PSNI informed the Inquiry that they accept that, in the past, the focus at times has been reliant on the evidence provided by the child or young person. However, as their knowledge and understanding of child sexual exploitation has grown over the years, they have recognised that the focus should be on the offence and the offender. This is now reflected in current practice guidelines and service instructions.

⁴⁹ *Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures, and the provision of pre-trial therapy.* http://www.dojni.gov.uk/index/publications/publication-categories/pubs-criminal-justice/abe_2012.pdf

They pointed in particular to the increased use of Harbourers Warning Notices (explained later) and a more proactive approach to perpetrator profiling, which is still developing.

The Inquiry recommends:

Supporting Recommendation 50:

PSNI, in its review and development of the Public Protection Units, should move to develop perpetrator profiling and a greater focus on perpetrators.

7.13 Disruption

The challenges of securing a conviction make it all the more important that efforts are made to disrupt any grooming or exploitation activities that have commenced.

We described how care staff attempt to disrupt suspicious activity by diverting the young people, or following them when they leave the unit, possibly putting themselves at risk. Staff have also described how they challenge people who turn up at the unit to collect a young person and record car details. They may persuade a young person to hand in their mobile phone at night. Sometimes these strategies work but often they do not. Some police officers talked about disrupting by waiting outside children's homes. A foster carer described an incident where her foster child was dropped off one night by a group of men in a car. The carer went out to the car and asked the men a lot of questions about what had been going on. She believed that it was possibly due to this that the men did not come back for the child.

There are a number of more formal approaches to disruption, based on legislation. The Child Abduction (Northern Ireland) Order 1985 makes it an offence for someone to detain a child under 16 without lawful authority or to keep that child out of the control of the person with responsibility for the child. This applies to all children. There is another offence that applies to some children in the care system – up to the age of 18. This applies not just to taking or detaining a child away from the person with lawful authority, but also to inducing, assisting or enticing the child away from that person. The Children (Northern Ireland) Order 1995 also provides for a recovery order from the court where the child is subject to a care order or an emergency protection order, or is in police protection. A recovery order can: direct the person who is keeping the child to produce her or him or to give information about the child's whereabouts; authorise a constable to enter any premises specified in the order and search for the child, using reasonable force if necessary; and authorise removal of the child by any authorised person.

Less formal methods that have developed include the issuing of harbourers warning notices (HWNs), which inform the person who is harbouring the child that the person with responsibility for the child does not agree to them associating with that individual. This provides an evidence base on which legal action under one of the two pieces of legislation referred to previously might later proceed. PSNI advised that use of HWNs is rising steadily. Figures provided to the Inquiry show that they are being used more in some police districts than others.

In the period from 1 April 2013 to 31 March 2014, numbers across the eight PSNI districts were:

PSNI district	Use of HWNs
A	30
B	6
C	28
D	8
E	3
F	25
G	47
H	14

A recent judicial review criticised some aspects of practice around HWNs.⁵⁰ The decision of this case hinged on the potential for parents to support a harbourer's warning notice for malicious reasons which led to the requirement for a fuller investigation from police. There were mixed feelings amongst police officers about the efficacy of HWNs but mostly they were described as a useful tool. A parent we spoke to was clear that the HWN had made a huge difference to her child and recommended that all parents should be alert to their existence. The young people involved in the VOYPIC consultation also approved of harbourer's warning notices. Their report comments:

“Harbouring orders were discussed by young people as a way of preventing child sexual exploitation and keeping young people safe. They called them Harbouring orders as opposed to their legal term harbourer's warning notice. They described these orders as a way of keeping an alleged perpetrator away from a young person. They suggested that they should be used more to protect young people if concerns are raised about CSE. Whilst they had little knowledge of how they work in practice, it is positive to note that young people are aware of use of harbouring warning notices as a way of preventing CSE.”

Police officers sometimes referred to their lack of formal powers to search for and remove a child. No reference was made to the possibility of obtaining a recovery order in relation to those children for whom this was a possibility. Nor do such orders appear to be adequately explained in guidance on joint investigations or missing children.

Other orders used as part a disruption approach include sexual offences prevention orders (SOPOs) and risk of sexual harm orders (RoSHOs) made under the Sexual Offences Act 2003. SOPOs can be made by the court in relation to offenders convicted of specified crimes and can prohibit the defendant from doing anything described in the order for a fixed period of not less than five years, provided that this is necessary to protect the public from serious sexual harm.

⁵⁰ *Application by Richard Swann for Judicial Review*. Heard in the High Court of Justice, Queen's Bench Division, 13 June 2014. Available at: <http://www.courtsni.gov.uk/en-gb/judicial%20decisions/publishedbyyear/pages/home.aspx?RootFolder=Documents/2014>

RoSHOs can be made by a court in respect of any person aged 18 and over who has, on at least two occasions, engaged in sexual activity involving a child or in the presence of a child; caused or incited a child to watch a person engaging in sexual activity or to look at a moving or still image that is sexual; given a child anything that relates to sexual activity or contains a reference to such activity; or communicated with a child, where any part of the communication is sexual.

PSNI considers that SOPOs have proved worthwhile in the management of sex offenders and in enhancing the protection of children. RoSHOs are also a useful means of safeguarding children, but the qualifying criterion relating to two occasions can be difficult to achieve. They say it is difficult to quantify how effective SOPOs and RoSHOs are in tackling child sexual exploitation, without some in-depth research into each particular case. However, they consider that SOPOs and RoSHOs have been effective in prohibiting convicted sexual offenders and suspected sexual offenders from having access to children. There have also been breaches that have resulted in convictions.

The multi-agency risk management arrangements known as PPANI (Public Protection Arrangements in Northern Ireland) include persons who have a current RoSHO. Their risk is discussed on a multi-agency basis and an appropriate risk management plan will be devised. Similarly all individuals who have a SOPO are subject to the notification requirements of the Sexual Offences Act 2003 and are automatically assessed for risk under the PPANI arrangements.

PSNI advised that the DOJ is constantly reviewing the relevant legislation and is currently considering allowing SOPOs to have positive obligations included, as opposed to just prohibitions, which will clearly strengthen their effectiveness.

Perpetrator activity may also be disrupted by sharing information with relevant people to pre-empt exposing a child to danger. Circular HSS CC 3/96 (Revised): Sharing to Safeguard: Information Sharing about Individuals Who May Pose a Risk to Children issued in 2009⁵¹ encouraged agencies to share information about persons posing a risk to children, even if they had not been convicted of an offence. A recent judicial review concluded that this process contained insufficient protection for the rights of unadjudicated persons, including the absence of any right of appeal. In correspondence, the DHSSPS conceded that practice had strayed from the focus on the protection of individual children to public protection generally. It was indicated to us that the circular would be reviewed. In the meantime, the DHSSPS issued a memo stating “The Department is not withdrawing the Circular at this stage. However, in light of the judgment, the Department will review the Circular, determine the way forward and advise further in due course. In the meantime, you are asked to take account of the judgment and to note the interim considerations...”, which were set out in the memo.

Nevertheless, many of those who spoke to the Inquiry expressed hesitation about the application of the circular. In July 2014, the DHSSPS issued a further letter, drawing attention to court judgements listed and hyperlinked. It assured recipients that Circular 3/96 remained extant while it was under review.

⁵¹ Circular HSS CC 3/96 (Revised): *Sharing to Safeguard: Information Sharing About Individuals Who May Pose a Risk to Children*.

It seems to the Inquiry that it is a lot to ask of practitioners that they should refer to court judgements when working in an area of such complexity with the knowledge of the possibility of legal challenge.

The possibility of sharing information on unadjudicated offenders is of particular importance in Northern Ireland where, for historical reasons, many offenders will have been unlawfully dealt with by local paramilitary groups. They will not consequently have entered the justice system, been convicted or be known to any statutory authority.

Better enforcement of licensing laws could also assist disruption of offending against children. This was an avenue favoured by some community workers and parents. We discussed previously the concerns about lock-ins after hours in bars, and the tolerance of under-age drinking. We also referred to the practice of taxi drivers buying and delivering alcohol to premises for possible consumption by children. The legality and propriety of this practice should be explored.

Our attention was drawn to recent legislation in England and Wales in relation to hotels and guest houses that is worthy of consideration. The Anti-Social Behaviour, Crime and Policing Act 2014 addresses the problem of hotels, guest houses and bed and breakfast accommodation being used for the purpose of CSE. Where police believe CSE is taking place, the Act allows them to require these establishments to provide them with names and addresses of guests and other relevant information.

In Chapter 2, we recommended education and enforcement in relation to the use of alcohol by children. We further recommend:

Supporting Recommendation 51:

The HSC Board in conjunction with SBNI should ensure that the availability of Recovery Orders in terms of section 69 of the Children (Northern Ireland) Order 1995 is highlighted in guidance and training.

Supporting Recommendation 52:

The DHSSPS should ensure that the revision of Circular HSS CC 3/96 (Revised), Sharing to Safeguard: Information Sharing about Individuals who may pose a Risk to Children, is accompanied by clear guidance to workers that will give them the confidence to act appropriately.

Supporting Recommendation 53:

The DHSSPS should consider further actions to protect children against offenders who will not have been brought to the attention of the statutory authorities in Northern Ireland for historical and cultural reasons.

7.14 Collaborative Working

At the level of law and policy, there is a commitment to joint working and cross-sectoral cooperation expressed, for example in the Children (Northern Ireland) Order 1995, the Safeguarding Board Act (Northern Ireland) 2011 and in Co-operating to Safeguard Children (DHSSPS 2003).

It has been suggested to the Inquiry that this could be strengthened by introduction of a statutory duty to co-operate that would complement existing duties. We were also made aware of difficulties in translating these commitments into practice, both at strategic and operational level.

7.14.1 Strategic Level

We were advised that there is a proliferation of partnerships and collaborative ventures involving the same people. For example, there is a significant overlap of membership between SBNI and the Children and Young People's Strategic Partnership (CYPSP). These people meet on different occasions under different labels. We acknowledge that the role and function of these bodies is different, but we understand that the relationship between comparable bodies takes various forms throughout the United Kingdom, which may provide some reason to reflect on how they operate. There are lots of joint initiatives and partnerships but it still seems to be difficult for people to work together effectively:

“Too much duplication at a higher, strategic level in Northern Ireland for such a small place.” [Statutory agencies]

“Northern Ireland is an over-managed and public sector region. Anything that helps simplify all of the separate agencies would help.” [Health professional]

“A huge number of partnerships.” [Statutory agency]

“How can anyone understand all of these processes? It is not simple – it is like five year olds playing football. They all chase the ball at the one time, regardless of where it goes.” [Health professional]

“There are different strategies, e.g., re sexual violence. Police and community safety partnerships also have action plans. We would like Ministers to give one authority to take the lead on CSE. It should be SBNI. Departments of Health, Justice and Education need to be talking to each other.” [HSC trust]

7.14.2 Health and Social Care Board Regional Social Services CSE Management Group

Within the context of CSE, we were told about the Regional Social Services CSE Management Group, established by HSC Board, on which every HSC trust is represented. Its aims include safeguarding the young people involved in Operation Owl and ensuring that HSC Board and HSC trusts operate a consistent approach to the investigation. From what we were told, this appears to be a successful venture.

7.14.3 Operation Owl

Operation Owl appears to have had a positive impact on inter-agency collaborative work, extending beyond its original focus. Many expressed the opinion that a great part of its success was due to the co-location of professionals, which facilitated a common understanding and relationships that facilitated joint working.

The contribution of police analysts was welcomed. HSC trust staff commented that it helped gain a sense of referrals across Northern Ireland.

The Inquiry understands that Operation Owl has now ended and that its activities are now incorporated into normal PSNI business, within revised structures for the recently established Public Protection Command.

Given the concern about difficulties in inter-agency working it will be important to learn from Operation Owl and build on its strengths. Staff clearly wanted reassurance that the expertise and collaborative working would continue even after the conclusion of this particular operation. Many HSC trust workers reported that relationships with the police had improved since September 2013. Some said they would like more local arrangements like Operation Owl.

7.14.4 Willowfield

The Inquiry also received positive comments on the work of a co-located project based at Belfast's Willowfield police station. This was a pilot project involving a worker from Barnardo's Safe Choices Service working with the police to identify what led to young people going missing, in order to help prevent them from being sexually exploited and/or entering the care system. The project has now ended and an evaluation will be available in the near future.

7.14.5 Safeguarding Board for Northern Ireland (SBNI)

The SBNI was established by Safeguarding Board Act (Northern Ireland) 2011 to:

- coordinate and ensure the effectiveness of what is done by each person or body represented on the SBNI for the purposes of safeguarding and promoting the welfare of children
- promote awareness, across the community, of the need to safeguard children and promote their welfare
- develop good communication between the SBNI and children and young people
- undertake case management reviews, in order to learn lessons in cases where children have died or have been seriously injured
- review information in relation to the sudden and unexpected deaths of children
- develop policies and procedures to help professionals and agencies work together more effectively
- arrange consultation and discussion, where appropriate, in relation to safeguarding matters

SBNI had already identified CSE and e-safety as priorities in its business plan. It set up a CSE Strategic Partnership Group as a time-limited committee of the SBNI to develop a strategic and coordinated plan to tackle CSE. This group has now been stood down on the basis that the tasks assigned to it had either been completed or subsumed into other projects.

The first stage in the SBNI's work on an e-safety strategy was completed on 22 January 2014 with the publication of a research report commissioned by the SBNI from the National Children's Bureau (NCB), Northern Ireland⁵².

The SBNI's business plan states that it will work with member agencies to develop a coordinated strategy and working model to help children at risk of:

- becoming criminalised through on-line activity
- bullying through cyber-activity
- sexual abuse (through sexting and on-line activity)

An e-safety forum has been established, and there are plans to commission research on the effectiveness of current internet safety messages.

Although independent of the DHSSPS, in certain circumstances the SBNI may be directed by the DHSSPS. Such a direction was made in 2013, requiring the SBNI to carry out a thematic review of the cases of 22 young people who were the focus of concern of the Operation Owl investigation. The terms of the direction require the SBNI to examine and evaluate the actions and effectiveness of member agencies.

Frequent references were made to the role of SBNI in the course of the Inquiry's work. We met with some sympathy and understanding about the fact that it was still a relatively new organisation that had been presented with the challenge of undertaking the thematic review. However, there was also some frustration at lack of progress on matters such as information sharing and data collection. We understand from SBNI that a draft information sharing protocol has been produced but they have been asked by the DHSSPS not to publish it pending the production of some high level principles on information sharing following on from review of Circular 3/96 (previously discussed). They also reminded the Inquiry that their role regarding data collection is to produce a plan rather than to gather the data. They are working directly with relevant agencies to progress this.

Some commentators said they could see the need for someone to take the lead in coordination and that they are looking to SBNI for leadership. The minutes of SBNI show concerns about the size and complexity of the organisation and the capacity of member agencies to make the practical contributions that are necessary to make the Board effective. Work on the thematic review has also identified tensions within the functions of SBNI. On the one hand, it is expected to be a learning community that reflects on its own practice and, on the other hand, it has an evaluation role in relation to the activities of its members. It has to ensure the effectiveness of member agencies, without having any operational responsibility, and it must hold them to account.

The high quorum of the SBNI's Board (two-thirds) means that it is difficult to achieve this when some members who have an interest in matters under consideration are required to withdraw due to a conflict of interest. The SBNI is well aware of these difficulties and has expressed them to the Northern Ireland Assembly's Health Committee.

⁵² NCB. Content, Contact, Conduct, Commercialism: An exploration of e-safety messages to young people, parents and practitioners in Northern Ireland. Belfast: SBNI (January 2014). <http://www.safeguardingni.org/sites/default/files/sites/default/files/imce/E-safety%20report%20exec%20summary%20200114.pdf>

While it has made progress on the thematic review, it has faced some difficulties and legal problems about access to information. It has, in the meantime, embarked upon an awareness campaign in relation to CSE which has been noted and referred to by many to whom we spoke. In October 2014, the SBNI Board published Child Sexual Exploitation: Definition and Guidance, a document for practitioners, informed by its collaboration with the CSE Knowledge Transfer Partnership. The Board informs us that this has been widely disseminated and well received.

Local Children's Safeguarding Boards (LSCBs) are common in England and Wales but, whilst they can provide a model for Northern Ireland, they operate in a variety of ways and are less regulated by statute. The SBNI is a creature of primary legislation and regulation and is limited in the extent to which it can respond to the challenges that inevitably face a new organisation.

7.14.6 Conclusion in Relation to the Strategic Level

Northern Ireland has a population of 1.84 million, of whom 432,015 are under 18. This relatively small population has advantages and disadvantages. The advantages are that professionals working in the same areas should know each other and this should facilitate joint working and information sharing. The disadvantages are that, if the structures attempt to replicate what exists in a larger jurisdiction such as England, they risk becoming oppressive. Northern Ireland needs structures and processes adapted to its scale that build upon the advantages of its size and counteract the disadvantages of the loss of specialisation that a tighter focus might entail.

We understand that, following the conclusion of the Thematic Review, a review will be undertaken of SBNI's functioning, in line with plans formulated at the Board's inception. The Inquiry recommends:

Key Recommendation 10:

The DHSSPS should ensure that the forthcoming, planned review of SBNI should consider streamlining joint working arrangements to make them more realistic, efficient and effective.

7.14.7 Operational

At an operational level, comments about difficulties in collaborative working focused on the following:

- accessing services out of hours
- information sharing
 - barriers to sharing across agencies
 - lack of analysis of information
 - insufficient gathering from frontline agencies and the need for a trigger tool
- inconsistencies of response by agencies, made more complex by the overlapping of agency boundaries
- inconsistent terminology
- lack of training in CSE and specifically regarding the guidance on missing children
- lack of clear pathways for reporting and appropriate feedback

- undervaluing of the status and contribution of non-statutory agencies
- staff competence and capacity

A very common complaint across all sectors was the difficulty in accessing services from partner agencies out of business hours.

Social services introduced a regional out of hours service in May 2013. It is managed by the Belfast HSC Trust but operates across Northern Ireland with a number of local bases. This is a welcome innovation and an improvement on what went before, but we received comments from other agencies and from the community about the difficulty of accessing this service and the kind of assistance that it could provide. It was regarded by some as a desk-based service. Police officers recounted difficulties in accessing social workers out of hours.

The Belfast HSC Trust had a different perspective. They explained that the service provides a localised response from its four bases. In the first 10 months of operation, 142 children were placed in care by this service where that was assessed as being in the child's best interests. The Inquiry is not in a position to reconcile these different perspectives but they do reflect a theme emerging from different sources, including various services and individuals, that it is difficult to get an effective, joined-up response to take forward a concern about a child out of business hours.

HSC trusts commented on the lack of availability of Police PPU's after 5pm.⁵³ There were comments about the lack of availability of adolescent mental health facilities out of hours in some HSC trust areas, resulting in young people in crisis being subjected to an adult assessment. Workers from the ambulance service felt there was no joined-up access to crisis intervention out of hours. A young person commented:

“Workers are in homes nine to five. After that, there's only one or two members of staff. Not every young person fits into that slot. They need help and support outside that.”

Paradoxically, agencies are working at their weakest at the points when young people are putting themselves most at risk.

The Inquiry recommends:

Key Recommendation 11:

The DHSSPS should ensure that there are clear reporting pathways, 24 hours a day, seven days a week, for reporting concerns about children and young people, including CSE, with appropriate feedback provided to the individual or agency making the report.

Supporting Recommendation 54:

The DHSSPS, supported by DOJ, should ensure that existing out of hours services across the health, social care and police sectors, are co-ordinated and strengthened. They should enable frontline staff from all sectors, as well as communities and concerned individuals, to access relevant information and skilled advice about safeguarding matters relating to children, including CSE.

⁵³ PSNI advise that 6 out of 8 PPU's work shifts. The ongoing review of PPU's within Northern Ireland has identified that not all PPU's perform shift working. It is anticipated that the outworkings of the review will address this point.

Supporting Recommendation 55:

The DHSSPS supported by DOJ should ensure that information received by out of hours services regarding CSE should be communicated to the multi-agency safeguarding hub or equivalent model referred to in Supporting Recommendation 60.

Supporting Recommendation 56:

All agencies, especially HSC trusts and PSNI must ensure that appropriate feedback is given to any person making a report regarding CSE.

Even within business hours, there were barriers to effective collaborative working. Many expressed to us the difficulties in ensuring that information was shared appropriately amongst agencies involved in child protection generally, including CSE. This is a longstanding issue about what information is collected, how it is recorded, and perceptions about what can be shared without breaching rights to confidentiality and privacy. Some records are still held manually. Where there are electronic systems, they are often unable to communicate with each other. As discussed earlier, the SBNI is in the process of producing an information-sharing protocol.

It seems ironic that a lot of the problems around CSE are based on the fact that children and their exploiters are sharing information very effectively, whereas the agencies that are trying to help are finding this very difficult. In particular, statutory agencies appear wary of sharing information with non-statutory agencies. There is a need for them to have a common understanding of expectations about sharing information. This is a critical matter given the lingering mistrust of statutory agencies in some communities in Northern Ireland. Non-statutory agencies have a key role to play and should be regarded and treated as equal partners.

The value of the information shared is dependent upon how it is gathered and communicated. Frontline workers, such as the ambulance service and health professionals, need a simple tool to help them assess the risk to young people. These workers, alongside parents and volunteers, need to know what kind of evidence is valuable and how it should be recorded. They must have clear pathways for reporting concerns and appropriate feedback to give them the confidence to carry on reporting. Professionals also need to understand that information must be shared in a way that makes it useable. Passing information on in the form of a telephone call or in the course of a meeting is not the same as making a proper, documented referral that the receiving agency cannot ignore and is able to use.

Young people also need to feel confident about sharing information with those who might help protect them. PSNI gave some very good examples of interaction between police officers and young people in residential care, including initiatives such as Pizza and Peeler, which promote informal contact between police officers and the residents of children's homes. However, we note that these operate inconsistently in different police districts.

Much has been said about the need for agencies to share information appropriately, but appropriateness should take account of the rights and needs of children to privacy and confidentiality. A young person described to the Inquiry how a LAC review had been attended by a school teacher. Private information about the young person was shared. The young person felt it difficult to look the teacher in the eye on return to school and asked why it had been felt necessary to share so much detail about their private life.

This emphasises the need for information to be shared on a need to know basis so that any intrusion on the young person's privacy is proportionate.

The Inquiry recommends:

Key Recommendation 12:

The protocol for sharing information amongst agencies being developed by SBNI should be concluded as a matter of priority.

Supporting Recommendation 57:

SBNI should ensure that as part of its information sharing protocol consistency of terminology is pursued as an aid to effective information sharing.

Supporting Recommendation 58:

SBNI should explore the potential for a regional electronic system for collating and analysing CSE data.

Supporting Recommendation 59:

SBNI should ensure that the information sharing protocol being developed addresses any hesitations on the part of statutory agencies about sharing information with non-statutory agencies.

Information sharing is not an end in itself but a means to an end. It must be interrogated, analysed and acted upon. Collaborative working is hampered where there are inconsistencies of response. In Northern Ireland, overlapping agency boundaries, specifically between police and the HSC trusts, mean that workers have to deal with different people, processes and terminology. We understand that there is an intention to realign the boundaries of police districts and reduce their number to align better with the Trust areas.

Lack of appropriate training and a shared understanding can also impact negatively on joint working. This has been noticeable particularly in relation to the response to missing children. The capacity of all professionals working with children and young people needs to be boosted by training on CSE. There is merit both in training specific to a professional group and joint training. These are both appropriate and should be organised so as to be complementary. The Inquiry recommends:

Key Recommendation 13:

SBNI and its member agencies should seek to ensure that there is delivery of professional training, both multi-agency and profession-specific, and that this is based upon a clear, agreed and shared definition of CSE.

We understand that consideration is being given in Northern Ireland to the establishment of a multi-agency safeguarding hub (MASH) along the lines of those that work in England and Wales.

The Inquiry recommends:

Supporting Recommendation 60:

The DHSSPS should consider development of a model for a multi-agency safeguarding hub (MASH) in Northern Ireland which should take into account learning from the good practice in recent projects such as Operation Owl, the co-located project at Willowfield, and the Regional CSE Group.

7.15 Adequacy of the Law

In general, those we spoke to considered the current legislation to protect children as adequate, adding that the issue was more about awareness and training. The DOJ advised that its policy and legislation section is looking at the implementation of the EU Directive on sexual violence, and this could incorporate issues relevant to CSE.

Nevertheless, a number of suggestions were made as to how the law could be improved:

- PSNI reported that, the use of prostitution and pornography, within the legislation, was outdated and minimised the very real abuse of children. This use of language presented difficulties for officers in working with both offenders and victims.
- PSNI advised that the current grooming legislation, under the Sexual Offences (NI) Order 2008 does not allow for police action/intervention when someone is enticing a child. Other international grooming definitions have a wider remit allowing the offence to be complete as soon as any enticement is proven. This would be a useful tool to disrupting CSE before any further harm is caused to a child or young person.
- PSNI said that, in terms of harbourer's warning notices, by having a legally enforceable order, with additional powers of search and entry, and to ban named persons from specific areas, such as the vicinity of children's homes, would facilitate officers in the execution of their duty. However, they add that the burden of proof for this level of intervention is likely to be high, especially in the light of the Judicial Review referred to earlier.
- Police officers commented that the differential application of the law to those under 16 and those under 18 was confusing.
- Police officers noted that Article 19 of the Police and Criminal Evidence Act does not allow them to enter party houses unless there is serious risk. PSNI advise that Article 19 allows a police officer to enter premises (such as a party house) to protect life or limb, prevent serious harm or to arrest for an indictable offence. The majority of offences that are considered in relation to CSE are indictable offences, for example, indecent assault.

The Northern Ireland Human Rights Commission identified a number of areas where the law could be improved. Most of these have been the subject of comment by the UN Committee on the Rights of the Child (see Chapter 9 of this report) and we consider these should be addressed. They expressed concern about:

- The requirement on the prosecution to disprove reasonable belief regarding the age of a child victim between the ages of 13 and 18 in relation to the offence of purchasing sexual services from a child.
- The requirement to disprove reasonable belief regarding the age of a child under 16 in relation to the offence of sexual grooming.
- The fact that some of the protections afforded to children stop at the age of 16 whereas the definition of child in terms of international law extends to 18.
- The possibility for private fostering arrangements to be abused for the purposes of exploiting children.
- The lack of a system of guardians for unaccompanied or separated children, especially those who have been trafficked. [This matter is currently under consideration in a Private Members' Bill which has Ministerial support.]

The NIHRC also commented on the limited operation of the NCA in Northern Ireland and its impact on the ability to protect children from exploitation.

The Inquiry asked PSNI about this and they responded:

“There was concern in Northern Ireland that the tackling of serious crime, in terms of the NCA, would be hampered as important parts of legislation around the sharing of information and evidence have not been enacted in Northern Ireland. The practical out workings of no legislative basis to the relationship between the PSNI and CEOP may not be fully known for some time. However, the PSNI continues to work with CEOP, particularly around overt and covert technical issues around indecent images of children material, and build on the current good working relationship to protect children locally, nationally and internationally, and bring offenders to justice.

PSNI eCrime continues to work with CEOP in relation to overt and covert technical issues regarding material relating to the indecent images of children, including the sharing of ‘hashes’. A ‘hash’ is a like a digital fingerprint. Indecent images of children are ‘hashed’ by law enforcement agencies and are available on databases, allowing for previously known images to be quickly identified.

Within our organisation, eCrime uses a ‘hash’ database, as do most United Kingdom police services. The Home Office is currently trying to establish a full UK National Hash Database in conjunction with CEOP.

Although yet to be determined, Northern Ireland may fall outside this due to judicial issues in the sentencing guidelines used here.”

The Inquiry recommends:

Key Recommendation 14:

The DOJ should lead on a project to examine legislative issues highlighted in this report and bring forward proposals for change.

These include:

- a) Ensuring compliance with international standards by extending protection to children up to the age of 18, specifically, the Child Abduction (Northern Ireland) Order 1985 and the Sexual Offences (Northern Ireland) Order 2008.**
- b) Providing for a Recovery Order under the Child Abduction (Northern Ireland) Order 1985, on the model of that in section 69 of the Children (Northern Ireland) Order 1995.**
- c) Replacing all references to child “prostitution” with “child sexual exploitation”.**
- d) Extending the offence of “grooming” to include “enticing”.**
- e) Reversing the rebuttable presumption in the Sexual Offences (Northern Ireland) Order 2008 in relation to “reasonable belief” as regards the age of a child.**
- f) Whether recent legislation in England and Wales relating to hotels, guest houses and bed and breakfast accommodation would be helpful in addressing CSE in Northern Ireland. These are contained in the Anti-Social Behaviour, Crime and Policing Act 2014.**

7.16 Conclusions

CSE is an issue that threatens the safety and well-being of every child in Northern Ireland. Preventing and tackling it will require the whole community – public and professional – to come together. The Inquiry therefore recommends:

Key Recommendation 15:

The DHSSPS should lead the development of a regional strategy to prevent, identify, disrupt and tackle CSE.

It should involve the Departments for Justice and Education and should:

- a) Be informed by the experiences and views of children, parents and carers.**
- b) Recognise parents and carers as partners in preventing and tackling CSE, unless there are strong indications that they are involved or complicit.**
- c) Recognise the support and training needs of frontline workers in all agencies in relation to CSE.**

- d) Reflect the particular role of schools in raising awareness and identifying concerns about CSE.**
- e) Acknowledge the role of health workers in early intervention, prevention and reporting of CSE, which should be made more explicit in policies, guidance and training.**
- f) Recognise agencies operating in the voluntary (non-statutory) sector as equal and valued partners.**
- g) Equip communities with the information, support and confidence to identify and report concerns about CSE.**
- h) Link into, and build upon, existing work in relation to child trafficking as well as strategies tackling known vulnerabilities for CSE, such as alcohol, drugs (including “legal highs”), sexual health and domestic violence.**
- i) Explore the potential contribution to this issue of strengthening a statutory duty to co-operate among stakeholder agencies.**
- j) Establish a process for promoting and monitoring the implementation of the recommendations of this report.**

CHAPTER 8: SUPPORTING RECOVERY FROM CHILD SEXUAL EXPLOITATION

8.1 Introduction

Whilst much has been said in this report about raising awareness of CSE, facilitating identification and providing pathways for reporting, it would be a poor outcome for those who have suffered if there were insufficient services to support recovery. Identifying perpetrators and disrupting their activities may help the young person to disengage from the situation and may help protect others from the perpetrator, but it will be important to help the victims of CSE to recover from the trauma of abuse and develop resilience to avoid a repetition.

8.2 Current Service Provision

Both the RQIA self-assessment survey and the call for evidence invited respondents to identify local initiatives relevant to preventing and tackling CSE. Many responses related to existing general services that were presented as capable of accommodating CSE cases, in theory at least.

The most specialist service in Northern Ireland is the Barnardo's Safe Choices Service. Set up in 2004, previously known as Beyond the Shadows, it works with children and young people who are being sexually exploited, at risk of sexual exploitation and/or going missing from home or care. The service works with young people who are both within and outside of the care system. It offers a service to males and females up to the age of 18. It is a regional service both in terms of the provision of a direct service to children and young people and of the provision of training and consultancy. It currently has bases in Belfast and Coleraine. Safe Choices works in partnership with all the HSC trusts, the PSNI and a range of other agencies. Since its establishment, Safe Choices has completed more than 250 cases. In October 2014, it had 99 ongoing cases with a further 46 referrals being processed. The service currently has seven full time practitioners, two of whom are funded by the HSC Board and five funded by Barnardo's Voluntary Funds.

More specialised services that can address CSE even though that is not their specific focus include:

- Scaffold Consultation and Therapy Service – identified by the Southern HSC Trust.
- The ROWAN Sexual Assault Referral Centre (SARC).
- The forensically trained, specialist child sexual abuse worker employed by the Southern HSC Trust.
- A new intensive support service in the community which will help a small number of very traumatised children, referred to by the YJA.

- The Therapeutic Support Services/Child Care Centre in Belfast, whose work is not focused specifically on CSE. However, many of these children will have current or past experience of CSE. They believed their service capable in principle of taking on some of this work. The practicality of doing so was limited by their perspective that the therapeutic services are under-resourced and fragmented and lacking in adequate training for staff. The child care centre has to charge for services in some areas of Northern Ireland.
- Nexus NI, which offers counselling and support to survivors of sexual abuse, victims of sexual violence including those who have experienced rape and sexual assault. Counselling is available for anyone aged 16 or over in 25 centres across Northern Ireland including Belfast, Derry/Londonderry, Portadown and Enniskillen.
- We were advised that some young people are placed in a therapeutic unit in the Republic of Ireland, called “Fresh Start”. It has a holistic approach involving psychiatry and other services. We were told there was no equivalent in Northern Ireland.

The NSPCC presented a list of projects relevant to CSE in various ways. Those that appear to be most relevant to supporting recovery are described by NSPCC as follows:

- Letting the Future In: a post-disclosure therapeutic recovery programme for children and young people aged 4-17 who have been sexually abused. It encourages the young person to explore, express and manage their feelings and teach them how to keep safe. The teams have extensive experience of dealing with post abuse recovery work leading to better outcomes for children and young people who have been sexually abused and will enable children to recover. Letting the Future In is delivered in Foyle and Craigavon and provided on an outreach basis to a number of HSC trusts.
- Turn the Page: a structured treatment programme for children and young people who display harmful sexual behaviour. NSPCC research has found that young people are responsible for two thirds of the sexual assaults inflicted on children. Sexual abuse becomes more common during teenage years up to the age of 17, with girls as the main victims. The Change for Good manual aims to establish a consistent and rigorous approach to treating these children that can be compared against techniques already being used.

Action for Children Northern Ireland also identified preventive and support services (including functional family therapy, the choices service and the floating support service) which, although not focusing on CSE, addressed underlying vulnerabilities. They provided examples of some cases of known or potential CSE that had been identified by these projects.

8.3 Suggested or Proposed Service Provision

The DHSSPS identified several of the projects referred to earlier as recipients of funding to support victims of sexual abuse. In terms of the development of services to promote recovery from CSE, the DHSSPS, in a meeting with the Inquiry, acknowledged the limitations in current service provision, including:

1. Attitudes to sex and sexuality have had an adverse impact on Northern Ireland's ability to develop a universal approach to building resilience to support the development of healthy sexual identity.
2. There is a need to review the current response to supporting traumatised young people, especially older young people who are experiencing abuse.
3. It was noted that there had been significant investment in services for victims of the Troubles. Some of this might be used to strengthen services for adults relating to their experiences in childhood.

Suggestions arising from other sources included:

- Intensive support service in the community whether in or out of care – 24/7. [HSC trust staff]
- Psychotherapy for CSE children. [Delegate at event]
- Specialised, free counselling available at the point of need. [Individuals]

The HSC Board advised the Inquiry that it had identified CSE as a strategic priority within commissioning of social services.

8.4 Mental Health

Mental health issues can render a young person more vulnerable to CSE but can also be a consequence of it. It is important that mental health practitioners are alert to the indicators of CSE and equipped to respond appropriately.

Research suggests that the rate of mental health issues amongst sexually exploited victims is in the region of 40%, and that victims of CSE are 17 times more likely to become psychotic than other young people.⁵⁴

“Victims often have Intrusive thoughts and flashbacks.

Young People suffering from post-traumatic stress may be treating their own symptoms by using drugs and alcohol.”

Throughout the Inquiry, concern was expressed about the availability of child and adolescent mental health services (CAMHS) especially, as previously indicated, out of business hours, in some HSC trust areas.

The survey conducted by ETI showed that almost all of the schools reported that there were insufficient community based services to deal with the rising numbers of young people with mental health issues. The Educational Psychology Service said their evidence showed an increase in the numbers of children and young people with more complex mental health issues. They would like to see the CAMHS service based in schools, rather than in clinics in the community, as they feel this would be more effective and efficient.

⁵⁴ Kirtley, P., *If you shine a light on it you will probably find it: Report of a Grass Roots Survey of Health Professionals with regard to their Experiences in Dealing with Child Sexual Exploitation*. NWG Network (2013). <http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/child-sexual-exploitation/Documents/Shine%20a%20Light.pdf>

In terms of positive developments, it was acknowledged that the opening of Beechcroft residential facility had had an impact in minimising the number of young people admitted to adult mental health wards. The Inquiry was also advised of plans to establish a regional, forensic CAMHS team that would focus on the Juvenile Justice Centre at Woodlands and Lakewood Secure Centre.

We received some suggestions for improvement. NIASW pointed to the Champions Model in the Northern HSC Trust as a possible model for CSE. It was described as an example of excellent practice in terms of improved working between adult mental health services and children's services. There is a specially trained and skilled practitioner in each area who is identified as either a child care or mental health champion. This individual will act as a resource to their team for discussion of cases, offering guidance and mentoring and will also offer training. The champions meet regularly to develop policy and agree joint areas for work. The Belfast HSC Trust advised the Inquiry that it also operates this model.

A group of health professionals suggested that primary mental health training for all staff might avoid some referrals to CAMHS. A mental health worker suggested there should be more therapeutic placements involving a combination of a long term residential settings with significant input from mental health therapeutic services.

8.5 What is Required

Growing awareness of CSE is likely to be followed by increased referrals. Services need to be prepared to respond. Adults who suffered CSE as children told us that a lack of appropriate support leads victims into drugs and alcohol and abusive relationships. Some referred to Northern Ireland's troubled history as a contributing factor:

“This island has a big problem and history in this area that will take generations to deal with effectively, even if the right funding and programmes are instituted.”

Some said young girls who have been abused don't know how to parent their own children. One woman said she was 47 before anyone said to her – you are a nice person and it wasn't your fault:

“It took a weight off my shoulders.”

It was suggested that what would help would be a safe space where victims could go and have a cup of tea and not have to talk to anyone. They should be able to move at their own pace until they had built up trust. They should not be rushed into a court case before they were ready.

There are a number of good initiatives and helpful suggestions, but they need to be joined up into a strategic approach to ensure equality of access and availability at the time of need.

One of the biggest challenges was articulated by a member of staff of a HSC trust:

“We are very good at assessment and planning. The challenge is to find a safe place for a young person.”

8.6 Conclusions

In order to address these issues, the Inquiry recommends:

Key Recommendation 16:

The HSC Board should adopt a strategic approach to the provision of support services for those who have been subject to CSE, to ensure equality of access. This should build on current, good practice examples.

Key Recommendation 17:

The HSC Board should ensure that accessible and appropriate support services are made available for adults who were abused as children.

CHAPTER 9: HUMAN RIGHTS AND INTERNATIONAL STANDARDS

9.1 Introduction

The human rights of children provide a framework within which issues relating to CSE can be addressed. Some contributors to the Inquiry expressed the view that children's rights are a barrier to taking action to protect them. This chapter will explore which human rights are involved, what they mean and how a human rights framework can provide a holistic approach that promotes effective child protection and the wellbeing of children and young people.

9.2 United Nations Convention on the Rights of the Child (UNCRC): General Principles

There are many human rights documents relevant to children. The most fundamental and comprehensive is the UNCRC. The most relevant provision is Article 34, which states:

“States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

- a) The inducement or coercion of a child to engage in any unlawful sexual activity.
- b) The exploitative use of children in prostitution or other unlawful sexual practices.
- c) The exploitative use of children in pornographic performances and materials.”

How this is interpreted and implemented can best be understood by placing it within the context of the UNCRC as a whole.

The UNCRC sets out four basic principles that apply in all circumstances as well as a number of articles relevant to particular situations. It defines a child as any person up to the age of 18.

The four principles are:

- Children are to enjoy these rights without discrimination (Article 2.1).
- The best interests of the child are to be at least a primary consideration in all actions concerning the child (Article 3.1).
- Every child has an inherent right to life, and States are obliged to ensure, to the maximum extent possible, the survival and development of the child (Article 6).

- Children have a right to express their views on all matters that affect them and these views must be given due weight in accordance with the age and maturity of the child (Article 12.1).

There are other relevant provisions within Article 3 that will be addressed later, but it is important first of all to be clear about what these fundamental principles say and how they relate to each other.

There is a tendency to view children's rights simply as a commitment to respecting the autonomy of a child. This is an over-simplification, and in fact a distortion, of what the Convention says. Taking the principles together, the fundamental message is that actions in relation to children should be driven by the best interests of the child. The child's views, where the child wishes to express them, are an essential part of the process of identifying where those interests lie. The relationship between Articles 3 (interests) and 12 (views) was addressed in a General Comment by the UN Committee on the Rights of the Child, which concluded:

"There is no tension between Articles 3 and 12, only a complementary role of the two general principles: one establishes the objective of achieving the best interests of the child and the other provides the methodology for reaching the goal of hearing either the child or the children. In fact, there can be no correct application of Article 3 if the components of Article 12 are not respected. Likewise, Article 3 reinforces the functionality of Article 12, facilitating the essential role of children in all decisions affecting their lives."⁵⁵

The General Comment also referred to Article 5 of the Convention, which sets out the rights and responsibilities of parents and carers to give direction and guidance to children as to how the children should exercise their rights. It says:

"Consequently, the child has a right to direction and guidance, which have to compensate for the lack of knowledge, experience and understanding of the child and are restricted by his or her evolving capacities, as stated in this article. The more the child himself or herself knows, has experienced and understands, the more the parent, legal guardian or other persons legally responsible for the child have to transform direction and guidance into reminders and advice and later to an exchange on an equal footing. This transformation will not take place at a fixed point in a child's development, but will steadily increase as the child is encouraged to contribute her or his views."⁵⁶

A false view that children have an unqualified right to autonomy can allow adults to abdicate their responsibilities for keeping the child safe, and can allow governments to evade their responsibility to commit resources to ensure the child's survival and development to the maximum extent possible.

A holistic view, based on a thoughtful reflection on the whole spectrum of children's human rights, can assist in identifying an achievable way forward in particular cases.

⁵⁵ UN Committee on the Rights of the Child. *General Comment No 12 (2009): The right of the child to be heard*, Para. 74.

⁵⁶ *Ibid.*, Para 84.

This is not to downplay the significance of respect for the child's view and the fact that, in some circumstances, that view will in fact be determinative. Certainly, as far as older children are concerned, protective measures that have not taken account of the views of the child will be difficult to enforce. They may also not be targeted on the actual problems being experienced by the child. This emphasises the importance of creating an environment in which children can build trusting relationships with adults. Only in those circumstances will children, who are often weighing up and managing the risks in their lives, feel able to share that burden with adults and move towards an effective solution.

Article 3 of the UNCRC contains other critical provisions relevant to CSE:

- States are “to ensure the child such protection and care as is necessary for his or her well-being” (Article 3.2); and
- States are to ensure that “institutions, services and facilities responsible for the care or protection of children” conform to appropriate standards as regards safety, health, staffing, etc., (Article 3.3).

The interplay between all of these articles makes it clear that there is a positive obligation on governments to do their utmost to protect all children and young people up to the age of 18. As children become older and are able to exercise more practical autonomy, this task becomes more difficult. However, the duty to care for and protect remains, alongside the child's right to be cared for and protected.

9.3 United Nations Convention on the Rights of the Child (UNCRC): Specific Provisions

Other provisions of the UNCRC that have a particular relevance for CSE include:

- The right to protection from all forms of violence, abuse or exploitation while in the care of parents or other carers. There should be support for children and effective forms of prevention, identification, reporting, referral and investigation (Article 19).
- The right to rest, leisure, play and recreational activities (Article 31).
- The right to protection from the illicit use of drugs and other substances (Article 33).
- The duty of States to take steps to prevent the abduction, sale of or traffic in children for any purpose or in any form (Article 35).
- The duty to protect children from any other kinds of exploitation (Article 36).
- Commitment to the principle that deprivation of liberty should be a last resort and for the shortest appropriate period of time (Article 37).
- The right to services to promote physical and psychological recovery from neglect, exploitation or abuse (Article 39).
- Commitment to keeping children out of the criminal justice system as far as possible (Article 40).

There are other provisions that would be relevant to children in particular situations, for example: children separated from their parents (Articles 9 and 20), children with disabilities (Article 23) and children in care (Article 25).

In addition to the General Comment referred to earlier, the UN Committee has issued other General Comments relevant to CSE. The General Comment on the Right of the Child to Freedom from All Forms of Violence⁵⁷, makes it clear that violence, in terms of Article 19, includes exploitation and sexual abuse. It makes a pertinent point about identification:

“Children must be provided with as many opportunities as possible to signal emerging problems before they reach a state of crisis, and for adults to recognise and act on such problems even if the child does not explicitly ask for help.”⁵⁸

It insists that the commitment to non-discrimination involves countering prejudice based on children’s clothing or behaviour (Para. 60). It also points out that:

“As the experience of violence is inherently disempowering, sensitive measures are needed to ensure that child protection interventions do not further disempower children but rather contribute positively to their recovery and reintegration via carefully facilitated participation.” (Para 63)

This is relevant to the debate about the resort to restraint and secure accommodation.

The General Comment on the Right to Leisure, Play and Recreational Activities acknowledges that the importance of this right, and its relationship to other rights, is not always understood. It can be perceived as referring to activities that are “frivolous or unproductive” (Para. 33). It points out that violence, sexual exploitation and the deprivation of liberty impede these rights (Para. 30) and refers to the adolescent need for risk-taking and challenge (Para 14). It adds:

“Human factors can also combine to place children at risk in the public environment: high levels of crime and violence; community unrest and civil strife; drug and gang-related violence; risk of kidnapping and child trafficking; open spaces dominated by hostile youth or adults; aggression and sexual violence towards girls (Para. 36).”

The right of the child to play and recreational activities (Article 31) offers a basis for exploring the potential for prevention and support that appropriate activities offer.

The General Comment also refers to the growing role of electronic media in young people’s activities, offering huge benefits but posing significant risks as well. (Para 45)

These documents emphasise the very weighty responsibilities on the part of States, corresponding to very significant rights on the part of children, that the United Kingdom government has promised to respect. For any individual child, a number of provisions may come into play and it is important to take a broad view of how these relate to each other and their potential for providing a framework for a balanced and effective approach to the child’s situation.

⁵⁷ UN Committee on the Rights of the Child, *General Comment No 13 (2011): The right of the child to freedom from all forms of violence*, para. 4.

⁵⁸ *Ibid*, para. 48.

Where there is uncertainty about where a child's best interests lie, a children's rights impact assessment can be carried out as an aid to identifying a way forward.

9.4 United Nations Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography

The United Kingdom has signed up to the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography, thus committing itself to ensuring that these activities are addressed by its criminal law. They must take measures to prevent these offences, raise public awareness of them and promote the recovery of victims. They must also protect the rights and interests of child victims at all stages of the criminal justice process.

9.5 Recommendations of the United Nations Committee on the Rights of the Child

The UN Committee regularly examines the progress States have made in implementing the provisions of the UNCRC and its Optional Protocol. In its examinations of the United Kingdom, the Committee has, in successive reports, expressed concern about: the sexual violence against children and the lack of a co-ordinated strategy to address it; the possibility of children being criminalised as a consequence of acts committed against them; the lack of data on children who were the victims of child sexual exploitation.

In 2008, the Committee recommended that the United Kingdom ratify the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse.

In 2014, the UN considered the measures taken by the United Kingdom to implement the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography. It recommended:

- The Sexual Offences (Northern Ireland) Order 2008 be amended to ensure that all children under 18 are protected. (Recs 12 and 29)
- Reversal of a rebuttable presumption in the Sexual Offences (Northern Ireland) Order 2008. Currently, a defendant can assert that he/she believed the victim of offences to be over the age of 16. It would then be up to the prosecution to prove that he "did not reasonably believe" this. (Rec 29)
- Comprehensive measures for the recovery and reintegration of child victims of all the offences covered by the Protocol. (Rec 41)

The Committee also expressed concern about any barriers in Northern Ireland to access to the CEOP as a result of the lack of jurisdiction in Northern Ireland of the NCA.

9.5.1 United Nations General Comments and Documents

In 2006, the UN published the UN Secretary General's Study on Violence Against Children. It was a global study but has a number of recommendations relevant to the response to CSE in Northern Ireland.⁵⁹

9.6 European Convention on Human Rights

Children also have the right to benefit from the more general statements of human rights such as the European Convention on Human Rights. Submissions to the Inquiry identified in particular the relevance of:

- Article 2 – the right to life
- Article 3 – the right not to be subject to torture or inhuman or degrading treatment or punishment
- Article 4 – the prohibition of slavery and forced labour
- Article 5 – the right to liberty and security of the person
- Article 8 – the right to respect for private and family life
- Article 10 - The right to freedom of expression, including freedom to receive information

It is important to look to the text of the Convention when interpreting these rights and applying them to specific cases as some are absolute whilst others have qualifications written in to them.

9.7 Conclusions

The UN Committee on the Rights of the Child's General Comment on Violence (Para. 59) emphasises that:

“A child rights approach is one which furthers the realisation of the rights of all children as set out in the Convention by developing the capacity of duty bearers to meet their obligations to respect, protect and fulfil rights (art. 4) and the capacity of rights holders to claim their rights ...”

Recognising rights means recognising the responsibilities of the duty-bearers and resourcing them to fulfil their responsibilities.

⁵⁹ UN Secretary General, *Report on Violence Against Children* (2006): <http://www.unviolencestudy.org/>

CHAPTER 10: CONCLUSIONS

The Inquiry is clear that child sexual exploitation is happening in Northern Ireland and takes many forms. Some forms of CSE have been known for decades but new ones, such as sexting and its implications, are developing in line with communication technology. These developments allow greater possibilities for contact and networking that render more children than ever before vulnerable to CSE. This includes those with disabilities and those with no other known vulnerabilities.

We believe that some exploitation is organised and planned in a targeted way. There is a spectrum of organisation, ranging from criminal gangs to loose groups of perpetrators that coalesce around vulnerable young people. The group scenario featured more prominently in what we heard than the gang scenario.

Children are also more vulnerable to CSE because of the emergence of an increasingly sexualised culture. They are exposed to messages about sexuality both passively, in terms of what is broadcast in print and electronic media (including television), and actively, through what they can access on the internet. These messages have contributed towards what has been described as a new normality that colours children's aspirations, renders them more vulnerable to grooming, and contributes to peer abuse.

There are particular Northern Ireland dimensions to CSE. We heard about the threats posed by powerful individuals with links to paramilitary organisations. Communities are reluctant to report these for fear of reprisals and because they do not have confidence in the ability of the statutory authorities to respond appropriately and effectively. The fact that some offenders in the past were dealt with illegally by paramilitary organisations, means that there is no record of their offending behaviour that would link them into the protections afforded by the Sex Offenders Register and the provisions for sharing information about individuals posing a danger to children.

The Inquiry has made specific recommendations aimed at preventing, identifying, disrupting and tackling CSE, but three themes emerge:

1. The need for greater **awareness** across the whole population in Northern Ireland.
2. The need for **balance** in response to the reality of CSE, so that it:
 - does not focus purely on children in the care system
 - does not lead to a panic response that scares children and parents and results in disproportionate repression or suspicion, and
 - does not result in a sudden lurch towards CSE as a stand-alone priority.

CSE is facilitated by underlying vulnerabilities such as neglect, poverty, substance misuse (including alcohol) and domestic violence. CSE will not be effectively tackled if these vulnerabilities are not also addressed. CSE also has links to trafficking which has been the subject of much recent, and welcome, activity. These issues are not in competition. They are all linked. Whilst an initial awareness boost is necessary whenever new threats to children's safety and welfare emerge, it makes more sense for this to be complemented by a move towards integration of the new messages, procedures, training and resources into what already exists. Nevertheless, we have made some recommendations about service provision where we believe this is a necessary response to these emerging threats to the safety and welfare of children.

3. The need to promote **confidence** on the part of children, parents, workers and the community that they can respond appropriately to the threat of CSE. This is reflected in the Inquiry's recommendations about awareness raising, education and training, developing clear pathways for reporting, and promoting an effective response to reports.

We are aware of some advances made in the criminal justice system in recent years, but there still needs to be a greater focus on developing a child-centred approach. This includes increasing the awareness of legal professionals about the dynamics of child abuse, including CSE. Much work also remains to be done to build up relationships between the police, young people and some communities. All of these have emerged during the Inquiry as barriers to reporting CSE and to engaging with the criminal justice process.

A central theme of our recommendations is that listening to the views and experiences of children and young people, and taking them seriously, are critical for achieving effective change.

An inquiry such as this inevitably draws attention to problems, challenges and deficiencies. It is important to record that we also came across dedication, commitment and innovation, from: police officers who go out of their way to spend informal time with young people in residential care; care workers who pursue young people putting themselves at risk, even when it might expose the worker to danger; support workers who accompany exploited young people through their journey to acknowledgement and recovery; health and education workers, keen to find out what they can do to help keep young people safe; taxi drivers who gave up their own time to attend events about CSE and inform the debate; and community workers who are passionate about regenerating their communities and supporting and protecting their children.

We conclude that Northern Ireland has some very strong human resources for tackling the challenges presented by CSE.

CHAPTER 11: SUMMARY OF RECOMMENDATIONS

The Terms of Reference require the Inquiry to make recommendations on the future actions required to prevent and tackle CSE and who should be responsible for these actions.

Recommendations are noted as **Key Recommendations** or **Supporting Recommendations**, each with its own numbering sequence. This allows the key recommendations to stand out as a broad picture of what the inquiry seeks to achieve.

The Inquiry made 17 key recommendations and a further 60 supporting recommendations.

NORTHERN IRELAND ASSEMBLY

Key Recommendation 7:

The Northern Ireland Assembly, through the Office of the First Minister and Deputy First Minister, should re-affirm its commitment to strategic, long-term and sustained funding of services for prevention and early intervention.

ALL AGENCIES

Key Recommendation 6:

The DHSSPS, along with the HSC Board and HSC trusts, should consider how “safe spaces” could be developed for children and young people at risk of, subject to, or recovering from CSE. This development should take account of models of best practice and the views of young people, and should respect international human rights standards.

Supporting Recommendation 11:

All agencies both statutory and non-statutory should work with local communities to identify how they can best engage together in a way that will build up trust.

Supporting Recommendation 1:

All agencies involved in awareness-raising should ensure that language used is meaningful to the target groups.

Supporting Recommendation 56:

All agencies, especially HSC trusts and PSNI must ensure that appropriate feedback is given to any person making a report regarding CSE.

DEPARTMENT OF EDUCATION

Key Recommendation 8:

The Department of Education (DE) should conduct a review of youth services that takes into account the views of young people and aims to ensure that such provision is attractive and appropriate.

Supporting Recommendation 5:

The Department of Education should give guidance to schools on how they can provide flexible support sessions about CSE that are accessible for parents of disabled children.

Supporting Recommendation 7:

The Department of Education should ensure that all young people can access more information and support on healthy relationships, including LGBT young people. This could be included within the CCEA review of Relationships and Sexuality guidance materials.

Supporting Recommendation 29:

The Department of Education should ensure that there is provision for parents, carers and other educational professionals to improve their knowledge and skills in relation to modern methods of communication and to keep up-to-date on developments in social media.

Supporting Recommendation 30:

The Department of Education should work with other departments to ensure that there are appropriate safeguarding arrangements for children in all non-statutory education settings.

Supporting Recommendation 32:

The Department of Education should develop a central register of quality assured external agencies and/or programmes that schools could access to source appropriate specialist support to deliver the preventative curriculum.

Supporting Recommendation 33:

The statutory personal development curriculum should specifically reference CSE, with a clear focus on progressively developing the confidence, self-esteem, resilience and personal coping strategies of all children and young people in schools.

Supporting Recommendation 34:

School staff and wider education professionals should receive training on CSE with the aim of integrating it into general safeguarding training.

Supporting Recommendation 35:

The Department of Education should ensure that schools receive additional, regularly updated training and resources to support them in educating pupils and parents on how to use social media and online resources responsibly, and how to keep their pupils safe.

Supporting Recommendation 36:

The Department of Education should give further guidance to schools on CSE and in its review of Relationships and Sexuality Education guidance for schools, CCEA should consider specifically referencing CSE.

Supporting Recommendation 37:

The Department of Education should explore the possibilities for peer education and mentoring as a way of informing and supporting young people about CSE.

Supporting Recommendation 38:

The Department of Education should provide schools with clear, consistent guidance on recording, storing and handling of child protection records including CSE.

Supporting Recommendation 40:

The Department of Education should ensure that youth workers, whether paid or voluntary, should receive training to help them to inform and support young people who may be at risk of CSE, and to identify and report safeguarding issues appropriately.

SCHOOLS

Supporting Recommendation 3:

In order to improve understanding and vigilance, schools should be alert to the possibility that young people who do not return after holidays abroad may have been subject to forced marriage. Any concerns should be reported to the designated teacher for child protection within the school for further escalation if appropriate.

Supporting Recommendation 4:

Schools should be encouraged to engage parents with regard to the preventative curriculum, including those with literacy difficulties or for whom English is not the first language.

Supporting Recommendation 31:

Schools should ensure that Relationships and Sexuality Education is delivered by people with the skills and confidence to do so.

Supporting Recommendation 39:

Schools should ensure that all school governors have child protection awareness training which includes reference to CSE. The designated governor for child protection should have additional, enhanced training.

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Key Recommendation 1:

In response to the reality of CSE identified in this report, DHSSPS should direct the Public Health Agency to undertake a public health campaign on CSE-related issues. This should complement the work being undertaken by SBNI.

Key Recommendation 3:

The DHSSPS in conjunction with DOJ should develop guidance for parents and carers, including foster carers and residential workers, on how best to capture information and/or evidence when a child returns from a period of being missing or is otherwise considered to be at risk of CSE.

Key Recommendation 5:

The DHSSPS should explore the benefits of amending or adding to standards for inspection of children's homes to ensure that they:

- a) promote a culture conducive to respect for the best interests of the child; and
- b) take account of the specific needs of separated and trafficked children and those affected by CSE.

The DHSSPS should issue a circular and associated guidance stating how these issues should be taken forward.

Key Recommendation 10:

The DHSSPS should ensure that the forthcoming, planned review of SBNI should consider streamlining joint working arrangements to make them more realistic, efficient and effective.

Key Recommendation 11:

The DHSSPS should ensure that there are clear reporting pathways, 24 hours a day, seven days a week, for reporting concerns about children and young people, including CSE, with appropriate feedback provided to the individual or agency making the report.

Key Recommendation 15:

The DHSSPS should lead the development of a regional strategy to prevent, identify, disrupt and tackle CSE. It should involve the Departments for Justice and Education and should:

- a) Be informed by the experiences and views of children, parents and carers.
- b) Recognise parents and carers as partners in preventing and tackling CSE, unless there are strong indications that they are involved or complicit.
- c) Recognise the support and training needs of frontline workers in all agencies in relation to CSE.
- d) Reflect the particular role of schools in raising awareness and identifying concerns about CSE.
- e) Acknowledge the role of health workers in early intervention, prevention and reporting of CSE, which should be made more explicit in policies, guidance and training.
- f) Recognise agencies operating in the voluntary (non-statutory) sector as equal and valued partners.

- g) Equip communities with the information, support and confidence to identify and report concerns about CSE.**
- h) Link into, and build upon, existing work in relation to child trafficking as well as strategies tackling known vulnerabilities for CSE, such as alcohol, drugs (including “legal highs”), sexual health and domestic violence.**
- i) Explore the potential contribution to this issue of strengthening a statutory duty to co-operate among stakeholder agencies.**
- j) Establish a process for promoting and monitoring the implementation of the recommendations of this report.**

Supporting Recommendation 8:

DHSSPS in conjunction with DOJ should pursue an All-Ireland Information Sharing Agreements to achieve closer collaboration on CSE and related issues.

Supporting Recommendation 9:

DHSSPS should ensure that any Public Health campaign(s) should seek to challenge cultural norms that may seem to legitimise or promote CSE.

Supporting Recommendation 10:

DHSSPS should ensure that the forthcoming revision of the guidance, Co-operating to Safeguard Children should take account of the conclusions and recommendations of this Inquiry.

Supporting Recommendation 14:

DHSSPS should ensure the involvement of young people in any future review of the Regional Guidance on Police Involvement in Residential Units/ Safeguarding of Children Missing from Home and Foster Care.

Supporting Recommendation 20:

DHSSPS, in conjunction with the HSC Board, should review the notifications that residential care staff make following an incident, with the aim of producing a single form that will act as the response to all agencies who have to be notified.

Supporting Recommendation 23:

DHSSPS should consider bringing forward regulations to require supported accommodation for young people under 18 to be registered by RQIA.

Supporting Recommendation 28:

DHSSPS should take the findings of this Inquiry into account in its review of the definition of vulnerable adult to ensure that it is capable of accommodating young people who are vulnerable to CSE.

Supporting Recommendation 52:

DHSSPS should ensure that the revision of Circular HSS CC 3/96 (Revised), Sharing to Safeguard: Information Sharing about Individuals who may pose a Risk to Children, is accompanied by clear guidance to workers that will give them the confidence to act appropriately.

Supporting Recommendation 53:

The DHSSPS should consider further actions to protect children against offenders who will not have been brought to the attention of the statutory authorities in Northern Ireland for historical and cultural reasons.

Supporting Recommendation 54:

The DHSSPS, supported by DOJ, should ensure that existing out of hours services across the health, social care and police sectors, are co-ordinated and strengthened. They should enable frontline staff from all sectors, as well as communities and concerned individuals, to access relevant information and skilled advice about safeguarding matters relating to children, including CSE.

Supporting Recommendation 55:

The DHSSPS supported by DOJ should ensure that information received by out of hours services regarding CSE should be communicated to the multi-agency safeguarding hub or equivalent model referred to in Supporting Recommendation 60.

Supporting Recommendation 60:

The DHSSPS should consider development of a model for a multi-agency safeguarding hub (MASH) in Northern Ireland which should take into account learning from the good practice in recent projects such as Operation Owl, the co-located project at Willowfield, and the Regional CSE Group.

HSC BOARD

Key Recommendation 16:

The HSC Board should adopt a strategic approach to the provision of support services for those who have been subject to CSE, to ensure equality of access. This should build on current, good practice examples.

Key Recommendation 17:

The HSC Board should ensure that accessible and appropriate support services are made available for adults who were abused as children.

Supporting Recommendation 6:

The HSC Board should ensure that child protection issues are consistently and skilfully addressed in LAC and disability settings, where these are separate from specific child protection processes.

Supporting Recommendation 13:

The HSC Board should monitor the arrangements for private fostering to ensure that awareness of CSE is raised and to ensure identification of cases that have not been notified to the HSC trusts.

Supporting Recommendation 15:

The HSC Board should address as a priority the provision of joint training on Regional Guidance on Police Involvement in Residential Units/ Safeguarding of Children Missing from Home and Foster Care.

Supporting Recommendation 16:

The HSC Board Strategic Action Plan – Children Missing from Home or Care should be revised and implemented as part of the strategic overview of CSE.

Supporting Recommendation 21:

The HSC Board in conjunction with HSC Trusts should ensure that adequate support is available for foster carers (including kinship carers) and foster children, including health support through LAC nurses.

Supporting Recommendation 22:

The HSC Board, in conjunction with the HSC trusts, should assess the appropriateness of existing unregulated placements to ensure that the assessed needs of young people in these placements are being met.

Supporting Recommendation 26:

The HSC Board should consider the development of region-wide guidance about care and control in residential units. This should involve input from both young people and residential care workers.

Supporting Recommendation 41:

The HSC Board, in conjunction with the SBNI, should work with frontline workers including the ambulance service, to develop a simple “trigger” tool to help them to identify potential cases of CSE. This could build on existing models within the UK.

Supporting Recommendation 51:

The HSC Board in conjunction with SBNI should ensure that the availability of Recovery Orders in terms of section 69 of the Children (Northern Ireland) Order 1995 is highlighted in guidance and training.

HSC TRUSTS

Supporting Recommendation 18:

HSC Trusts should ensure that when a child returns after being missing, he or she is offered a return interview with an independent person in line with Regional guidance.

Supporting Recommendation 25:

HSC Trusts should endeavour to provide stability by minimising the movement of both children and staff throughout residential and foster care settings.

Supporting Recommendation 27:

HSC Trusts should take responsibility for ensuring that frontline staff in residential facilities are helped to feel confident that they will be supported by management if something goes wrong when they have done their best. They should also feel confident about speaking up if they feel young people are in danger and they cannot keep them safe.

Supporting Recommendation 42:

HSC Trusts should explore the potential for school nurses to play a wider role in safeguarding issues, including CSE.

Supporting Recommendation 49:

HSC Trusts should consider how best to address the appropriate availability of social workers for Achieving Best Evidence interviews.

DEPARTMENT OF JUSTICE

Key Recommendation 9:

The DOJ should establish an inter-agency forum drawn from across the criminal justice sector and third sector stakeholders to examine how changes to the criminal justice system can achieve more successful prosecutions of the perpetrators of CSE. This must be informed by the experiences and needs of child victims.

Supporting Recommendation 43:

PSNI and criminal justice partners in the Prosecution Service and Court Service should continue to develop their approach to responding to victims of CSE in a way that treats them fairly and sensitively and avoids blaming them for offending behaviour associated with their abuse. This involves attitude, not just policy or process.

Supporting Recommendation 44:

The Department of Justice should continue to seek to develop and improve the experiences of young witnesses, taking into account research and learning from other countries. This should include consultation with stakeholder groups and with young witnesses.

Supporting Recommendation 46:

Awareness-raising about the dynamics of child abuse and CSE in particular should be available for all legal personnel and should be mandatory for all legal professionals dealing with child abuse cases. This should be made the responsibility of the PPS for its own legal staff, the Northern Ireland Bar for its staff and the Judicial Studies Board for Judges.

Supporting Recommendation 47:

While we acknowledge the work already undertaken by the Department of Justice in order to avoid delay, robust case management is necessary. The DOJ should ensure that both statutory case management and statutory time limits are introduced in Northern Ireland. Both have already been the subject of clear recommendations by the Criminal Justice Inspection in Northern Ireland.

LEGISLATION

Key Recommendation 14:

The DOJ should lead on a project to examine legislative issues highlighted in this report and bring forward proposals for change. These include:

- a) Ensuring compliance with international standards by extending protection to children up to the age of 18, specifically, the Child Abduction (Northern Ireland) Order 1985 and the Sexual Offences (Northern Ireland) Order 2008.
- b) Providing for a Recovery Order under the Child Abduction (Northern Ireland) Order 1985, on the model of that in section 69 of the Children (Northern Ireland) Order 1995.
- c) Replacing all references to child “prostitution” with “child sexual exploitation”.
- d) Extending the offence of “grooming” to include “enticing”.

- e) **Reversing the rebuttable presumption in the Sexual Offences (Northern Ireland) Order 2008 in relation to “reasonable belief” as regards the age of a child.**
- f) **Whether recent legislation in England and Wales relating to hotels, guest houses and bed and breakfast accommodation would be helpful in addressing CSE in Northern Ireland. These are contained in the Anti-Social Behaviour, Crime and Policing Act 2014.**

PUBLIC PROSECUTION SERVICE

Supporting Recommendation 45:

PPS should ensure that prosecutors dealing with sexual offences against children continue to receive training at regular intervals on the dynamics of child abuse, including CSE.

POLICE SERVICE OF NORTHERN IRELAND

Key Recommendation 2:

The Inquiry encourages the PSNI to pursue its commitment to strengthening relationships with communities and with young people as a priority in the context of the current climate of austerity.

Supporting Recommendation 2:

PSNI should take action to strengthen enforcement of licensing laws and especially those concerning the supply of alcohol to young people. Police and Community Safety Partnerships should lead localised approaches to address the issue.

Supporting Recommendation 12:

Police and Community Safety Partnerships should seek to add value to the policing of communities by creating innovative mechanisms to hear and reflect issues of local concern. This should specifically reflect issues affecting children and young people.

Supporting Recommendation 17:

Police evidence about the circumstances in which a child was found after going missing or putting themselves at risk can be vital to protection arrangements. PSNI should review current processes to ensure that, in all circumstances, information is recorded and transmitted appropriately, both internally and to partner agencies.

Supporting Recommendation 48:

PSNI should conduct a review of resources and operational delivery in respect of digital evidence examination to ensure that any evidence of CSE is provided to investigators in a timely manner, and to avoid delay in the courts.

Supporting Recommendation 50:

PSNI, in its review and development of the Public Protection Units, should move to develop perpetrator profiling and a greater focus on perpetrators.

RQIA

Supporting Recommendation 24:

RQIA should consider re-introducing the involvement of young people as peer reviewers in inspections of children's homes.

SBNI

Key Recommendation 4:

SBNI's developing plan for data collection should include a commitment to collation and analysis of the data in a way that will facilitate a strategic response to CSE.

Key Recommendation 12:

The protocol for sharing information amongst agencies being developed by SBNI should be concluded as a matter of priority.

Key Recommendation 13:

SBNI and its member agencies should seek to ensure that there is delivery of professional training, both multi-agency and profession-specific, and that this is based upon a clear, agreed and shared definition of CSE.

Supporting Recommendation 19:

SBNI should periodically audit that all statutory agencies record details of CSE in a consistent manner.

Supporting Recommendation 57:

SBNI should ensure that as part of its information sharing protocol consistency of terminology is pursued as an aid to effective information sharing.

Supporting Recommendation 58:

SBNI should explore the potential for a regional electronic system for collating and analysing CSE data.

Supporting Recommendation 59:

SBNI should ensure that the information sharing protocol being developed addresses any hesitations on the part of statutory agencies about sharing information with non-statutory agencies.

PART B: APPENDICES

APPENDIX 1: SUGGESTIONS FROM YOUNG PEOPLE AND PARENTS

Children in Northern Ireland (CiNI) via Participation Network

Young people's views on what people/agencies should do...

Government	<ul style="list-style-type: none"> • Give more money to raise awareness and employ people to help • Give social workers more powers • Work with offenders to stop them offending • Provide more groups and counselling for victims • Make sure social workers and youth workers are trained in CSE • Make sure pupils get mandatory teaching on CSE every year
Young people	<ul style="list-style-type: none"> • Tell when it is happening to you or your friends • Look out for your friends • Warn people about CSE • Young people should be trained to tell other young people about CSE – peer education
Social workers	<ul style="list-style-type: none"> • Work with vulnerable young people to make sure they are not exploited • Visit houses and check for dangerous situations • Talk to young people more to find out what is happening • Give advice to parents
Parents	<ul style="list-style-type: none"> • Tell children about CSE • Have a good relationship with your child and each other • If you notice something take action
SBNI	<ul style="list-style-type: none"> • (Role of SBNI had to be explained) • Be more thorough – look into every case • Tell people about CSE
Teachers	<ul style="list-style-type: none"> • Teach children about what a healthy relationship is • Be approachable to children after class • Teach about CSE
Police	<ul style="list-style-type: none"> • Investigate all concerns from children • Have special officers to deal with this • Always act – even if it seems minor • Have a better relationship with young people
Youth service	<ul style="list-style-type: none"> • Have information evenings about CSE • Notice changes in young people • Act as a link between young people who want to report CSE and the PSNI
The public	<ul style="list-style-type: none"> • Tell police or social workers of any suspicions • It is your business – should be an advertising campaign • Get informed
Care homes	<ul style="list-style-type: none"> • Make sure young people know dangers • Always know who young people's friends are

The courts	<ul style="list-style-type: none"> • Put exploiters in prison • Have harsher sentences
The Inquiry Board	<ul style="list-style-type: none"> • Tell the Ministers what young people think • Make sure CSE is taught in schools • Get everyone to work together (police, youth service, social workers)
NSPCC/Barnardo's	<ul style="list-style-type: none"> • Go into schools and educate young people about CSE • Run a free CSE telephone helpline – 24hours • Help victims • Advertise what you do • Run parenting courses so they know how to protect their children
Neighbours	<ul style="list-style-type: none"> • Set up neighbourhood watch • Tell parents if child is acting strangely • Ask young people if everything is okay
You	<ul style="list-style-type: none"> • Tell people you feel safe with what is happening to you • Join a youth group • Look out for signs among your friends

Voice of Young People in Care (VOYPIC)

During the consultation, young people came up with suggestions and recommendations to help keep them safe and help prevent CSE:

Campaigns and public messages	<p>Re-think the term. Young people do not relate to the term CSE. Any public campaign should take this into account and consider alternative language.</p> <p>Branding on the front of leaflets and other materials should be subtle so that young people will not be put off picking up and reading them.</p> <p>Young people did not understand the process and the nature of exploitation. All information materials should use clear, simple and age-appropriate language. Information should include how to recognise an exploitative relationship and how to keep safe.</p> <p>Young people get a lot of their information from TV and other media outlets. Any public campaign should consider using local and national TV stations and programmes to promote their message.</p> <p>Most of the young people used social media regularly. Facebook, Twitter and other social media sites should be used to promote key messages on CSE. Social media providers have a responsibility to educate young people on keeping safe online in order to protect them from exploitation.</p> <p>All of the young people talked about the value of learning from their peers and hearing real-life stories. Peer education should be a key component of any awareness raising strategy.</p>
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	<p>Young people highlighted that all current messages appear to be focused on potential victims of CSE. They would like to see a public campaign that sends a clear message to perpetrators that they would be pursued and prosecuted.</p>
<p>Protecting children in care</p>	<p>The children and young people we spoke to are aware that this is a community wide issue but they had particular recommendations for protecting children in care.</p> <p>Children and young people highlighted that they would like to be able to develop strong and individual relationships with staff in children’s homes. The care system should support and encourage quality and continuity of relationships at its heart.</p> <p>Children and young people want to be involved in developing personal rules and sanctions in response to their own risk-taking behaviour if required to ensure that the response is age appropriate and meaningful.</p> <p>There appears to be difference of opinion between adults and young people about what is risky or dangerous. At times young people do not understand adult’s level of concern; and this can cause tension. Joint workshops with staff and young people will help them understand each other’s position and develop meaningful and effective responses to young people at risk.</p> <p>Young people commented on staff learning on the job and not having the confidence to deal with specific situations. All newly qualified and bank staff should have appropriate training and support.</p> <p>To address young people’s perception of an over the top response by the PSNI and carers, young people should be involved in any future review of Regional Guidance: Police Involvement in Residential Units, Safeguarding of Children Missing.</p> <p>There did not appear to be a standard response to young people when they return home from being missing. Some young people described difficulty disclosing information to staff and carers. They suggested having an independent person or advocate to help them share sensitive information more easily.</p> <p>Young people did not think that secure accommodation was an effective response to CSE. They would like help to develop strategies to avoid exploitative situations and relationships when placed back in the community.</p>
<p>A community response</p>	<p>Young people talked openly about widely known party houses where drugs and alcohol are available. Safeguarding authorities need to work with the local community to disrupt the activities of adults who would take advantage of young people.</p>

	<p>Young people talked about wanting to socialise and take part in activities as a way of avoiding risky or dangerous situations. We need to explore how youth and community groups provide safe but attractive ways for young people to socialise.</p> <p>The use of drugs and alcohol was raised by all young people. We need an updated and robust regional strategy to tackle the prevalence and impact of both legal highs and illegal substances.</p>
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Include Youth Working Group

1. Educating young people	<p>Key finding: Young people stated that sex education in school is poor and called for the delivery of a wider and more consistent curriculum.</p> <p>Recommendation: Young people suggested that schools provide more information on sex and relationships and that teachers be better trained to deliver this.</p>
2. Educating parents	<p>Key finding: Young people felt that parents and carers had a lack of awareness and understanding of CSE which could impact on their ability to talk to children about it.</p> <p>Recommendation: Young people suggested that parents and carers be provided with more information on CSE in order that they might confidently talk to children about it.</p>
3. Educating others	<p>Key finding: Young people felt there should be other adults they could talk with if they had a concern about CSE.</p> <p>Recommendation: Young people suggested that all professionals working with children receive appropriate training on CSE.</p>
4. Feeling supported	<p>Key finding: It was felt that young people who have police or social services involvement in their lives do not always feel supported and find it difficult to know who is on their side.</p> <p>Recommendation: It was suggested that young people involved in cases of CSE be better informed about the function of all professionals they come into contact with.</p>
5. Empowering young people	<p>Key finding: Young people stated that in attempts to protect children and young people the focus was often on increasing the powers of others rather than empowering them.</p> <p>Recommendation: Young people suggested they could be empowered through increased access to information.</p>

Parenting NI

<p>Summary of Section 5: Recommendations</p>	<p>Nearly all online respondents (98%) agreed that everyone has a responsibility for the safety of children. Whilst 88% said they felt that their children felt safe in the community in which they lived.</p> <p>Focus group participants identified their main concerns about CSE as: vulnerability of children/young people; not knowing how to deal with this as a parent; living in a highly sexualised society and inaction by authorities.</p>
<p>Eight Key Recommendations</p>	<p>Parents made eight key recommendations on what needs to be done to deal with CSE in Northern Ireland:</p> <ol style="list-style-type: none"> 1. Provide clear information/education about CSE; 2. Use effective methods of delivering CSE safety messages; 3. Help empower parents who have a key role in preventing CSE; 4. Strengthen the law around CSE; 5. Undertake CSE related research to inform good practice; 6. Training for all professionals in contact with children; 7. Clarify Protocols for reporting; 8. Invest in preventive work and support services for children and their families.

APPENDIX 2: INQUIRY TEAM BIOGRAPHIES

The Inquiry Team had six members, three external to Northern Ireland, (Kathleen Marshall, Sheila Taylor and Fiona Smith) and the others representing the three Northern Ireland inspectorates: Glenn Houston, Chief Executive of RQIA; Noelle Buick, Chief Inspector of ETI; and Derek Williamson, Inspector from CJI.

Kathleen Marshall is a child law consultant. Her early experience was in local government. From 1989 to 1994 she was Director of the Scottish Child Law Centre and since then her work has focused on children's rights. She chaired the Edinburgh Inquiry into Abuse and Protection of Children in Care, whose report, "Edinburgh's Children" was published in 1999. After 10 years as an independent child law consultant, Kathleen was appointed Scotland's first Commissioner for Children and Young People, with a remit to promote and safeguard children's rights. Since demitting office in 2009, she has been writing and speaking about children's rights and has assisted with a pilot scheme set up by the Scottish Government to listen to and acknowledge the experiences of adults brought up in residential care. Kathleen was a member of the team that undertook the Review of Youth Justice in Northern Ireland that reported in 2011.

Noelle Buick was appointed as Chief Inspector of the Education and Training Inspectorate (ETI) in May 2011 to lead the inspection of early years, schools, further education and training, youth, initial teacher education, learning and skills in prisons and DCAL funded provision. Noelle also leads the Inspectorate in its inspection of the safeguarding arrangements that education and training organisations put in place to protect children and young people. This includes reporting on the quality of safeguarding arrangements on every inspection and following-up on provision that needs improved. Noelle, a graduate of Queen's University, Belfast, has been an inspector since 1998. She has previously worked for the Further Education Funding Council (Inspectorate), the Adult Learning Inspectorate and Ofsted – the Office for Standards in Education, Children's Services and Skills.

Glenn Houston joined RQIA as Chief Executive in March 2009. A social worker by profession, Glenn was Director of Women's and Children's Services and Executive Director of Social Work in the Northern Health and Social Care Trust between 2007 and 2009. Since joining RQIA he has been involved in a number of thematic reviews including, child protection, fostering services and the Northern Ireland Guardian Ad Litem Agency (NIGALA). Glenn has over 30 years' experience working in health and social care services in Northern Ireland, and was also Chief Executive of the former Craigavon and Banbridge Community Trust between 2004 and 2007.

Fiona Smith undertook a combined RGN/RSCN course at Great Ormond Street, London. Following qualification she moved to Nottingham where she held a variety of posts and was involved in numerous projects aimed at enhancing services for children and their families. Prior to taking up post as the Royal College of Nursing Adviser in the autumn of 2001, Fiona was Associate Director of Nursing/Paediatric Advisor and Named Nurse for Child Protection in Leicester, a post she had held for approximately six years. As the RCN Adviser in Children's and Young People's Nursing, Fiona provides professional support to all members, staff and a range of over 40 forums and special interest groups in the field of children's and young people's nursing, including paediatric and neonatal intensive care, adolescent health, school nurses, looked after children and child protection professional forums. Fiona works nationally and internationally, collaborating with other organisations in relation to health, social care and education, to actively shape policy and service provision for children and young people.

Fiona is the coordinator of the Paediatric Nursing Associations of Europe and an Honorary Fellow of the Royal College of Paediatrics and Child Health. She has led intercollegiate professional activity across royal colleges and professional bodies to establish agreed policies, safeguarding and looked after children roles and competences for health care staff working with children and young people.

Sheila Taylor has been involved in tackling the issues involved with sexually exploited children and young people since 1999. She is extremely determined to highlight the problem of child sexual exploitation. She became the Chief Executive of the NWG Network from July 2011. NWG is a network organisation of over 595 organisations that all have an interest in tackling the issues of child sexual exploitation within the United Kingdom. Sheila works closely with Ministers, Children's Commissioners and the National Crime Agency and has also developed links across Europe, America and South East Asia with regard to sharing good practice with some of the countries that recognise internal trafficking as an issue. Sheila has been involved in the Office of the Children's Commissioner, Rotherham and Northern Ireland Inquiries, a number of serious case reviews and supporting professionals to 'Get It Right' at strategic and operational levels. In June 2011 she was awarded the MBE for her services to children, and in January 2013 was bestowed the honour of becoming an Honorary Master of the University of Derby.

Derek Williamson was appointed as an Inspector of Criminal Justice in Northern Ireland in June 2010. Since then he has led a number of high profile thematic and other inspections on behalf of Criminal Justice Inspection (CJI) Northern Ireland. He was formerly a Detective Chief Superintendent in the Police Service of Northern Ireland. During his policing career of over 30 years he specialised in areas including major crime investigation and child abuse. Derek holds a BA (Hons) in Social Policy and in June 2010 was graciously awarded the Queens Police Medal.

APPENDIX 3: METHODOLOGY

Establishment of the Inquiry

In September 2013, the Independent Inquiry into Child Sexual Exploitation (CSE) in Northern Ireland was commissioned under Article 35 of the Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003⁶⁰ by the Minister for Health, Social Services and Public Safety, Edwin Poots MLA and the Minister of Justice, David Ford MLA in a statement to the Northern Ireland Assembly. The Minister for Education, John O'Dowd MLA, agreed that the Education and Training Inspectorate (ETI) would enjoin the Inquiry to assist in relation to the role of schools and the statutory curriculum.

Arrangements to support and facilitate the Inquiry were established by the Regulation and Quality Improvement Authority (RQIA), Criminal Justice Inspection Northern Ireland (CJI) and the Education and Training Inspectorate (ETI). A project manager and project administrator from RQIA were identified to become the Inquiry Secretariat. As the Inquiry progressed, supplementary support for specific pieces of work was provided by project management and administration staff from the Reviews Directorate in RQIA. The Inquiry was managed using PRINCE2 project management methodology.

Following the appointment of the Inquiry Lead, Kathleen Marshall, the Minister for Health, Social Services and Public Safety made a further statement to the NI Assembly in November 2013 announcing the agreed terms of reference.

An Inquiry Board was established during November 2013 when roles and responsibilities were agreed, as well as a schedule of meetings. This included representation from the Inquiry Lead, the Chief Executive of the National Working Group Network (NWG), Sheila Taylor and the Chief Executive from RQIA, Chief Inspector from ETI and an Inspector from CJI. Fiona Smith, Children and Young People's Advisor from the Royal College of Nursing, joined Inquiry Board in late December 2013, bringing expertise from a health perspective.

An outline methodology was agreed which would include:

- Engagement with key stakeholders
- Engagement with children, young people and parents
- A call for evidence
- Interviews/engagements emanating from the call for evidence
- Separate workstreams to include engagement with the three sectors, ie: health and social care, criminal justice and education

As the Inquiry moved into engagement, both an Ethics Strategy and a Protocol for Rules of Direct Engagement with Individual Young People via External Agencies were agreed and utilised.

⁶⁰ <http://www.legislation.gov.uk/nisi/2003/431/contents/made>

In order to ensure access to the Inquiry, a website was launched in December 2013 and a dedicated email address established. The RQIA Twitter account was also used to tweet key messages. A Post Office box for anyone who wished to contact the Inquiry, to include those who wished to submit information anonymously was also provided from June 2014.

Engagement with Stakeholders

Initial engagement took place with key stakeholders in November 2013 and engagements with a wide ranging list of individuals, voluntary agencies and community groups, as well as organisations from the statutory sector continued throughout the duration of the Inquiry. Engagements also covered England, Scotland and the Republic of Ireland.

A list of contributors to the Inquiry can be found at Appendix 4.

Various engagements also took place with officers from SBNI to ensure communication in relation to the Thematic Review being undertaken by SBNI.

In December 2013, members of the Inquiry Board appeared before the NI Assembly Committee for Health, Social Services and Public Safety. Progress reports were provided to the Ministers for Health, Justice and Education through the three inspectorates, and in June 2014 the Inquiry Lead met with the Minister for Health to provide a verbal update.

Stakeholder events were held as follows:

- Stakeholder Event for the voluntary sector on 3 June 2014: this was attended by 14 representatives.
- Stakeholder Event for the statutory sector on 4 June 2014: this was attended by 83 representatives.

These events were utilised to further elicit views on the issues of CSE and to help inform the Inquiry. They were also used to take stock and check with stakeholders whether there was anything else that the Inquiry needed to do to ensure a full and robust engagement. Some high level themes that were emerging were also referred to, with the aim of identifying any gaps or areas that the Inquiry should be exploring further. Agreement was obtained at these events in terms of keeping any information confidential.

A targeted engagement also took place following the stakeholder event in June 2014 when the Inquiry Lead contacted a wide range of royal colleges and professional associations, requesting that they disseminate information to all members.

The stakeholder events in June 2014 were followed by a stakeholder event on 10 September 2014 which was attended by 73 representatives from all sectors. Again, high level themes that were emerging were shared and participants invited to share their expertise in how arrangements for identifying, tackling and preventing CSE could be improved in Northern Ireland. Agreement was obtained at these events in terms of keeping any information confidential.

Call for Evidence

A call for evidence was launched on 11 December 2013, with a closing date of 18 March 2014 (14 weeks). Forty-one submissions were received by the closing date.

However, the Inquiry continued to receive submissions up to mid-October 2014, resulting in 50 submissions from both organisations outlining their policy and practice in relation to CSE and individuals, some of whom came forward to share their personal experience, or the experience of a family member, of CSE. Evidence submissions were forwarded to the Inquiry's dedicated email inbox or mailed to the RQIA postal address. A telephone number was provided for anyone wishing to meet with the Inquiry Team to give oral evidence.

Oral evidence sessions were also held with several individuals to clarify details from their submissions.

A list of those who contributed to the call for evidence is outlined in Appendix 4: Contributors to the Inquiry.

Engagement with Children, Young People and Parents

In order to ensure the Inquiry approached the engagement with children, young people and parents in the most appropriate way to undertake a robust engagement, the Inquiry Lead met with groups of parents from Parenting NI and Youth Justice to harness their suggestions in January 2014.

The first engagement with children and young people was in early February 2014 with over 40 young people from the NI Commissioner for Children and Young People's (NICCY) Youth Panel. This allowed the Inquiry Lead to hear what the young people's perception of CSE was and how the Inquiry could best engage with children and young people. This was followed by a further engagement with the Panel and the Inquiry Lead in June 2014.

The Inquiry commissioned three separate pieces of work:

1. **Children in Northern Ireland (CiNI) via Participation Network** to engage with children and young people living at home. This engagement would include children and young people from across NI in both urban and rural environments, incorporating specific groups such as black, minority ethnics (BME); lesbian, gay, bisexual, transgender (LGBT), young mothers and staff working with those children/young people with disabilities.

This resulted in engagement via focus groups and semi-structured interviews with 64 children and young people from:

- Gay and Lesbian Youth NI (GLYNI)
- Enniskillen Youth Action Leadership Programme
- Western Education and Library Board Youth Group in Londonderry
- Southern Education and Library Board Youth Group in Craigavon
- Staff from Barnardo's Disabled Children and Young People's Participation Project

The full CiNI (Participation Network) report can be accessed on the RQIA website at: www.rqia.org.uk and on the CiNI website at: www.ci-ni.org.uk.

2. The **Voice of Young People in Care (VOYPIC)** to engage with children and young people in care.

This resulted in engagement via focus groups with 55 children and young people in care from:

- non relative foster care
- kinship care
- children's residential homes
- independent living
- secure accommodation

The full VOYPIC report can be accessed on the RQIA website at: www.rqia.org.uk and on the VOYPIC website at: www.voypic.org.

3. **Parenting NI** to engage with parents. This engagement included parents from across NI in both urban and rural environments, incorporating black and minority ethnic (BME) parents and parents who have children/young people with a disability.

This resulted in engagement with over 200 parents. Twenty-four parents attended focus groups and 183 parents responded to an online survey.

The full Parenting NI report can be accessed on the RQIA website at: www.rqia.org.uk and on the Parenting NI website at: www.parentingni.org.

From the outset, Inquiry Board explored the idea of forming a group of young people to inform and advise the Inquiry. This culminated in the commissioning of **Include Youth** who brought together a group of 19 young people.

The group was drawn from a range of organisations from across NI which had been involved in the earlier engagements. The working group included young people from:

- Children's Law Centre
- GLYNI
- Include Youth
- VOYPIC
- Youth Action

Others invited to participate felt that due to the sensitive nature of the topic and the specific experiences of the young people they worked with, this method of involvement would not be beneficial. In such instances alternative methods to feed into the group were offered.

The working group had representation from male/female, urban/rural environments, different religious and ethnic backgrounds, and included those with disabilities and caring responsibilities.

The working group came together over a number of days in order to share ideas, consider the challenges of addressing CSE and to respond to questions raised by the Inquiry.

It was agreed that the Working Group should feed into the stakeholder event in June 2014 and a DVD was produced by the Working Group and presented to stakeholders at the event.

The full Include Youth Working Group report can be accessed on the RQIA website at: www.rqia.org.uk and on the Include Youth at: www.includeyouth.org.

Further engagement with **children and young people** took place as follows:

- Direct engagement with young people from year 10 and 11 in schools took place and is described under the education sector workstream.
- Individual interviews with three young people from the Barnardo's Safe Choices Service in Northern Ireland who came forward to share accounts of their personal experience of CSE in Northern Ireland.
- Individual interviews with five individuals (now adults) who came forward to share accounts of their personal experience of CSE, previously as a child/young person in Northern Ireland.

Further engagement with **parents** took place as follows:

- An individual interview with a parent who came forward to share the account of their child's experience of CSE in Northern Ireland.
- A thematic survey by ETI as part of the education sector workstream which resulted in engagement with 570 parents and carers of Year 10 and 11 pupils in post primary schools who responded to parental questionnaires.
- ETI also engaged with 17 parents in special schools.

The engagement with children, young people and parents examined the terms of reference to:

- seek the views of children and young people in Northern Ireland and other key stakeholders;
- engage with parents to identify the issues they are facing and seek their views on what needs to be done to help them keep their children safe from the risk of CSE;
- seek to establish the nature of CSE in Northern Ireland and a measure of the extent to which it occurs;
- examine the effectiveness of current cross sectoral child safeguarding and protection arrangements and measures to prevent and tackle CSE; and
- consider specific safeguarding and protection issues for looked after children.

Criminal Justice Workstream

A workstream to engage with the criminal justice sector was established in March 2014.

The workstream included:

- Validation of submissions to the Inquiry.
- Semi-structured interviews and focus groups with close to 120 PSNI staff (this included: Public Protection and Child Abuse Inquiry Units;

Response and Neighbourhood policing disciplines; Public Protection Unit Inspectors; Youth Diversion Officers; Missing Vulnerable Adults Unit, Domestic Abuse Officers, PSNI senior command and management from Public Protection.

- A meeting with Human Trafficking lead in the PSNI.
- A meeting with Director of Public Prosecution and Senior Public Prosecutors.
- Semi-structured interviews and focus groups with seven staff from the Public Prosecution Service including specialist sexual crime practitioners and Assistant Directors.
- Engagement with the Northern Ireland Prison Service (NIPS).
- Meetings with the Probation Service, NI Courts Service, and the Department of Justice (DOJ).
- Engagement with the Youth Justice Agency.
- A visit to Woodland Juvenile Justice Centre.
- Engagement with the Judiciary.

This workstream examined the terms of reference to:

- seek to establish the nature of child sexual exploitation (CSE) in Northern Ireland and a measure of the extent to which it occurs;
- examine the effectiveness of current cross sectoral child safeguarding and protection arrangements and measures to prevent and tackle CSE;
- consider specific safeguarding and protection issues for looked after children

In total there were more than 30 separate meetings with over 130 people seen (some on multiple occasions).

Education Workstream

A workstream to engage with the education sector was established in March 2014.

The workstream included:

- Validation of submissions to the Inquiry.
- A Thematic Survey which included:
 - Engagement with over 353 Year 10 and 11 pupils from 20 post-primary schools and four special schools
 - Engagement with 570 parents and carers of Year 10 and 11 pupils in post primary schools who responded to parental questionnaires
 - Engagement with 17 parents in special schools
 - Engagement with designated staff such as Chairs of Governors, Head Teachers and pastoral staff
 - A review of the personal development curriculum
 - Cluster group meetings with staff from the Education Welfare Service, Child Protection Service for Schools, Educational Psychology Service, Independent Counselling Service for Schools, Primary Schools, Further Education Student Support Manager Forum, Teacher Training Institutions, Alternative Education Providers Group and the Education and Library Boards; Department of Employment and Learning and the ETI Associate Assessors and Safeguarding Panel

The full report of the ETI Thematic Survey can be accessed on the ETI website: www.etini.gov.uk.

This workstream examined the terms of reference to:

- seek the views of children and young people in Northern Ireland and other key stakeholders; and
- engage with parents to identify the issues they are facing and seek their views on what needs to be done to help them keep their children safe from the risk of CSE.
- seek to establish the nature of child sexual exploitation (CSE) in Northern Ireland and a measure of the extent to which it occurs;
- examine the effectiveness of current cross sectoral child safeguarding and protection arrangements and measures to prevent and tackle CSE;
- consider specific safeguarding and protection issues for looked after children

Health and Social Care Workstream

A workstream to engage with the health and social care sector was established in March 2014. The workstream included:

- Validation of submissions to the Inquiry.
- Completion of a self-assessment by staff from the five HSC trusts.
- Meetings and focus groups with over 200 social care staff from across the five HSC trusts, to include frontline practitioners, executive management, senior management and middle management.
- Meetings and focus groups with over 80 health care professional staff from community health services, primary care services, emergency and unscheduled care services, maternity services, mental health and learning disability services, CAMHS, sexual health and family planning services, school nurses and the family nurse coordinators.
- A meeting with senior management staff and clinical support officers from the NI Ambulance Service Trust.
- A meeting with staff from the CAMHS unit at Beechcroft.
- A meeting with and visit to the Northern Ireland Sexual Assault Referral Centre (SARC) at the Rowan.
- A meeting with senior management and guardians from the Northern Ireland Guardian Ad Litem Agency (NIGALA).
- Meetings with RQIA Children's Team, Regulation Directorate.
- Meetings with the DHSSPS, HSC Board, PHA, SBNI and representatives from other regional groups such as the Northern Ireland Sexual Health Improvement Network and the Children and Young People's Strategic Partnership (CYPSP).
- Visits to two children's residential homes in Lurgan and in Downpatrick
- Completion of an online survey by 42 children's residential care homes across NI to examine numbers of children occupying places, numbers, status and grades of staff and numbers and arrangements of children going missing over two periods during September 2014.
- A meeting with NI Fostering Network.

This workstream examined the terms of reference to:

- seek to establish the nature of child sexual exploitation (CSE) in Northern Ireland and a measure of the extent to which it occurs;
- examine the effectiveness of current cross sectoral child safeguarding and protection arrangements and measures to prevent and tackle CSE;
- consider specific safeguarding and protection issues for looked after children

APPENDIX 4: CONTRIBUTIONS TO THE INQUIRY

Engagement with Children, Young People and Parents

Engagement with over 40 young people from the NI Commissioner for Children and Young People's (NICCY) Youth Panel.

Engagement with 64 children and young people in consultations facilitated by the Children in Northern Ireland Participation Network from: Gay and Lesbian Youth NI (GLYNI), Enniskillen Youth Action Leadership Programme, Western Education and Library Board Youth Group in Derry/Londonderry, Southern Education and Library Board Youth Group in Craigavon and staff from Barnardo's Disabled Children and Young People's Participation Project.

Engagement with 55 children and young people in care in consultations facilitated by Voice of Young People in Care (VOYPIC), from: non relative foster care; kinship care; children's residential homes; independent living; and secure accommodation.

Engagement with 353 Year 10 and 11 pupils from 20 post-primary schools, and 46 young people in four special schools via the Education and Training Inspectorate (ETI).

Engagement with 19 young people via Include Youth established as part of a group of young people to inform and advise the Inquiry.

Individual interviews with three young people from the Barnardo's Safe Choices Service in Northern Ireland who came forward to share accounts of their personal experience of CSE in Northern Ireland.

Individual interviews with five individuals who came forward to share accounts of their personal experience as a child/young person of CSE in Northern Ireland.

An individual interview with a parent who came forward to share the account of their child's experience of CSE in Northern Ireland.

Engagement with over 200 parents via Parenting NI (24 parents attending focus groups and 183 parents responding to an online survey).

Engagement with 570 parents and carers of Year 10 and 11 pupils in post primary schools who responded to parental questionnaires via the ETI.

Engagement with 17 parents in special schools via the ETI.

Information Received by the Inquiry via the Call for Evidence

1. Action for Children NI
2. Ards PCSP
3. Barnardo's NI
4. Brook NI
5. Carrickfergus Grammar School
6. Catholic Church - Archdiocese of Armagh
7. Children's Law Centre
8. College of Agriculture Food and Rural Enterprise
9. CSE Knowledge Transfer Partnership
10. Health and Social Care Board
11. Include Youth
12. National Crime Agency
13. National Society for the Prevention of Cruelty to Children
14. NI Association of Social Workers
15. NI Guardian Ad Litem Agency
16. NI Human Rights Commission
17. North Eastern Education and Library Board, Education Other Than At School
18. Northern Health and Social Care Trust
19. Parenting NI
20. Parents Against Child Sexual Exploitation
21. Police Service of Northern Ireland
22. Probation Board of Northern Ireland
23. Public Health Agency
24. Royal College of Nursing
25. Royal College of Paediatrics and Child Health
26. Royal College of Speech and Language Therapists
27. Safeguarding Board for Northern Ireland
28. School of Nursing and Midwifery, Queen's University Belfast
29. South Eastern Domestic Violence Partnership
30. South Eastern Health and Social Care Trust
31. Southern Health and Social Care Trust
32. St Columban's College
33. St Mary's High School, Downpatrick
34. Stranmillis University College
35. Therapeutic Support Service/Child Care Centre, Belfast Health and Social Care Trust
36. Voice of Young People in Care
37. Western Health and Social Care Trust
38. Women's Aid Federation NI
39. Youth Justice Agency

A further 11 submissions to the Call for Evidence were made from others who did not want their identifying details to be published.

Engagement and Meetings with Individuals and Organisations

EDUCATION SECTOR:

- Alternative Education Providers Group
- Child Protection Service for Schools
- Education Welfare Service
- Educational Psychology Service
- Education and Training Inspectorate
- Further Education Support Manager Forum
- Independent Counselling Service for Schools
- Initial Teacher Educators
- Not in Education, Employment or Training Group
- Post Primary Schools Staff via the ETI workstream
- Primary School Staff: Principals via the ETI workstream
- Special Schools via the ETI workstream
- Teacher Training Institutions

CRIMINAL JUSTICE SECTOR:

- Community Safety Branch, Department of Justice
- Department of Justice
- NI Courts Service
- NIPS Head of Psychology
- PSNI A District Public Protection Unit Staff
- PSNI A District Response and Neighbourhood staff
- PSNI B District Public Protection Unit staff
- PSNI B District Response and Neighbourhood staff
- PSNI C District Response and Neighbourhood staff
- PSNI C District Public Protection Unit staff
- PSNI D District Public Protection Unit staff
- PSNI D District Response and Neighbourhood staff
- PSNI E District Response and Neighbourhood staff
- PSNI E District Public Protection Unit staff
- PSNI F District Response and Neighbourhood staff
- PSNI F District Public Protection Unit staff
- PSNI G District Public Protection Unit staff
- PSNI G District Response and Neighbourhood staff
- PSNI H District Public Protection Unit staff
- PSNI H District Response and Neighbourhood staff
- PSNI Lead for Human Trafficking
- PSNI Public Protection Unit Inspectors
- PSNI Youth Diversion Officers
- PSNI Assistant Chief Constable, Service Improvement Department
- PSNI Head of Public Protection
- Public Prosecution Service Director of Public Prosecution and Senior Public Prosecutor
- Public Prosecution Service Senior Prosecutors
- Woodlands Juvenile Justice Centre
- Youth Justice Agency

HEALTH AND SOCIAL CARE SECTOR:

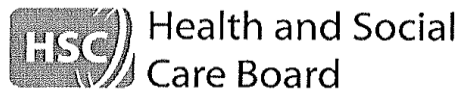
- Belfast Health and Social Care Trust: Senior Management and staff from social care services from Gateway Team, Family Intervention/Support Team; LAC Team; Residential Care Team; Fostering Team; Leaving and After Care/16+ Team and Safeguarding Leads
- Northern Health and Social Care Trust: Senior Management and staff from social care services from Gateway Team, Family Intervention/Support Team; LAC Team; Residential Care Team; Fostering Team; Leaving and After Care/16+ Team and Safeguarding Leads
- South Eastern Health and Social Care Trust Senior Management and staff from social care services from Gateway Team, Family Intervention/Support Team; LAC Team; Residential Care Team; Fostering Team; Leaving and After Care/16+ Team and Safeguarding Leads
- Southern Health and Social Care Trust Senior Management and staff from social care services from Gateway Team, Family Intervention/Support Team; LAC Team; Residential Care Team; Fostering Team; Leaving and After Care/16+ Team and Safeguarding Leads
- Western Health and Social Care Trust: Senior Management and staff from social care services from Gateway Team, Family Intervention/Support Team; LAC Team; Residential Care Team; Fostering Team; Leaving and After Care/16+ Team and Safeguarding Leads
- Northern Ireland Ambulance Service Trust: Senior Management and Clinical Support Officers
- Health Care Professionals from:
 - CAMHS Unit at Beechcroft
 - Community Health Services and Primary Care, eg: health visitors, pharmacists
 - Emergency and Unscheduled Care
 - Family Nurse Coordinators
 - Maternity Services
 - Mental Health and Learning Disability: CAMHS, Drug and Alcohol Services.
 - School Nurses
 - Sexual Health and Family Planning Services
- Children and Young People's Strategic Partnership
- Children's Residential Home Staff: Lurgan
- Children's Residential Home Staff: Downpatrick
- Department of Health, Social Services and Public Safety
- Health and Social Care Board

- Northern Ireland Assembly: Health, Social Services and Public Safety Committee
- Northern Ireland Guardian Ad Litem Agency
- Northern Ireland Sexual Health Improvement Network
- Public Health Agency
- RQIA Children’s Team, Regulation Directorate
- Safeguarding Board for Northern Ireland
- Staff from over 40 children’s residential homes across Northern Ireland (contributing to an online survey)
- The Rowan: Northern Ireland Sexual Assault Referral Centre

We also had meetings with representatives from 18 agencies in the voluntary sector as well as 6 individuals and persons associated with the CSE Inquiries in England and Scotland and the Historical Institutional Abuse Inquiry in Northern Ireland.

APPENDIX 5: MISSING CHILDREN STRATEGIC ACTION PLAN

Annex B



STRATEGIC ACTION PLAN

CHILDREN MISSING FROM HOME OR CARE

August 2010

**Strategic Action Plan
Children Missing from Home or Care**

Background

It is important that everyone is aware of the risk associated with situations where children and young people go missing, given the vulnerability of young people and the risks they are exposed to when missing from home or care.

Children and young people, whilst missing, are not protected by responsible adults and may be subjected to pressures they would not normally have to face, resulting for example in hitchhiking for transport, or stealing to eat, or being exploited by peers or adults as a consequence of their increased vulnerability.

Practice experience and research show that the more often children and young people go missing, the more risks they face and the less anchored they become to their home or carers.

Key Findings from Research

Research undertaken on young runaways in Northern Ireland in 2001 (Lost Youth, P Raws) highlighted the following:

- Almost one in ten young people in Northern Ireland will run away, or be forced to leave home overnight, before they are 16, with over 2,000 young people under 16 running away from home each year;
- One in five of overnight runaways had first run when under the age of eleven (and this group are more likely to run away repeatedly after the first incident);
- Prevalence rates are similar for different areas of the Province - urban, suburban and rural;
- There is no difference in running away rates between males and females, in contrast to the UK as a whole where young women are more likely to run away;
- One in seven of those away for at least one night said that they had been forced to leave home;

- Most young people only run away once but one in five go on to run away on three or more occasions; and
- The majority of young people stay away for just one night but around a quarter had spent a week or more away from home.

In addition the research found:

- The main reason for running away is problems at home – mostly arguments and conflict (27%) – often aggravated by personal problems or problems at school;
- More than a quarter of young runaways said they left because of physical abuse (or the threat of it), emotional abuse or neglect;
- Young people who run away repeatedly have particularly high levels of family disruption and problems; and
- Running away from substitute care is a significant and complex phenomenon. Most young people who go missing from care are *continuing* to run *within* care rather than *starting* to run from care.

When children are missing the research found:

- Around one in twelve young people said that they had been sexually assaulted while they were away from home;
- Most young people had a place to stay whilst away from home – either with friends (33%) or relatives (25%). But 36% said that they had slept rough. This figure is significantly higher than that found for the UK as a whole (25%);
- There is an identifiable high-risk group of young people who run away more frequently, for longer periods and are more likely to sleep rough than is the case for “average runaways”;
- Most young people remain in their local areas when they run away;
- Across the UK there was no discernible ‘career’ for those who ran away more than once: no coherent, consistent or developing pattern of experiences; and

- Young people who run away repeatedly do face more risks, but this was apparent in their experiences from the first time they ran.

Children Missing from Home and Care

Analysis of police missing person management systems within England and Wales, and other research suggests that the majority of children who runaway or go missing do so from their family home. Looked after children are a much smaller proportion of young people who run away although they are far more likely to be reported as missing, and also far more likely to run away repeatedly, so account for the larger number of missing person incidents that the police deal with. Many of the actions that should be taken to investigate an instance of missing and ensure a child's safety are the same whether the child has gone missing from their family home, or from the care of a Trust.

Regardless of whether a child is living with their family, are in a Trust children's home or in foster care, running away should be seen as a sign that something is wrong in their lives. All instances of running away brought to the attention of Trusts should be taken seriously and acted on.

Looked-after children are particularly vulnerable and may be targeted by those wishing to abuse and exploit them. These children depend on the Trust to act as their 'corporate parent'. A care-placement where the child or young person feels safe and secure, and where their concerns are taken seriously, is likely to be the most effective way of reducing the likelihood that they will be motivated to run away. However, it may be necessary to take extra measures to make sure that they are effectively safeguarded and protected from exploitation.

Sexual Exploitation

Children may go absent or missing following grooming by adults who will seek to exploit them sexually. The supply of drugs and alcohol or the offering of gifts may be used to entice or coerce children into associations with inappropriate adults. Both girls and boys are at risk of

sexual exploitation and those living within residential care units are particularly vulnerable to being directly targeted in this way. Encouraging children to run in order to disrupt their placement is often part of the abuse.

In some instances individuals may allow children to be in their company e.g. to stay in their home or to associate with them in other places, even arranging for transport and without informing the child's carer of their intentions. They either directly or indirectly encourage them to go missing or to stay away from their carers. This can lead to an increase in the number of children who are reported as missing or unauthorised absence. Such acts can be considered to be a form of abduction.

Some of these individuals actually target these children for the purpose of exploiting their vulnerabilities and as a result serious offences may be committed against these children.

Looked After Child Trafficked from Abroad

Some looked after children may be unaccompanied asylum-seeking children and some of this group may have trafficked into the UK and are likely to remain under the influence of their traffickers, even whilst they are looked after.

The process of assessment and related risk assessment will have to be sensitively managed and provision may have to be made for the child to be in a safe place before an assessment is complete bearing in mind that the child may not be in a position to disclose full information about their circumstances immediately.

Strategic overview

Safeguarding and promoting the welfare of children – and in particular protecting them from significant harm – depends on effective joint-working between agencies and professionals that have different roles and expertise.

Individual children, especially some of the most vulnerable children and those at greatest risk of social exclusion, need co-ordinated

help from health, education, children's social care, the Police, the voluntary sector and other agencies.

In order to achieve effective joint-working, there needs to be constructive relationships between individuals in a range of agencies. It is vital that those with strategic responsibility in the statutory agencies concerned build up good working relationships to agree the level and type of information to monitor and review local arrangements for responding to children who go missing.

Clearly the issue of children and young people going missing from home or care is not a new issue and work to reduce and manage the risks involved has been ongoing. In particular, in April 2009 the four Area Child Protection Committees agreed a regional protocol to support joint working between the Police and Social Services both in relation to children's residential care and where children go missing from home and foster care. DHSSPS also funded the Safe Choices project to raise awareness and provide training to key professionals around sexual exploitation.

Practice experience and the publication of The Department of Children and Families July 2009 Statutory Guidance on Children who Run Away and Go Missing from Home or Care and The National Policing Improvement Agency Draft Guidance on the Management, Investigation and Recording of Missing Persons have prompted a review of the arrangements currently in place in respect of missing children.

Missing Children Strategic Action Plan				
Strategic Area	Action	Responsible Organisation	Date	
Statistical Information	Baseline current information from within the Corporate Parenting Report for LAC.	HSCB	September 2010	
	Implement the revised Untoward Incident reporting mechanism by Trusts to the HSCB to include children going missing.	HSCB/HSCT	September 2010	
Regional Guidance	Review and amend the statistical data sets to; <ul style="list-style-type: none"> i. Improve strategic oversight of missing children issue ii. Monitor the implementation of the revised joint protocol iii. Synchronise the data collation between HSCB and PSNI iv. Support the RCPC in the safeguarding of children going missing within the community. 	HSCB/PSNI/ HSCT/RCPC	December 2010	
	Complete the revision of the Regional Joint Protocol between Police and Social Services: Children Missing from Home and Foster Care and Police Involvement in Residential Units.	HSCB/PSNI	January 2011	
	Joint training for Police Officers and Social Workers.	HSCB/PSNI HSCT/Voluntary	February to April 2011	

		Organisations	
	Fully implement Joint Protocol.	HSCB/PSNI HSCCT/Voluntary Organisations	April 2011
	Review operation of Joint Protocol using revised data set.	HSCB/PSNI	October 2011
Local Oversight Arrangements	Establish arrangements within each Health and Social Care Trust area to monitor Police involvement in residential care units including the response to children going missing and children at risk of sexual exploitation.	HSCCT/PSNI/Voluntary organisations	April 2011

<p>Sexual Exploitation</p>	<p>Establish Safe Choices working group as a sub committee of the Regional Child Protection Committee to provide strategic oversight for safeguarding children of risk of sexual exploitation. Report on safeguarding issues and outcomes in the business plan.</p>	<p>RCPC</p>	<p>April 2010</p>
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HSC Board Strategic Action Plan: Children Missing from Home or Care

Update at September 2013:

Missing Children Strategic Action Plan					
Strategic Area	Action	Responsible Organisation	Date	Updates September 2013	
Statistical Information	Baseline current information from within the Corporate Parenting Report for LAC.	HSCB	September 2010	Completed	
	Implement the revised Untoward Incident reporting mechanism by Trusts to the HSCB to include children going missing.	HSCB/HSCT	September 2010	The Board has also developed an untoward events process which requires a report for each episode of a young person missing for over 24 hours to be supplied to a single point in the Board for review. Professional follow up if necessary and information collation. Completed	
	Review and amend the statistical data sets to; i. Improve strategic oversight of	HSCB/PSNI/HSCT/RCPC	December 2010	The Board has amended the Delegated Statutory Functions reporting information from the Trusts to include more detail.	

Strategic Area	Action	Responsible Organisation	Date	Updates September 2013
	<p>missing children issue</p> <ul style="list-style-type: none"> ii. Monitor the implementation of the revised joint protocol iii. Synchronise the data collation between HSCB and PSNI iv. Support the RCPC in the safeguarding of children going missing within the community. 			<p>Initial changes required reporting on individual childrens homes, number of young people and the number of episodes per each young person. A further change was introduced from April 13 to include not only young people missing for more than 24 hours but also the collated information regarding the total number of contacts from a home to the police with the reason. The first report is due 30 Sept. 13.</p> <p>Regarding synchronising data collection between HSC and PSNI. Initial discussions took place and contact was made by Board information Officers but this has not progressed further on a regional basis. This is</p>

Strategic Area	Action	Responsible Organisation	Date	Updates September 2013
Regional Guidance	Complete the revision of the Regional Joint Protocol between Police and Social Services: Children Missing from Home and Foster Care and Police Involvement in Residential Units.	HSCB/PSNI	January 2011	<p>now an aspect of the SBNI role. Ongoing</p> <p>The Regional Guidance documentation was revised In April 2011 and revised again in May 12. Completed</p>
	Joint training for Police Officers and Social Workers.	HSCB/PSNI HSCT/ Voluntary Organisations	February to April 2011	<p>The Guidance was revised further and reissued in May 2012 (copy attached) Joint training was in the process of being planned for Autumn 2012 when in the light of possible changes to the National ACPO Guidance in this area PSNI requested that the training be put on hold until the situation became clearer. Ongoing</p>

Strategic Area	Action	Responsible Organisation	Date	Updates September 2013
	Fully implement Joint Protocol.	HSCB/PSNI HSCT/ Voluntary Organisations	April 2011	As outlined above Completed with the exception of joint training.
	Review operation of Joint Protocol using revised data set.	HSCB/PSNI	October 2011	Ongoing
Local Oversight Arrangements	Establish arrangements within each Health and Social Care Trust area to monitor Police involvement in residential care units including the response to children going missing and children at risk of sexual exploitation.	HSCT/PSNI/ Voluntary organisations	April 2011	Included within the revised guidance-ongoing.

Strategic Area	Action	Responsible Organisation	Date	Updates January 2011
<p>Sexual Exploitation</p>	<p>Establish Safe Choices working group as a sub committee of the Regional Child Protection Committee to provide strategic oversight for safeguarding children of risk of sexual exploitation.</p> <p>Report on safeguarding issues and outcomes in the business plan.</p>	<p>RCPC</p>	<p>April 2010</p>	<p>SBNI have taken this forward as a key objective and set in place the necessary working group arrangements – completed</p> <p>Ongoing</p>

APPENDIX 6: ABBREVIATIONS USED

BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CAWT	Cooperation And Working Together
CCEA	Council for the Curriculum Examinations and Assessment
CEOP	Child Exploitation and Online Protection Centre
CiNI	Children in Northern Ireland
CJI	Criminal Justice Inspection Northern Ireland
CPSSS	Child Protection Support Service for Schools
CSE	Child Sexual Exploitation
CYPSP	Children and Young People's Strategic Partnership
DE	Department of Education
DEL	Department for Employment and Learning
DHSSPS	Department of Health, Social Services and Public Safety
DOJ	Department of Justice
ECHR	European Convention on Human Rights
ELB	Education and Library Board
EOTAS	Education Other Than At School
ETI	Education and Training Inspectorate
EWS	Education Welfare Service
GEM	Going the Extra Mile Scheme
GUM clinic	Genitourinary Medicine clinic
HSC	Health and Social Care
HSC Board	Health and Social Care Board
HSC trust(s)	Health and Social Care trust(s)
ICSS	Independent Counselling Service for Schools
ISVA	Independent Sexual Violence Advisors/Advocate
JJC	Juvenile Justice Centre (Woodlands)
LAC	Looked After Children
LGBT	Lesbian, Gay, Bisexual and Transgender
LSCBs	Local Children's Safeguarding Boards
MLA	Member of the Legislative Assembly
NCA	National Crime Agency
NCB	National Children's Bureau
NCALT	National Centre for Applied Learning Technologies
NIAS	Northern Ireland Ambulance Service Trust
NICTS	Northern Ireland Courts and Tribunals Service
NIGALA	Northern Ireland Guardian Ad Litem Agency
NIHE	Northern Ireland Housing Executive
NIHRC	Northern Ireland Human Rights Commission
NIPS	Northern Ireland Prison Service
NRM	National Referral Mechanism
NSPCC	National Society for the Prevention of Cruelty to Children
NWG Network	NWG Network Tackling Child Sexual Exploitation
OCC	Office of the Children's Commissioner for England
OFMDFM	Office of the First Minister and Deputy First Minister
PACE	Parents Against Child Sexual Exploitation

PBNI	Probation Board for Northern Ireland
PHA	Public Health Agency
PPANI	Public Protection Arrangements in Northern Ireland
PPS	Public Prosecution Service
PPU	Public Protection Unit
PSNI	Police Service of Northern Ireland
RCN	Royal College of Nursing
RCSLT	Royal College of Speech and Language Therapists
RQIA	Regulation and Quality Improvement Authority
RoSHOs	Risk of Sexual Harm Orders
SARC	Sexual Assault Referral Centre
SBNI	Safeguarding Board for Northern Ireland
SOPOs	Sexual Offences Prevention Orders
TCI	Therapeutic Crisis Intervention
UCL	University College London
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
VOYPIC	Voice of Young People in Care
VWCU	Victim and Witness Care Unit
YJA	Youth Justice Agency
YLT	Young Life and Times

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