SBNI
Safeguarding Board for Northern Ireland

Getting Focused and Staying Focused

'Looked After Children', Going Missing and Child Sexual Exploitation

A THEMATIC REVIEW

Professor John Pinkerton
Dr Lisa Bunting • Dr David Hayes • Dr Anne Lazenbatt

Queen's University Belfast

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August 2015

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Acknowledgements

The authors would like to thank all those who contributed in various ways, large and small, to this Thematic Review. We are particularly appreciative of the decision by ten young people to allow us access to their case files and to the three of them and one parent, who also discussed their experiences with us.

We also recognise as central to the Thematic Review, the experience and judgement brought to it by the work of the File Reviewers. Our thanks to them.

We very much appreciated the full co-operation of staff, at all levels of the organisations, who provided us with the information we required, in agreeing and working through a complicated, time consuming but necessary process.

The discussions with those actively involved with delivering and developing practice and policy for 'Looked After Children' in the area of CSE were very helpful to us – so thank you to all those who took part in them.

We acknowledge the valuable advice and oversight provided by the three Independent External Advisors, Professor Jenny Pearce, Marion Davis and Assistant Chief Constable Peter Davies, which gave us a UK and international perspective. We also appreciated the advice, guidance and project management support we received from Hugh Connor, Glenys Johnston, Sharon Beattie, Helen McKenzie and Carol Carson at the SBNI.

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Preface

When this Review was first established, the Safeguarding Board of Northern Ireland (SBNI) was concerned to ensure that its objectivity and rigour should be of the highest order. We were each approached to act as External Advisors to the Review. Our role was not to conduct the Review, but to act as external objective advisors throughout the process of the Review. We were appointed to draw on our awareness of other examples of Child Sexual Exploitation (CSE) in other parts of the UK, our backgrounds collectively covering academic, child protection and law enforcement perspectives on CSE. This included exposure, at a national level, to much of the learning that has been derived from the growing number of cases reaching the public eye over the last five years. We have followed this Review from its inception in late 2013 to the publication of this report.

The interests of children must always be at the forefront of our minds and it is clear that this Review has been somewhat restricted - in terms of the number of cases examined in depth, for example - by the appropriate consideration of the rights of the victims and survivors of abuse (as explained on page 19). Whilst the case file methodology has limitations, it added a unique perspective. It is conceivable that more could have been learned from this Review if it had been possible to access all the relevant information, from all the relevant agencies, more quickly and comprehensively than proved to be the case. In addition, the time that was taken to complete the case record reviews meant that there was a limited scope for us, as External Advisors to explore the thematic nature of the findings with the full Review Team. However, those cases that could be reviewed have yielded important data which, through proper analysis here, have presented us with some stark and uncomfortable conclusions.

It is important to remember that this Review focused on a small sample of an important segment of children and young people vulnerable to CSE (i.e. 'Looked After Children' in residential care) but the messages from this study have wider relevance to the continuing confrontation of CSE in Northern Ireland and this Review has undoubtedly identified some critical areas for rapid development.

While it has not been part of our role to review more recent changes taking place within Northern Ireland, we hope that in many aspects the service provided to children at risk of or directly affected by CSE, has already improved. As a number of initiatives are currently developing to tackle CSE (see HM Government 2015: Tackling Child Sexual Exploitation) this Thematic Review is timely and significant. To tackle CSE effectively, however, takes time and committed, sustained effort. The numerous cases, old and new, that have come to light and the learning that derives from studies such as Marshall (2014) and Beckett (2011), provide the stimulus and also the opportunity, for all the relevant agencies and those who oversee and co-ordinate them, to bring about in Northern Ireland the necessary transformation in the protection of children from sexual exploitation. We believe that this Review should contribute to this transformation.

Professor Jenny Pearce, Marion Davis, Assistant Chief Constable Peter Davies

Professor Jenny Pearce is Professor of Young People and Public Policy at the University of Bedfordshire who has extensive experience of applied research in the field of CSE.

Marion Davis, an independent consultant with extensive experience in children's social care at Assistant Director and Director levels. She has also been the President of the Association of Directors of Children's Services 2010/2011.

Assistant Chief Constable Peter Davies has been Chief Executive Officer of the UK Child Exploitation & Online Protection Centre and the National Policing Lead on Child Protection and Abuse Investigation and Missing Children.

Executive Summary

Background

In 2012, the Police Service of Northern Ireland (PSNI) identified a group of 'Looked After Children' reported by Health and Social Care Trusts (H&SCTs) who had repeatedly 'gone missing' and where there were serious concerns about CSE; a form of child sexual abuse which was increasingly gaining attention. Subsequently Operation Owl was set up as a multi-agency investigation to review the cases in respect of the concerns about CSE and pursue the prosecution of potential offenders. This prompted the Minister of Health, Social Services and Public Safety to set up, with the Minister for Justice, an independent, expert-led inquiry to focus more widely on CSE within Northern Ireland (NI) (Marshall, 2014), as well as directing the SBNI to commission a Thematic Review to identify key learning and opportunities for improvement.

Thematic Review Methodology

A methodology was designed, based on a team of independent and experienced professionals retrieving and reviewing information up to September 2013, from case files held by the H&SCTs; the PSNI; the Youth Justice Agency (YJA) and Barnardo's NI, relating to ten young people. That work was then further reviewed by a team from Queen's University. There was minimal take up on planned semi-structured interviews with young people and with their parents. Internal 'desk top reviews' undertaken by the H&SCT's were also considered, along with a redacted copy of the PSNI scoping study that prompted Operation Owl and an internal review by the YJA. Four workshops were held with frontline staff and managers from across a range of relevant agencies. Meetings were also held with senior staff from the Department of Health, Social Services and Public Safety (DHSSPS), the Regulation and Quality Improvement Authority (RQIA), the Health & Social Care Board (HSCB), the H&SCTs and the PSNI. There were also consultations with three External Advisors with extensive experience of work in the area of CSE.

Five Thematic Areas

1. Recognising the complexity of the young people's lives

Reflecting what is known in the emerging field of CSE, attention is drawn in the report to the risks associated with childhood adversities and with poor parenting and their impact– though it is also noted that children and young people from a wide range of backgrounds can become caught up in CSE. The limited knowledge about the perpetrators of CSE is also noted. Given what is known about CSE, that it is the result of complex interactions between factors at different levels between the individual and society, a 'Whole Child/Whole System' approach is needed to both understand and respond to CSE. That perspective frames the choice to consider the pathways of the young people prior to being 'Looked After', when 'Looked After' and, where it applied, post 'Looked After'. 'Looked After Children' are those who are in the care of Social Services through the agreement of their parents or through court orders.

Pre-'Looked After' – An array of adversities is noted from this phase, including neglect and various forms of abuse (sexual, emotional, physical), domestic violence, parental substance misuse and parental mental ill health and self-harming behaviour. Such concerns had resulted in the children and their families being known to Social Services over long periods of time with significant input from a variety of family support services and other agencies. Being placed on the Child Protection Register (CPR) was noted as a significant feature. Service provision appeared to be largely reactive in nature, focusing on the immediate problems the young people were experiencing and the behaviours they were exhibiting, rather than being based on a holistic assessment of need, including the risk of CSE and a clear plan to address these. The impact of insufficient resources was also evident in some of these cases, as was a lack of engagement by both parents and young people.

'Looked After' – In the majority of cases the young people became 'Looked After Children' because their parent/carer was unable to cope with the presenting difficulties caused by the circumstances, including increasingly challenging and risky behaviour. Whilst 'Looked After', that behaviour tended to escalate. Almost all of the young people had experience of multiple placements, with an average of seven moves, with many moving between different residential units as well as between secure accommodation, admission to the Juvenile Justice Centre (JJC) and residential units. The majority of the young people had experience of being placed in either secure accommodation or admission to the JJC. When aged between thirteen and sixteen, all of the young people regularly went missing with concerns about them engaging in risky sexual activity raised by the Police and Social Services, as well as drug and/or alcohol misuse. There was also concern over aggressive or violent behaviour, towards family members, peers, staff and members of the public. This resulted in them being excluded from school and getting embroiled within the criminal justice system. There were concerns that the young people were being exploited through exchanging sexual acts for drugs, alcohol and money. In some, but not all cases this was specifically identified as concern about CSE.

Post-'Looked After' - Half of the group had left care by the end of the period covered by the file review; some following a period in the JCC, others from residential care.

The young people were successfully engaged, to varying degrees, with both the leaving and after care planning and with the services that were offered. There was a stronger sense of the young people engaging with professionals and being more open to support in finding ways to move on in their lives, to come to terms with past difficulties and find the physical safety, emotional attachment and social stability they needed.

2. Assessing need and identifying risk of CSE

Although it is important to note that research has consistently demonstrated that CSE can affect young people from any background, it is also the case that the majority of sexually exploited children are already vulnerable to abuse and this was certainly the case for this group of young people.

In seeking to address their needs, assessments, were generally completed within timescales and were compliant with policy and procedures. Communication between agencies was generally effective in identifying the needs, risks and trauma that the young people had experienced, although incidents of communication difficulties were identified. However, whilst information was collated and shared and risk factors generally identified, there was variability in connecting, assessing and then acting on these factors, as indicators of the risk of CSE.

Whilst interagency meetings and reviews took place and were generally well attended, their function appeared to be primarily about information sharing and reiterating safety plans. They did not appear to be routinely about Social Services, the Police, Health, Education and other relevant agencies coming together to assess need and identify the risk of CSE. Without an analysis and agreement on the implications of CSE for the dynamics of a case, the strategic case management necessary to plan and implement an intervention cannot be pursued effectively. This is particularly so where what is required is a combined approach, providing for a young person's safety and welfare and at the same time investigating, disrupting and prosecuting those who would sexually exploit them.

Six 'Areas for Improvement' are listed in Box 12 covering the following: the use of both general assessment and specialist assessment tools to identify CSE; the role of Child Protection Registration and of 'Looked After Children' Reviews in multi-agency assessment of CSE; addressing the implications of CSE for the dynamics of a case as part of a therapeutic approach; and using proactive policing investigation, including specialist interviewing, to identify CSE.

3. Using a combined approach to tackle CSE

Where CSE has been identified as the core dynamic of a case, the focus must be on mobilising services, which can not only protect and support the young person but also achieve the identification, disruption and prosecution of suspected perpetrators. In such cases, the H&SCTs, as the lead organisation responsible for responding to the young people's multiple and complex psycho-social needs, must work closely with those community safety agencies, primarily the PSNI, tasked to prevent crime and to prosecute.

Across the cases considered by the Thematic Review, there was a sense of professionals missing opportunities sufficiently early in the lives of these young people, for preventative and authoritative early intervention work. Then, when later faced with the young people's very challenging behaviour as adolescents there was an acceptance of just having to deal with events on a day by day basis. That included the PSNI response which was generally restricted to locating and returning young people who had 'gone missing'. That narrow interpretation of the policing role and the lack of a combined perspective on case management, led to a focus on the young person as the problem, rather than on any alleged or potential offenders.

Given the difficulty of effecting change by the time CSE had become a part of the young people's lives, as an emotional and behavioural response to their experiences of multiple adversities, which were identifiable in their early family life, the case for multi-agency early intervention and preventative family support is compelling. Equally compelling is the argument that when later faced with CSE, as part of the complex and challenging nature of these young people's lives, multi-agency intervention is also key. Proactive, combined therapeutic and policing interventions are required. That in turn requires proactive management oversight to open up a strategic, rather than reactive approach to case management, based on exploring alternatives tailored to the immediate and longer term safety, psychological and relationship needs of a young person.

Six 'Areas for Improvement' are listed in Box 12 covering the following: preventative and assertive family support and community based policing; strategic case management emphasising the use of different types of out of home placement along with multi-agency support; and proactive engagement with 'going missing' as opportunities to action case management objectives, both in support of the young person and pursuing those exploiting them sexually.

4. Enhancing Relationship Based Practice with Young People

Central to adequately ensuring the safety and promoting the wellbeing of the young people, was the need to engage them in understanding any abuse that they had experienced and addressing their related 'going missing', drug and/or alcohol use, self-harming and risk taking behaviours. This was done within the context of therapeutic perspectives based on: recognition that young people in residential care have suffered trauma and disadvantage; encouragement of staff to understand and address the needs and emotions underlying challenging behaviour, rather than simply responding to the behaviour; and providing both staff and young people with techniques for being aware of and regulating, their responses to stressful situations. The therapeutic perspective also emphasises the importance of staff understanding how their work impacts on them and vice versa.

For crucial periods of their lives, not only did the young people not share the professionals' view of the risk they were exposed to, but they also saw themselves as being in control of their lives; 'consenting' to the abusive activities they were caught up in. The success of those who were sexually exploiting the young people through the use of grooming and violence; the offer of material rewards; the use of social media; and the role of peer pressure to manufacture such 'abusive consent', emphasises the importance of focusing on the disruption and prosecution of perpetrators. Despite staff efforts, young people, at points in their lives when they needed help most, found it very difficult to engage in positive working relationships. At times they could be aggressive and abusive towards staff. Such behaviours may be encouraged by perpetrators.

The bedrock to the relationships adolescents need with dependable adults is consistent attention to their physical, emotional and social care. This was in general provided, along with watchful care and monitoring, where there were concerns that the exploitation experienced by the young

people resulted in them engaging in extremely risky behaviours. In some cases, staff intervention probably saved their lives. Staff were able to effectively manage certain risks, for example when young people were returned to the unit under the influence of alcohol and/or drugs, however, they were unable to persuade or prevent them from repeatedly 'going missing' from care and being vulnerable to CSE, as these residential units are open homes. (Legislation and guidance governs how and when young people can be placed in any type of secure provision). Staff were also not sufficiently equipped to engage in the multi-agency work needed to disrupt the activities of abusers who had targeted the child.

It was not apparent how the various therapeutic approaches used in residential care were contributing to managing CSE, as an aspect of the young people's multiple and complex needs. This raises questions about the levels of skilled application of the approaches, as well as their capacity to deal with CSE. Staff wanting to prevent young people from leaving the residential unit, to place themselves in 'at risk' situations, felt constrained in the actions or sanctions they could use. The use of secure accommodation provided a temporary solution and young people tended to engage more with professional staff whilst in these settings. However, none of these settings were able to generate sufficient momentum for change for the young people to sustain the advances they made when they returned to open units.

Whilst the young people remained in exploitative situations, having access to dependable adults, who continued to provide practical, emotional and social support, with the intention of securing their well-being, mitigated the worst effects of their experiences. As the young people got older and in some cases had children of their own, it also seemed that they were able to fall back on the store of professional support they had received. As the young people's perceptions of their own needs came more in line with the assessments of those working with them, more effective working relationships could be built.

Five 'Areas for Improvement' are listed in Box 12 covering the following: purposeful maintenance and building of relationships; provision of physical safety; use of authority within therapeutic approaches; managing the use of social media; and developing specialist CSE support, with particular attention to the views of young people, as to what works to meet their needs.

5. Continuously learning about and developing a response to CSE

There is at present a very strong sense of a momentum for change having been built up in regard to CSE, which has been focused and given direction by the Marshall Report (2014). It is now an established part of thinking about the needs and risks in the lives of vulnerable children, in a way that it was not, at the time that Operation Owl was set up. This growing recognition of CSE, particularly during the period 2010 to 2013, was noticeable in the case files as the concept and its implications became more apparent, not just for the ten young people but as a wider social policy challenge. This was strongly highlighted in staff workshops and the meetings held with senior staff. There is an active engagement with CSE as an aspect of the lives of a proportion of 'Looked

After Children', in particular those in residential care, a readiness for exchange around new policy as it is emerging and most importantly for learning about more effective practice, based on the experience of young people themselves and those that care for and about them, both practitioners and families.

In order to capitalise on this momentum, work to promote the growing confidence, respect and trust between staff working at different levels across agencies in this difficult area, needs to be developed. There needs to be a culture of continuous improvement in practice and service provision. The focus now needs to be on demonstrating that more effective interagency intervention, with better outcomes for young people with multiple and complex needs, can be achieved. Particular attention needs to be given to the still very limited understanding of the profile of the perpetrators and how they operate. The management and accountability structures of the various organisations involved with 'Looked After Children' and with CSE, need to be used to create a learning community.

There are Six 'Areas for Improvement' listed in Box 12 covering the following: co-location of experienced senior practitioners; optimum strategic use of routinely gathered information; attention to staff wellbeing, critical reflection and insight; induction, top up and advanced training; and monitoring, evaluation and research, with an emphasis on the various therapeutic approaches and policing strategies, in responding to CSE.

Conclusion and Overarching Recommendation

CSE is now an established part of thinking about the needs and risks in the lives of vulnerable children, in a way that it was not always, for the ten young people whose experiences have informed this report. For 'Looked After Children' as a group, significant change has been achieved in the recognition now given to the importance of 'going missing' as an indicator of CSE and the need to focus on an integrated interagency response, to both support young people with multiple and complex needs and disrupt and prosecute those prepared to sexually exploit their vulnerabilities. However, it is not yet clear whether these changes are making for more effective outcomes for young people and are sustainable under competing pressures for resources.

Accordingly, in addition to the identified Areas for Improvement, an overarching recommendation of this Report is that the SBNI lead a Regional Benchmarking Thematic Inspection in twelve months time, to determine the effectiveness of responses to those children and young people being 'Looked After' on a specified date, with a record of repeated 'going missing', where there are serious concerns about CSE.

A Delivering on the Remit

Background:

Growing recognition and engagement with Child Sexual Exploitation

This Thematic Review was commissioned to examine and evaluate what could be learnt from a group of 'Looked After Children' identified as having a record of repeated 'going missing' episodes, where there were serious concerns about Child Sexual Exploitation (CSE). This group of young people had been identified by the Police Service of Northern Ireland (PSNI) on the basis of a scoping exercise to quantify and consider evidence of the existence, prevalence and nature of CSE and trafficking of 'Looked After Children,' who were reported missing from Social Services premises in Northern Ireland (see Box 1). That initiative led to the setting up of Operation Owl (see Box 2).

1 Definitions of: Child Sexual Exploitation ; Human Trafficking; 'Looked After' Children; Going Missing

'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.' *SBNI 2014, adopted from CSE Knowledge Transfer Partnership NI.*

"Trafficking in human beings" shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. *Council of Europe Convention on Action against Trafficking in Human Beings (2005) Endorsed by the UK*.

'Looked After Children' (LAC) are either accommodated under voluntary arrangements with their parents or in care under a court order (Article 25, Children [Northern Ireland] Order 1995), They may become 'Looked After' for a variety of reasons including: having experienced, or being at risk of experiencing, abuse or neglect; engaging in risk taking behaviour that cannot be managed at home; family illness or the death of a parent; or having complex needs or disabilities. In addition, some children and young people do not have a parent or relative who is able to look after them, for example, unaccompanied asylum seeking children.

'Going Missing' (H&SCB and PSNI, 2012)
Missing – 'anyone whose whereabouts is unknown whatever the circumstances of disappearance. They will be considered missing until located and their wellbeing or otherwise established.'

Unauthorised absences - Children absent themselves from care for a short period of time and then return; often their whereabouts are known or thought to be known but unconfirmed.

Absconded – Absconding refers to a child who is missing from care, or who is 'Looked After' and is subject to bail conditions as a result of a Criminal Court 4 Order or is subject to a Secure Accommodation Order.

Abduction – taking a child who is in care, the subject of an Emergency Protection Order, or in Police Protection, away from the responsible person, or keeps the child away, or induces, assists, or incites such a child to run away or stay away from the responsible person.

Operation Owl took place at a time of increased awareness and concern amongst professionals and within the general public, about CSE across the UK. Whilst this form of sexual abuse of children and young people is not a new phenomenon, a series of high profile investigations in England (notably Rotherham, Rochdale, Derby and Oxford) indicated that the scale and forms it took required a sharpened focus on understanding and engaging with it (Ofsted 2014). Whilst it has primarily been the experience of investigations and inquiries in England that has driven concern over CSE, it is clearly a UK four nations' issue with both the Welsh Assembly and the Scottish Government having commissioned reviews (WAG, 2010, Scottish Parliament, 2014).

2 Operation Owl

Operation Owl was a review of investigations relating to children who went missing from care from the period January 2011 to August 2012 and involved the development of a co-located team of police officers and social workers investigating CSE. The original investigations were reviewed and further investigative actions identified, which were then taken forward by a Major Crime Investigation Team from the Serious Crime Branch, assisted by specialist child abuse detectives.

In Northern Ireland, research was commissioned by the Department of Health, Social Services and Public Safety (DHSSPS) in 2009, from Barnardo's NI (Beckett, 2011; see Box 3). The research made it clear that CSE was an issue in Northern Ireland, which needed to be addressed. In the context of the efforts by relevant agencies to address those issues, Operation Owl represented one response. In addition to investigating cases for prosecutions, that initiative provided the impetus to enquire into the regional context of CSE.

Accordingly, the Minister of Health, Social Services and Public Safety and the Minister of Justice set up an independent, expert-led inquiry into CSE in Northern Ireland led by Kathleen Marshall (Marshall, 2014). The inquiry sought to: establish the nature of CSE in Northern Ireland; measure the extent to which it occurs; examine the effectiveness of current cross-sector child safeguarding and protection arrangements and measures to prevent and tackle CSE; and make recommendations on the future actions required to prevent and tackle it and who should be responsible for these actions.

In addition to recognising the importance of understanding the wider context, the Minister of Health, Social Services and Public Safety appreciated the need to look for and learn lessons from how services had engaged with the young people, whose cases were subject to investigation by Operation Owl – all of whom had been 'Looked After' at the time that they were 'going missing' and when there were serious concerns about CSE. The result was a Ministerial Direction to the Safeguarding Board for Northern Ireland (SBNI) to carry out a Thematic Review in relation to the cases which had been identified by Operation Owl in order to identify key learning points and opportunities for improvement (see Appendix 1 for terms of reference).

3 Barnardos NI Research on Child Sexual Exploitation, "Not A World Away" (Beckett, 2011)

This study presented research undertaken between 2009 and 2011 into the sexual exploitation of children and young people in Northern Ireland, focusing on the risks for children in, or missing from, care. The report looked at reported cases of sexual exploitation, within a sample of 1,102 young people known to Social Services, assessed levels of risk within this group, along with findings from a survey of the self-reported experiences of sexual exploitation by the 786 16-year-olds completing the ARK Young Life and Times (YLT) Survey. Key findings from the review of 1,102 case files indicated that:

- Social workers identified sexual exploitation to be an issue of concern for almost one in seven young people in the sample (13.3 per cent; n=147).
- Using a specific CSE assessment tool, almost one in five (17.9 percent) of the overall sample were assessed to be at significant risk of sexual exploitation.

Qualitative interviews with professionals also revealed that many did not feel that they were able to adequately protect sexually exploited young people. They also highlighted an apparent failure to hold abusers to account, as a major source of frustration.

The terms of reference set by the Minister posed four questions to be examined and evaluated in regard to the welfare and safeguarding of the young people:

1. Had action been taken in accordance with policy, procedures and guidance?
2. Had action taken been effective?
3. Had communication and co-operation been effective?
4. Had relationships with the young people been of a quality that was effective?

Underlying those questions the terms of reference identified as key issues to be considered: assessment; care planning; risk management; provision of care; reported absences; response to criminal offences against the young people; reporting and information sharing; and the involvement and support of senior managers. The Ministerial directive also instructed that the Thematic Review should not "undermine, compromise or interfere with", in any way, the Operation Owl investigations and related legal proceedings.

Operation Owl had identified the cases of twenty two young people for investigation. Six of these cases were not available for consideration by the Thematic Review, by the decision of the PSNI, in consultation with the Public Prosecution Service, because of concerns that their involvement would jeopardise potential prosecutions. A further six were not available for review by the decision of the Health & Social Care Trusts (H&SCTs) responsible for them being 'Looked After'. Five of these

young people were not prepared to give permission for access to their files and the H&SCTs judged it not to be in the best interests of the young people's welfare, to release their files against their wishes. In the sixth case, a H&SCT judged that inclusion in the review would significantly affect the welfare of that young person. Accordingly, ten cases comprised the group whose experiences were considered to identify key learning points and opportunities for improvement.

In considering the experiences of this group of young people it is important to stress the context. As recognised by the Marshall Inquiry, it is the young people affected by CSE who must be the central reason for concern, but it is those that exploit them and the environment that enables and emboldens the exploiters to do so, that should be the focus of efforts to protect the young people. CSE requires a 'dual approach', based on authoritative prevention and support for children and young people, alongside aggressive disruption and the prosecution of those engaged in sexual exploitation.

There is much yet to learn about how the perpetrators of CSE operate in Northern Ireland but as the Marshall Report(2014) made clear there are known features that need to be emphasised: in a sexualised society CSE can flourish; CSE is organised to varying degrees, with the internet and social media playing an increasingly important role; CSE is perpetrated in a number of ways – abuse through commercialised sexual exploitation; abuse within a 'Party House' context; and sexually exploitative 'boyfriend/ girlfriend' relationships. Much but not all CSE involves illegal activity; some groups are particularly vulnerable to CSE and one of those groups is 'Looked After Children'.

Thematic Review Methodology

Although the SBNI has considerable experience and clear processes for undertaking Case Management Reviews (Devaney et al., 2013), a review of this nature had not been undertaken before. It is important to be clear that this Thematic Review is not a Case Management Review, nor an inspection of the type undertaken by the Regulation and Quality Improvement Authority (RQIA), nor an evaluation as might be carried out by academic researchers – though it shares features of all three. Whilst finding an appropriate methodology was challenging, the goal of the Thematic Review was clear; to identify key learning points and opportunities for improvement. That required examination and evaluation of a range of information pertaining to the experiences of the young people, but it is not a comprehensive descriptive account or inquisitorial investigation of those experiences. Care has been taken to obtain and report information in a manner that does not identify the young people or their families – including some redrafting in response to H&SCT and DHSSPS concerns, prior to the Review being published.

This particular small group of young people was identified because they stood out in PSNI records through repeated 'going missing' reports by Social Services staff and serious concerns about their vulnerability to CSE. That means it is important not to over generalise from their experiences. The experience of this group of ten certainly should not be regarded as a representative sample of the 2,644 'Looked After Children' in Northern Ireland in 2012, or even the 9% of those within that population who were in residential care. It is worth recalling the old adage: 'hard cases make bad law'. However, at the same time, extreme cases should receive special attention, precisely because so much is at stake for those involved and because they do test the robustness of the system.

In addition to being clear about its goal, mindful of what it was and what it was not, the SBNI was very conscious that the Thematic Review had to be and be seen to be, independent and objective in its work. Accordingly, care was taken to bring together people to undertake the review who, whilst knowledgeable about child welfare in Northern Ireland, had no conflict of interest with the process. In addition, three Independent External Advisors from England with extensive experience of work within the field of CSE were engaged. The Thematic Review also had to take account of ongoing PSNI work and Social Services involvement with the young people. It was seen to be imperative that nothing done under the auspices of the Thematic Review was detrimental to the young people's health, welfare, rights and general sense of control over their own lives.

With all those considerations in mind, a methodology was decided on, based primarily on reviewing information, up to September 2013, in files held by those in whose care the young people were, or had been and by the PSNI, who had identified them. Information was also sought from the Youth Justice Agency (YJA) and Barnardo's NI in regard to those cases where they had been involved. An Information Retrieval and Review Record (IRRR) template was developed which focused on: the personal characteristics of the young person; family composition; case chronology; case management; management oversight; communication and co-operation within and across agencies; engagement and relationship with the young person; and engagement and relationships with parents/family. Accessing the files required to complete the IRRR involved a complicated and protracted procedure for obtaining permission. This was seen as appropriate to both respecting the young people's rights to data protection, as a part of promoting their sense of control over their own lives and ensuring that the ongoing work of the PSNI and Social Services with them was not adversely affected. As already noted, the agreed procedure resulted in files, relating to ten of the twenty two young people involved in Operation Owl, being made available for review.

Work on completing the IRRR for each of the ten cases was undertaken by a team of independent and experienced senior professionals. These File Reviewers were put into teams of two, each linked to an academic from the Queen's team. The File Reviewers and their linked Queen's academic met in order to address consistency and other issues raised in the extraction of information from the case files of the various relevant agencies. These meetings also served to facilitate discussion of themes and issues emerging from the review of each young person's case files. Further meetings took place to discuss these issues with the External Advisors.

The H&SCTs had undertaken their own internal 'desk top reviews', which were made available to the Thematic Review; as was a redacted copy of the PSNI scoping study that prompted Operation Owl and an internal review by the YJA. There was minimal take up of planned semi-structured interviews with the young people and with their parents, which would have added a significant dimension to the information and learning available to the Thematic Review. Four workshops were attended by around one hundred frontline staff and managers, from across a range of relevant agencies. Meetings were also held with relevant senior staff from the RQIA, the H&SCTs, the Health & Social Care Board (HSCB) (it commissions the services provided by the H&SCTs), the DHSSPS and the PSNI.

Placing file review at the centre of the methodology has advantages and disadvantages (Hayes and Devaney 2004). In terms of advantages, they can be expected to provide a fairly detailed and accurate account of events and decisions, thereby providing a reliable source of information. Files are not affected by a reviewer in the same way that a respondent is, when giving an account of a case during a face-to-face interview. File review is also efficient in terms of time taken to collect information. However, deficiencies in files are well documented in child abuse inquiries, Serious Case Reviews, referred to in Northern Ireland as Case Management Reviews and inspections. The commonest issues highlighted are that they are often not up to date or complete, poorly written, disorganised and lacking in analysis of information – though knowing that, is of course useful. Also case files are written with the particular purpose of informing the work of the agency, recording and analysing events in a way that is selective and partial. Their focus is primarily on individuals, rather than the organisational processes surrounding them.

Accordingly, the use of case files as a source of information and the conclusions drawn from their analysis must be treated with caution. As Gordon (1988: 12) states, they are not 'universally reliable, understandable or easy to use'. However, whilst they cannot be guaranteed to represent a wholly accurate picture of professional practice, they do provide: "…the only record available of what was done or not done, with or to whom, within what timescale and with what outcome." (Macdonald and Williamson 2002: 101). Based on what, in some cases, were the extensive files of the ten young people provided by the various agencies, the File Reviewers were able to complete IRRRs on each of them. That included making informed professional judgments about the work being undertaken to promote the welfare and safeguarding of individual young people and its effectiveness. The IRRR's were then used by the Queen's team as the basis for this report.

Format of this Report

This introductory section is followed by Section B, which gives an overview of the 'Looked After' pathways of the ten young people. That overview emphasises a major point to be noted - concerns about CSE need to be thought of in terms of a complex process of changing circumstances in which the young people enter into and then exit from the 'Looked After' system, as they move from childhood through adolescence to adulthood. It is within that process, rather than individual events, that the key messages lie about opportunities to disrupt and prosecute those who would take advantage of young people struggling with very troubled selves and circumstances. In that process too lie the opportunities to engage and respond to young people and their parents, in the supportive relationships they need to take hold of their lives, in ways that promote their welfare and ensure their safety.

Section B is followed by Sections C, D, E and F which each deal with a major theme that has been identified by the Review. These themes are: clarity in assessing need and identifying CSE; strategic mobilising of services to prevent and support the young person, along with disrupting and prosecuting the perpetrator; enhancing relationship based practice with young people; and continuous learning and development. At the end of each section Areas for Improvement are listed. The report then ends with a Conclusions and Areas for Improvement section which draws together the Areas for Improvement from the previous sections, linking them to the Key Issues noted in the terms of reference and to relevant recommendations from the Marshall Report. One additional overarching recommendation is put forward, to ensure that the work being undertaken with 'Looked After Children' with multiple and complex needs, continues to be driven forward.

B

CSE and Phases of Being 'Looked After'

The group of young people who are the focus of this report were all 'Looked After Children'. They were either accommodated under voluntary arrangements with their parents, or in care under a court order (Article 25, Children [Northern Ireland] Order 1995). They were also reported to be repeatedly 'going missing' and there were serious concerns about CSE. Like all 'Looked After Children' these young people had lives prior to becoming 'Looked After' and have, or will go on to have, lives after ceasing to be 'Looked After'.

A clear theme emerging from this Review is that CSE should not be thought of as isolated events, either single or repeated, in these young people's lives but as part of the wider process of their growing up and of their experience of being 'Looked After'. There are pathways that can lead into CSE which need to be understood and blocked at the earliest point possible, including actions taken to disrupt perpetrators. Where CSE is occurring it must be managed to provide maximum safety to the young person, along with opportunities to end it as speedily as possible. There needs to be recognition that, just as it is a process over time that leads to a young person being sexually exploited, it will also be a process over time that will release them from it.

In thinking about any 'Looked After Child' it is helpful to consider phases in their lives; a Pre 'Looked After' phase, a 'Looked After' phase and a Post 'Looked After' phase. The experiences of these three phases are covered in this section of the report, following initial consideration of what can be called the psycho-social ecology of CSE; emphasising the place of childhood adversity in creating vulnerability to CSE; the importance of parents; the profile of those who sexually exploit children and young people and the need for a whole child/whole system approach to tackling CSE.

CHILDHOOD ADVERSITIES AND CSE

Although it is important to note that research has consistently demonstrated that CSE can affect young people from any background, it is also the case that the majority of sexually exploited children are already vulnerable and this was certainly the case for this group of young people. CSE is particularly linked to 'going missing' from the family home, foster home or residential care, being homeless, the misuse of substances and alcohol and being in the 'Looked After' system (Chase and Statham, 2005; Jago et al., 2011; Pearce et al., 2002; Pearce, 2009; Scott and Skidmore, 2006; Smeaton, 2013; Stredder et al., 2009). One of the most widely studied vulnerability factors for CSE is childhood abuse and neglect (Matthews, 2008), especially children who have experienced prior sexual abuse (Estes and Weiner, 2005; Fergusson et al., 2008). Children, particularly when they are younger, depend on their parents and families to provide the physical, emotional and relational stability and security required to form meaningful attachments and to grow and develop in positive ways. However, not all parents provide this sense of stability and safety, either because they are unable, or are unwilling to do so.

Evidence shows that being a victim of sexual violence or abuse has a considerable impact on the development of mental health problems and disorders. Findings from three key studies have indicated that about half the children who had been sexually abused experienced depression, post-traumatic stress disorder (PTSD) or disturbed behaviour, or a combination of these (Monck and New 1995) and between 40 to 70 per cent of those diagnosed with emerging or borderline personality disorder reported having been sexually abused when younger (Zanarini, 2000). It has been argued (Finkelhor and Browne 1986) that the experience of sexual abuse could be analysed in terms of four trauma-causing factors responsible for 'traumagenic dynamics'. These include: traumatic sexualisation; stigmatisation; betrayal and powerlessness.

These traumas can alter the child's cognitive and emotional orientation to the world and create further trauma by distorting the child's view of the world, their self-concept and affective capacities and may manifest themselves in behaviour such as: precocious sexual activity; aggressive sexual behaviour or avoidance of sexual intimacy; isolation; self-harm or substance misuse; aggression; relationship difficulties or clinging; dissociation, phobias; and mental health disorders (see Finkelhor and Browne, 1986, pp. 186-187). Indeed, Lalor and McElvaney (2010) suggest a strong link between childhood sexual abuse and later involvement in CSE and highlight the co-existence of physical abuse as a significant risk factor for sexual re-victimisation. Other studies suggest that abused young people are likely to engage in sexual risk-taking as they reach adolescence, thereby increasing their chances of contracting a sexually transmitted disease or becoming sexually exploited (Johnson et al., 2006). That said, it is important to remember that not all sexually abused children go on to experience further abuse (Corby et al., 2012) and nor have all children and young people who are sexually exploited been victims of sexual abuse in their past.

It is important to highlight (Smeaton 2013) that there is not one single vulnerability, but rather a combination of risk factors, such as bereavement or other loss, social issues relating to the family and a history of abuse, which leads to a young person both running away and being sexually exploited. Although CSE can occur in any family, it is most often concentrated in families vulnerable to a combination of these more complex risk factors, which interact together to produce an even greater risk to families (Barnardo's, 2012; Berelowitz et al., 2013). These factors make for a long list. Children and young people may:

- 'go missing', especially on regular occasions from home or care;
- live in a dysfunctional family;
- live in single-parent homes;
- have experienced, or are experiencing, problematic parenting;
- have a history of domestic abuse within the family environment;
- have a history of abuse (including familial child sexual abuse, physical and emotional abuse and neglect);
- have long-term involvement with agencies;
- have parents who misuse drugs or alcohol;
- have parents with mental health problems;
- have parents who have experienced abuse in childhood;
- have experienced parental separation;
- have childhood mental ill health/self-harm/ attempt suicide;
- have a disability or learning difficulties;
- misuse alcohol and/or drugs;
- have been regularly missing school or not taking part in education;
- have been excluded from mainstream education;
- have friends who are sexually exploited; and
- do not have friends in the same age group.

These multiple risk factors clearly cover a wide range of circumstances and do not necessarily correlate with CSE. All of the young people who were the focus of this review had experienced some or all of the above adversities, to a greater or lesser degree.

Internationally, 'running away' has been identified as a significant indicator of the risk of becoming involved in CSE (UNICEF, 2012). 'Looked After Children' are significantly more likely than all other children to do so; with those in residential care an estimated three times more likely to go missing (Rees and Lee, 2005). It has been noted (Courtney and Zinn 2009) that young people who are 'Looked After' are more vulnerable to running away, due to their experience of abuse and neglect and their disconnection from the concept of 'family life' and home. A young person's vulnerability is often connected to gender inequalities, with the evidence showing that young women are more likely to be sexually exploited than young men – though it is also generally accepted that there are more young men sexually exploited than are identified in research (Cusick, 2002; Beckett et al., 2013; Child Line, 2012; Kirtley, 2013).

Furthermore, these children face significant risks of harm and are likely to be exposed to the risk of alcohol and drugs and criminal and sexual victimisation, including commercialised CSE, unwanted pregnancy and miscarriage, sexually transmitted diseases and arrest (Clark et al., 2008; Wade et al., 1998). Guidelines produced by the National Institute for Health and Care Excellence (2004) also suggest the strong links between CSE and self-harm and substance misuse, mental illness and domestic violence. The impact of sexual exploitation on a young person's mental health can be profound, either exacerbating existing mental health issues, such as Attention Deficit Hyperactivity Disorder (ADHD) and learning disabilities, or increasing anxiety, depression and behavioural disorders,suicide and post-traumatic stress disorder (Gilligan, 2015).

The provision of effective treatment and rehabilitation of these sexually exploited young people into society, has proved challenging for service providers, due to the complexity of their needs (Willis and Levy, 2002; Melrose and Pearce 2013). Research suggests that early childhood abuse and trauma can cause a persistent biological state, likely to function as a risk factor for the occurrence of mental disorders in later life (Shonkoff et al., 2012). Due to this fact, the ascertainment of abuse in childhood should be recognised as an important risk factor for the occurrence of mental disorders (Sidebotham and Heron, 2006).

PARENTING AND CSE

Whilst it is important to stress again that children and young people from a wide range of backgrounds can get caught up in CSE, an evaluation of several CSE services in the UK found that there was a significant deficit in parenting capabilities (The Office of the Children's Commissioner, 2012). Fathers were found often to be absent, leaving some of the young people to move into adult life prematurely, to seek the support they were lacking at home. These findings highlight how many children's lives today are characterised by a range of risks that create complex, connected difficulties that demand a range of coordinated opportunities and/or interventions to break

the vicious cycle of disadvantage and vulnerability that can lead to CSE. Family dysfunction and breakdown, along with inadequate parenting, are common precursors of CSE (Van Brunschot and Brannigan, 2002; Pedersen and Hegna, 2003). However, as 'Parents Against Child Sexual Exploitation' (www.pace.org.uk) forcefully argue, not all sexually exploited children are from dysfunctional families or experience poor or inadequate parenting.

A range of negative developmental experiences have been highlighted as present in the lives of many of the young people who are sexually exploited and engage in sex work in later life (Chase and Statham 2005). These include family problems: arguments at home; abuse and/or violence; running away from home or from substitute care; truanting from school; drugs; sleeping rough; and losing contact with family and social networks. Often it is the cumulative and compound nature of negative experiences that significantly increase the risks for later re-victimisation, including through sexual exploitation.

Parenting interventions can address some of the psychological and social reasons for parenting failures in the case of abuse and neglect. There is substantial evidence, still predominantly derived from the United States and Europe, that interventions aimed at supporting parents, through promoting good parent-child attachment and offering both realistic expectations and alternatives to harsh discipline, can play a significant role in reducing the incidence of child abuse (Lalor and McElvaney, 2010). Whilst a reasonable assumption, there is little direct evidence that this in turn reduces the risks of sexual exploitation. Based on a clear theory of change, however, and reflecting the experience of many sexually exploited young people, there is a basis for such claims.

Research argues that a supportive family environment and good quality parent-child relationships in particular, will create the conditions for establishing healthy patterns of social and emotional functioning (Stein et al., 1991; Murray et al., 1996). It has also been shown that 'good' parenting is influenced by the parent's own mental health and that mental health problems, such as maternal postnatal anxiety and depression, can interfere with positive parenting, having a long-term effect on children's socio-emotional development, particularly in the case of boys (Murray and Cooper, 1997). Moreover, given the connection between the experience of, or witnessing, violence at home, with increased vulnerability to a range of negative outcomes, interventions aimed at reducing that violence and strengthening positive early childhood, are some of the strategies that may reduce the risks of entry into sexual exploitation (Jago et al., 2011).

Any discussion of parenting has also to recognise that not only 'birth parents', but 'Corporate Parents' too, struggle with the difficult boundaries and balances that exist around the roles and responsibilities, with regard to the sexual activities of children and young people in their care (Barnardo's, 2014; D'Arcy et al., 2015). There is often a danger that behaviour that could be part of CSE is sometimes not checked and challenged quickly enough in residential units or foster placements.

CSE PERPETRATOR PROFILE

The research evidence suggests that far less is known about the individual characteristics of perpetrators of CSE, than is known about their victims. Of the data that is available, it is hard to draw many generalised conclusions about the individual characteristics of perpetrators. An English Inquiry into CSE in Gangs and Groups (Berelowitz et al., 2013) acknowledges that agencies rarely record data about perpetrators of CSE and the information they do record is often incomplete or inconsistent. However, what all perpetrators have in common, regardless of the differences in ethnicity, or social background (information on disability or sexual orientation are rarely available), is their abuse of power in relation to their victims and that the vast majority are male and their ages ranged from school age (e.g., peer-on-peer or gang-related abuse) to the elderly (Berelowitz et al., 2013). There is growing recognition of peer-on-peer abuse as a dimension of CSE (Firmin 2013). Women and victims of CSE can also be groomed to recruit and coerce other victims into CSE. Further problems are that the victim's ability to identify an offender may be impaired by drugs and alcohol given to them during the commission of the offence and therefore a clear description of the perpetrator/offender at the time may be missing. This perpetrator profile corresponds to what we know about child sexual abuse; i.e. that it is perpetrated by a wide group of people, including parents, other relatives, siblings, friends, or others known to the child (e.g., sports coaches, teachers, youth workers); and that the evidence overwhelmingly indicates that the majority of child sexual abuse is perpetrated by males (McCloskey and Raphael, 2005; Peter, 2009).

An increasing number of studies are looking at some of the factors that increase the risks linked to becoming a perpetrator of sexual violence and/or an exploiter of children and young people. Jewkes (2012) has identified six groups of risk factors, potentially amenable to change, that escalate risks of perpetration: adverse childhood exposures; attachment and personality disorders; social learning and delinquency; gender inequitable masculinities; substance abuse; and the use of firearms.

What creates the opportunities for those who will sexually exploit is that children and young people will often be in circumstances where they are isolated from protective and nurturing adults. They are in a position where they are unable to express their wishes and feelings, to make sense of their particular circumstances and exert control over what is happening to them. These children and young people may also be under very strong pressure and be intimidated, afraid and/or dependent on the exploiter(s) and may, therefore, reject offers of help and support. Interventions need to both curtail the power of the perpetrator and empower the young person, with this requiring a holistic approach; should the investments of time and resources in long term interventions. An important aspect of the work can be maintaining contact and being available to these children and young people, until they reach a point where they are ready to think about their situations and accept support.

'WHOLE CHILD/WHOLE SYSTEM' APPROACH TO CSE

There are numerous societal, community, relationship and individual risk factors that cause children and young people to be susceptible to sexual exploitation. It is best understood by focusing on the complex interactions between a number of factors at different levels, as they develop over time. From this socio-ecological perspective (Bronfenbrenner, 1979, 1986; Belsky et al., 2010; Cicchetti, 2014) child sexual abuse/exploitation is seen as occurring within the context of relationships between a perpetrator(s) and a victim(s), situated within what have been termed 'pathogenic relational environments' (Cicchetti and Toth, 2005, p. 409). As stated, the vast majority of sexually exploited children are already vulnerable and these vulnerabilities occur within a range of levels including:

- Individual level: the individual level includes the child and his/her parents/caregivers and deals with biological variables (e.g. age, gender) and with personal history factors that can influence susceptibility to child sexual abuse, emotional abuse, physical abuse and neglect, attachment difficulties and mental health and disability, self-harm and suicide.

- Relationship level: includes close personal relationships that can influence the risk of both perpetrating and being a victim of, CSE. This can include: poor parenting and attachment difficulties; stressors within families such as; bereavement; divorce; domestic violence; parental mental ill health; substance abuse; and financial difficulties. Peer pressures can also be a key relationship factor.

- Community level: includes those factors such as neighbourhoods and schools and the characteristics within those that might contribute to CSE, including prevailing norms about the treatment and status of children, gender, disability and sexuality as well as economic and social circumstances, including access to employment.

- Societal level: this includes, in particular, social and economic policy settings, including poverty and social norms that encourage harsh punishments, economic inequalities and the absence of social welfare nets.

In thinking about CSE it is important to take account of the resources and adversities at all these levels: national policies and programmes; voluntary and community resources; the physical and relational context in which families live; together with the individual genetic/biological and environmental influences, which can impact on the health and wellbeing of children as they grow up. It has been suggested (Firmin, 2013) that what is needed is contextualised safeguarding, based on strategies that directly address the context within which abuse takes place, as well as addressing the individual needs of the child or young person.

That approach requires multi agency provision of family support, through access to integrated preventative services. That needs to be complemented by proactive early and sustained authoritative intervention with families where childhood adversity indicators are identified, which if necessary can be escalated to child protection registration and/or to statutory intervention through court orders. It would also require proactive policing strategies, which are intelligence led and problem-oriented with an emphasis on focused deterrence, as well as prosecution. Alongside that, there needs to be community policing and engagement, focused on building a familiar, visible and approachable policing presence in communities. It is this combined focus on stopping the perpetrators and supporting the vulnerable that is required, if CSE is to effectively tackled.

CHARACTERISTICS OF THE PRE 'LOOKED AFTER' PHASE

As noted above, CSE is not an event, it is a process that develops over time within a complex context. There are pathways into CSE which need to be understood and blocked where possible. For the cases under review here those pathways included not only their period when 'Looked After' but also the period before that – the Pre-'Looked After' Phase. The starting point for that phase was taken as the time when a child or young person first came to the attention of Social Services in their own right.

The ages at which the ten young people were first referred to Social Services ranged from infancy to early teens and referrals came from parents, relatives, schools and the Police, as well as from Social Services staff. Involvement with Social Services tended to be continuous, up until the young person first became 'Looked After', although in some cases involvement was characterised by a series of short-term periods of involvement. The length of time that elapsed from the date of referral of the children, until the date on which they first became 'Looked After' (i.e. the Pre-'Looked After' phase), varied considerably. It ranged from just a few days to over a decade. In the main, the children and their families were known to Social Services for a significant period of time - the average length of time was four years. During that time, given the complexity of some family situations, it was very apparent that Social Services involvement with a family was specifically in relation to a particular child. Whereas, in other cases, where there were multiple needs and varying degrees of Social Services involvement, it was not always clear when sufficient focus had been achieved on the needs of the particular child to really regard the Pre-'Looked After' phase having started.

In the light of what is known about CSE, it was not surprising that there was a wide range of vulnerability and risk factors apparent in the histories of the young people during the Pre-'Looked After' phase. As significant as the range of indicators of adversity, is the way they cluster and accumulate. The number of childhood adversities experienced by any one young person ranged from two to eight and most had experienced five or more. These adversities increased throughout the Pre-'Looked After' phase, compounded by challenging and self-harming behaviours, including: school non-attendance; disruptive behaviour; aggression and violence within and outside of the family; risk taking; 'going missing' from home; substance misuse; sexual activity; and self-harming.

Having a child's name placed on a Child Protection Register (CPR) is a very significant marker of the extent of concern during the Pre-'Looked After' phase and nearly all of the children were registered. CPR serves to alert a range of agencies to the child's need for protection and cause for concern in one or more of the following areas - emotional abuse, neglect, physical abuse or sexual abuse. Which ever area the CPR formally records, it is clear from these cases that services need also to be alert to the danger that a child may be at the start of a pathway that will lead to CSE.

In response to the adverse childhood experiences of these ten young people and the issues and concerns that they were presenting, a variety of services were offered by a range of statutory and voluntary agencies. These included: Child and Adolescent Mental Health Services (CAMHS); counselling and/or mentoring; sexual health and/or education services; substance misuse services; self-protection work; behaviour management work; after schools clubs; family centres; and specialist therapeutic services. Whilst these helped some of the families and children with some of their problems, at some points in time, overall, the support proved insufficient.

There appeared to be three main issues which limited the effectiveness of services, in terms of meeting the needs of the young people and preventing their situations deteriorating, to the point that they had to be admitted to a 'Looked After' placement. Firstly, service provision in the Pre 'Looked After' phase appeared to be largely reactive in nature, rather than being based on a full assessment of need and a clear plan to address that need. This meant that the services provided were not adequate to address the issues being presented by the children and young people and in particular the escalation of their risk-taking behaviours and the risk that they might get caught up in CSE. Where assessments were inadequate at an early point of referral, later when the extent and nature of the difficulties became clearer, the provision of appropriate services was too late to prevent the children and young people becoming 'Looked After'.

The impact of insufficient resources was also evident; for example referrals not being given sufficient priority and out of home respite care not being offered during periods when children's risk-taking behaviour was escalating and parents were struggling to cope. If the Pre-'Looked After' stage is to provide an opportunity for preventing CSE and the escalation of need and diverting a child away from a 'Looked After' pathway, then earlier help and intervention, based on full and accurate assessment of the young person's and parent's needs and a plan to address those needs, is required.

Secondly, difficulties in engaging with both parents and young people were a significant barrier to the effectiveness of services. This lack of partnership occurred because there was no actively sought agreement on the need for services; or basic arrangements, such as appointments to meet, were not kept by parents and young people; or there was only limited involvement from parents and then disengagement after a relatively brief period of time.

Thirdly, service provision could be ineffective because the individual needs of a particular child or young person were lost within the competing and complex needs of their parents and siblings. In such cases, by the time the needs of the child were sufficiently in focus, the support provided was not sufficient to prevent their home situations from breaking down and the necessity of them becoming 'Looked After'.

The ending of the Pre-'Looked After' phase tended to be unplanned. Admission to out of home care was arranged on an emergency basis and generally because parents were unable to cope with the child or young person's increasingly problematic and risky behaviour. This included 'going missing' from home – a pattern of behaviour that tended to develop as the young people entered or approached adolescence and for half, predated their becoming 'Looked After'. The majority were accommodated with parental agreement rather than removed on a care order. Most were placed with non-kinship foster care, though residential care and kinship care were also used as a first placement. Most of the young people remained 'Looked After' following their first admission, but a few ceased to be 'Looked After' and then had a second episode of becoming 'Looked After' some time later, all subsequently remaining 'Looked After'.

CHARACTERISTICS OF THE 'LOOKED AFTER' PHASE

Whilst a small number of the young people became 'Looked After' for the first time in early childhood, to protect them from abuse or neglect, the majority became 'Looked After' aged 12 years and over, with the primary reason being that they were beyond the control of their parents who were unable to cope with the presenting difficulties caused by the circumstances, including increasingly challenging and risky behaviour. On becoming 'Looked After' their situation did not tend to stabilise and improve. Almost all of them experienced four or more placements with the average number being seven; including kinship care; foster care; residential care; placement with parents; and secure accommodation. The common pattern was initial placement with a foster carer or relative, followed by subsequent moves to a residential unit. Those who were in out of home placements earlier in childhood, tended to experience a degree of placement stability for relatively long periods of time and some were subsequently returned home. However, as they approached or entered adolescence there tended to be a marked change or deterioration in their behaviour, resulting from the escalation of abuse; and parents or carers felt unable to support the young people appropriately in this situation. In some cases, criminal behaviour also led to admission to the JJC.

These 'teenaged' placements tended to be characterised by frequent placement change with many young people moving between different residential units, secure accommodation and admission to the JJC. The majority of the young people had experience of being placed in secure accommodation or admission to the JJC. When JJC admissions are included, the number of placements experienced by them, rises from seven to nine, with some having been detained in the JJC multiple times whilst 'Looked After'.

Instability during the 'Looked After' phase and the difficulty staff had in meeting the young people's needs and managing their behaviour (discussed more fully in Sections C, D and E) was also reflected in the young people's patterns of 'going missing' from their placements. Reflecting and compounding the adversities and instability within their lives, the 'Looked After' phase was characterised by a wide range of emotional and behavioural difficulties. That included for some, self-harming behaviour, which involved significant and extreme incidents, which were regarded as placing their lives in frequent danger. In all cases there were concerns about their circumstances resulting in risky sexual activity, as well as drug and/or alcohol misuse. In a number of cases it was the latter that appeared to put them most at risk, including risk of sexual exploitation. Aggressive and abusive behaviour, either towards family members, peers, staff or members of the public was also cause for concern during the 'Looked After' phase. The overall impact of the escalation of abuse resulted in some young people being excluded from school and some getting embroiled with the criminal justice system including spending time in the JJC, often on more than one occasion. There were concerns that young people were being exploited through exchanging sexual acts for drugs, alcohol and money. In some, but not all cases, this was specifically identified as 'concern about CSE'.

Commonly the 'Looked After' phase was characterised by a constellation of concerns, not just about the young person 'going missing', but also about their circumstances resulting in underage sexual activity and their use of drugs and/or alcohol. Being missing in the company of older males was an additional danger. Concern that the young people were involved in sexual activity under the legal age of consent and being increasingly at risk of rape and abuse applied in almost every case. Whilst young people were clearly at risk, the extent to which that risk specifically centred on CSE varied. In part this is because, as made clear from the research reviewed above, CSE is associated with a wide range of behaviours. Some of these behaviours are illegal, regardless of age; others are illegal depending on the age of both parties at the time; and some, which are not illegal, are detrimental to the health and wellbeing of young people, putting them at risk of physical or emotional harm. Box 4 outlines the legal framework governing the most common offences which might come under the heading of sexual exploitation.

4 Most Common Offences Which Might Come Under the Heading of Sexual Exploitation

Offence Type	Definition
Sexual assault/rape	Under the Sexual Offences Order 2008 this is illegal across all age groups and an offender can be charged from the age of 10 (age of criminal responsibility).
Sexual activity aged 16+ years	Under the Sexual Offences Order 2008 the age of consent in NI is 16. Under the legislation it is legal for 16 and 17 year olds to have consensual sex with other 16-17 year olds or adults as long as they are not in a position of trust, e.g. care worker, teacher, residential worker.
Sexual activity aged 13-15 years	Under the Sexual Offences Order 2008 there are a range of offences which outlaw (consensual) sexual activity between under 16s and adults. It is also illegal for 16-17 year olds to have sexual contact with 13-15 year olds, although there is a lesser penalty than for adults. Although, technically, this makes all sexual activity between 13-16 year olds illegal, the intent of the legislation and associated guidance is not to criminalise consensual non exploitative activity amongst young people of the same age.
Commercial Exploitation	It is illegal for an adult to pay for sexual service or exchange goods for sex involving a child or young person under 18 years of age.

Again as found in the CSE literature reviewed above, the profile of those involved in the sexual abuse and/or exploitation was unclear. It appeared to involve a combination of teenage boys, as well as older males, thought to be aged 18 and over. There were concerns raised by the Police and Social Services about some of these men, as some had criminal records, including sexual offences and some being involved with running so-called 'Party Houses' and supplying alcohol and drugs to young people. Sexual involvement with these individuals was often inappropriately misunderstood as 'consensual', in the sense that the young people might not consider themselves to have been abused or exploited (an issue returned to in Section E). It was also reported that some young people had disclosed that they had been forced into sexual activity, or had sexual acts committed against them, whilst they were unconscious or incapacitated through drugs and alcohol. Whilst much of the CSE appeared more opportunist than organised, there were also serious concerns that young people were being commercially exploited through exchanging sexual acts for drugs, alcohol and/or money and even being trafficked across Northern Ireland for sexual purposes.

Overall it was clear that the 'Looked After' phase had been unable to address adequately the needs and vulnerability of the young people; much of which was carried over from the Pre- 'Looked After' phase. In particular, the escalating challenge of CSE was not managed in a way that allowed the young people to come to terms with their past difficulties and to build a secure platform of emotional attachment and social stability. Attempting to manage issues of physical safety and at the same time find ways to promote emotional and relational security, through combining placements in open units with periodic placements in secure units, created considerable instability, movement and disruption during the 'Looked After' phase.

CHARACTERISTICS OF THE POST 'LOOKED AFTER' PHASE

Half of the group ceased to be 'Looked After' in the period covered by the file review, so it is possible to make some observations on the Post-'Looked After' phase. They all 'aged out' of being 'Looked After' on their 18th birthdays. It is important to note that this is not the end of Corporate Parenting responsibilities. There is still a statutory duty to assess and meet the care and support needs of these young people until they are at least 21 years old or later, if still receiving help from a H&SCT with education or training. H&SCTs are required to provide a Personal Adviser and a Pathway Plan for all eligible young people. The Pathway Plan is intended to map out a route to independence for these young people and to be reviewed regularly to take account of a young person's changing circumstances and ambitions (see Box 5 for an overview of leaving care legislation and regulations).

It was clear from the case files that Pathway Plans were drawn up and Pathway Reviews undertaken in compliance with procedures. The Pathway Plans covered a wide range of issues: accommodation; health; identity and self-esteem; emotional and social development; family and other social relationships; personal support; finance; education and training; employment, careers; and criminal justice issues. They provided the opportunity to identify and monitor levels of risk and where necessary, put into place individual crisis management plans. Social Services very much took the lead with a wide range of agencies being involved as the specific circumstances of the case required.

5 Leaving Care Legislation and Regulations

The Children (Leaving Care) Act (NI) (2002), Children (Leaving Care) Regulations (NI) (2005) and Leaving and Aftercare: Volume Eight Guidance and Regulations (DHSSPSNI, 2005) provide detailed guidelines and regulation in relation to young people who are leaving care.

The Children (Leaving Care) Act (NI) (2002) amended the Children (NI) Order (1995) to place duties on HSCTs to prevent premature discharges from care and improve assessment, planning and support for care leavers. It also made new provisions for HSCTs to maintain contact with young people leaving care and ensure their welfare even after they leave care – a duty which extends until the child is 21 years or later if the Trust is supporting further education and training. HSCTs are also expected to assist and support the ongoing education and training of care leavers, including education and accommodation expenses until the age of 24.

The Children (Leaving Care) Regulations (NI) (2005) provide more detailed guidance for HSCTs on how best to assess and meet the needs of care leavers and include: the qualifying criteria for leaving and aftercare arrangements; the assessment of need; preparation and review of pathway plans to improve support for care leavers; the functions of personal advisors to ensure better support for young people after they leave care; and the assistance available for care leavers with regards to education, training, financial support and accommodation.

A care leaver is defined as a person who has been 'Looked After' for at least 13 weeks, since the age of 14 and who is in care on their 16th birthday.

This generally meant that the H&SCTs not only provided most of the information for assessment and review, but also provided key services. In addition to support from 16+ Team social workers and Personal Advisors, there was also outreach support from residential units, psychologists, specialist nurses for young mothers and education, training and careers advice. In addition, the PSNI continued to make their contribution and probation officers were also involved in some cases. Voluntary sector organisations made their contribution too, in regard to addressing issues of employability, drugs and alcohol abuse, mental health and parenting. The involvement of some parents and other family members played an important part in this mix of support. It is worth noting that some of the young people returned to live with their families. Parents' involvement in the formal processes was limited for a range of reasons, generally reflecting the state of their relationship with the young person and/or with Social Services. Whilst rifts in those relationships might be deep and long standing, where work was done by Social Services to maintain contact during the 'Looked After' period, even when that had not been easy to do, it paid dividends in the Post-'Looked After' phase.

During this phase young people were successfully engaged, to varying degrees, with both the planning and then the services that were offered. As had been the case in the 'Looked After' phase, there was a high degree of reacting to what was happening in the young person's life, rather than planned, sustained delivery of a service. Much depended on the young people's shifting levels of motivation in regard to any particular issue at any particular time – whether that was parenting, anger management, housing, or social security. However, the Post-'Looked After' phase was characterised by a much greater sense of the young people wanting and having expectations of support in areas that converged with the professional's assessment of their needs. It is worth noting that some of the young people were parents and this seemed to be a stabilising influence, encouraging their engagement with services. There appears to be an important opportunity that arises when care experienced young people become parents, to engage them in parenting programmes which can reduce both their own and their child's vulnerability.

It has been noted (Stein, 2009) on the basis of the fairly extensive research now available that young people leaving 'Looked After' placements tend to move between three loose categories, based on their experiences before and when 'Looked After' and their outcomes on leaving - those who are 'moving on', those who are 'surviving' and those who are 'struggling'. The first group are those who have clearly benefited from being 'Looked After' and are 'moving on' into their adult lives, requiring limited support. Then there are those whose experience of being 'Looked After,' have not been able to address important areas of need in their lives and find the transition from being 'Looked After' very difficult but are 'surviving'. They require a significant amount of professional support. The third group are really 'struggling' to cope. They tend to be those who had the most adverse pre-'Looked After' experiences, which were not successfully addressed or compensated for when they were 'Looked After' and are 'struggling' with a range of serious issues. They require extensive professional support.

Young people with the experiences of the group being reviewed here are unlikely to be 'moving on', certainly in the short period post 'Looked After' included in this review. That was indeed the case. Consideration was given to the broad outcomes achieved by the young people in six areas: accommodation and neighbourhood belonging; self/cultural identity and relationships; practical and social self-care skills; guidance and support (adult and peer); health and wellbeing (physical, emotional, mental and sexual); and education, training and employment. In the main, across all those areas, the picture seemed to fit the category of 'surviving' and being in need of considerable support.

Characteristically for 'survivors', the young people were increasing their engagement with services. They were benefiting from the multi-agency packages of care, built on support from specialist leaving care workers in the 16+ Teams, in combination with informal support from their family. Engagement with these formal and informal networks of support, especially the informal ones, had the potential for increasing emotional attachment and stability in their lives. If such a momentum for positive change can be sustained and increased in the Post-'Looked After' phase, young people can overcome the adversities they have had to face, including CSE and start 'moving on'. If change is not sustained, the risk is that 'surviving' can turn to 'struggling'. Young people who can re-establish positive contact with family and other informal supports, as well as engage with services, are those most likely to move on in time.

CHALLENGING LIVES

Considering the characteristics of the phases of being 'Looked After' makes it clear that the CSE of 'Looked After Children' has to be understood and tackled as part of a developing process. Experience of childhood adversities Pre 'Looked After' can become the escalating problem of CSE when 'Looked After'. The challenges of the Post 'Looked After' phase can include coping with CSE. Considering each phase also gives some idea of how challenging it can be for children and young people, in situations of adversity to cope with the experiences and choices they face as they grow up and how vulnerable they are to those prepared to exploit them sexually. It also shows how difficult it is to ensure their safety and well being, even when considerable resources are made available to support children, young people and their families during the various phases. To understand why that should be and what areas need to be improved, to ensure that services can strengthen the likelihood of resources having the necessary effect, attention needs to be paid to four further themes:

- assessing need and identifying CSE;
- mobilising services to both prevent and support young people along with disrupting and prosecuting those who sexually exploit;
- enhancing relationship based practice with young people; and
- continuous learning and development.

Each of those areas will now be considered in the sections that follow.

C

Assessing need and identifying risk of CSE as the basis for strategic case management

Working with families and children with multiple and complex needs can be an overwhelming task. It requires a methodical approach involving gathering information on which to base an assessment, which then informs planning, that directs action, which leads to results, which must be reviewed. Effective action requires attention to each of the elements in turn.

The case file reviews showed that in general, the first steps of information gathering and assessments were completed by staff to a good standard. Child protection pathway assessments, 'Looked After Children' Reviews, aftercare plans, risk assessments and risk plans were completed in a timely fashion and were compliant with policy and procedures. There was however, variability, both across cases and within cases over time, with some delay in completing initial assessments, as well as a lack of regular updating.

Improvement in the clarity of recording and assessment was found in the files for the more recent years. This appeared to have been helped by the introduction of regional initiatives, such as the assessment framework, Understanding the Needs of Children in Northern Ireland (UNOCINI), which started to be introduced in 2006. There was also the Regional Policy for Northern Ireland Health and Social Care Trusts relating to Administrative Systems Recording Policy, Standards and Criteria introduced four years later (DHSSPS, 2010). UNOCINI was a particularly important development, in that it provides a format for a preliminary assessment that can be undertaken by any professional, within any agency. It was developed by health and Social Services staff, along with other agencies and organisations, including education and the police.

Assessments, in the main, were fit for the purpose of identifying the complex range of risks to the young people. It was also apparent that over time there was a growing recognition that CSE was a major concern. There were significant differences between cases, in how early on the term was used to describe sexual abuse. In some it was as early as 2006, while in others it was not until the impact of Operation Owl made it a widely shared way of thinking about this form of sexual abuse. It was also apparent that for the young people at various points during their pathways into and through being 'Looked After', CSE was by no means the only or even the most serious risk, given other life threatening behaviours linked particularly with alcohol and drugs.

In light of the research on CSE, noted earlier, this multifaceted nature of the risk in these young people's lives is not surprising. Awareness of CSE must not obscure other difficulties young people are experiencing and at the same time it must not draw attention away from the particular dynamics that CSE can give to a case. The advantage of the term is that it clearly directs attention to factoring in the activities of the perpetrator, to any assessment of risk. These young people certainly had a range of problems, but primary amongst them was that there were adults prepared to sexually exploit their vulnerabilities. A CSE assessment becomes the basis for implementing a twinned approach to meeting the needs of the victims and actively pursuing the perpetrators, with a view to prosecution.

Recognition of CSE contributes to the extremely complex task of identifying and assessing need, in order to plan and implement an effective intervention, drawing on the contributions of all the relevant agencies. Identification of significant risk in the lives of children starts with looking for their exposure to what has been called the 'toxic trio' of parental domestic violence, substance misuse and mental ill health. Moving from the identification of these underlying vulnerabilities, to analysing their role in the life of a particular family or child however, is far from straightforward.

There is not enough known about the relative weighting that should be given to these factors, singly or in combination. In addition, there is a case for unpacking those factors further; for example distinguishing alcohol and drug misuse (Anda et al., 2002). There are also the additional known adversity indicators that need to be taken into account, such as parental criminality, bereavement and various form of child abuse. Identifying these risk factors is not the same as being able to predict which children in which families are going to be exposed to CSE, nor how that will affect the dynamic of the case, in particular, the interweaving of physical safety, relational stability and psychological security (Shuker, 2013).

Generally, communication between agencies was effective in identifying the risks and trauma that a young person had experienced and that certainly seemed to facilitate interagency working. However, whilst information was collated and shared and risk factors generally identified, there was variability in relating and assessing these factors as indicators of the future risk of sexual exploitation or even the existing experience of CSE. The risk factors were often referred to in isolation of the overall context and circumstances of the young people. Over time, there was growing recognition of the impact of CSE on the young people and considerable time and effort went into responding to it, but there appeared to be no point in the case management at which there was a clear interagency agreement that CSE was the driving dynamic and all services needed to be addressing it in a combined and concerted fashion.

Indeed there was some degree of mismatch between assessments by Social Services and other agencies. In the main, this seemed to reflect the differences between the focus of assessment required by different agencies according to their function; for example the JCC took risk of re-offending as its primary focus and Social Services focused on physical safety. This meant that no one single interagency assessment and analysis emerged, providing for a shared view of the centrality, or not, of CSE. Indeed it was clear that particularly around assessing the level and implications of concern about 'going missing', there were differences of opinion between PSNI and Social Services staff. These were not addressed and resolved at case level and generally there was no record of whether they had been 'escalated' and drawn to the attention of higher levels of management to be dealt with in interagency strategic discussions. The use of the 'traffic lights' (see Box 6) could have provided a basis for the necessary discussion and either agreement or failure to agree and then escalation for higher management resolution, but did not seem to function in that way. There are lessons from that as more sophisticated assessment tools, with their focus on scaling risk, become available to staff - such as that in the Interim Regional Guidance – Management of Child Sexual Exploitation Referrals (HSCB 2014). Such tools are necessary, but not sufficient, to provide the required agreed assessment. Only front line staff working together with management support, reaching agreement and where necessary recognising and resolving differences of opinion, can achieve that.

6 "Regional Guidance: Police Involvement in Residential Units; Safeguarding of Children Missing from Home and Foster Care" (HSCB and PSNI, 2012)

This guidance, first issued in 2008 and revised in 2012, was agreed jointly between the H&SCTs and the PSNI and 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 is coded on a risk assessed basis with a green, amber or red categorisation – a categorisation which governs the intensity and immediacy of response of both the PSNI officers and residential staff. As well as frequent and ongoing contact between the PSNI and residential unit, both agencies are also tasked with undertaking 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 the purposes of prevention, disruption and prosecution. The guidance also advises that the H&SCT 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.

Co-operation between the PSNI and Social Services was especially important in identifying and assessing the risk of CSE and this was apparent throughout the case files. The agreed protocol for the interagency management and investigation of CSE and any other child abuse allegations is the 'Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2013) and previous versions, were in operation since 1991. This working together appeared not to be without its frustrations on both sides but, in terms of management of risk, there was cooperation and significant communication between agencies although usually reacting to incidents after they happened.

Service provision also tended to be reactive to incidents, at a pace set by what was going on in the young person's life. Action was taken in response to events on a day-to-day basis, rather than strategic case management, based on an agreed interagency assessment, which had determined CSE to be the dominant concern, requiring a combined intervention, planned to meet the particular circumstances of each young person. There was also no apparent working model of change being applied, based for example on the therapeutic approaches that have been adopted by individual H&SCTs (see Box 7) in conjunction with strategies available to the PSNI in relation to disruption and prosecution (see Box 8).

7 Therapeutic Approaches in Residential Care in Northern Ireland (taken from MacDonald et al.2012)

In 2008/09 the DHSSPS invested £1m to enable H&SCTs to train residential staff in therapeutic approaches to working with 'Looked After Children'.

Belfast Trust – Social pedagogy
Relationship and good communication are essential to this model and it stresses a more collaborative or democratic approach rather than the hierarchical approach usually found in residential units. So-called "ordinary tasks or events" offer opportunities to encourage development and social pedagogy blurs the dividing line between the personal and the professional, whilst also recognising the private.

South Eastern Trust – Sanctuary model
The Sanctuary model highlights the effect of trauma on children and recognises that organisations and the staff within them can produce dysfunctional (defensive) ways of behaving. Change therefore has to be at a systems level. The model incorporates a trauma-informed, shared language – SELF – standing for Safety, Emotion management, Loss and Future. The language and philosophical foundations of the model are reinforced by a set of practical tools for staff and children to use.

Northern Trust – Children and Residential Experiences (CARE) model
CARE focuses on two core areas of competence: improving leadership and organisational support for change and improving consistency in and across team members in how they think about and respond to, the needs of the children in their care.

Southern Trust –Attachment, Regulation and Competency (ARC) model
ARC is described as a flexible framework that allows practitioners to choose from a "menu" of sample activities and interventions. These are organised into three areas: attachment, self-regulation and competency. Carers aim to help traumatised children to (re)build healthy attachments.

Western Trust – Model of attachment practice (MAP)
MAP uses attachment theory and research on neurodevelopment to help staff understand children's behaviour and what it means. Core components include: trauma, systematic practice, the building of emotional intelligence, competency and resilience in children and young people. It encourages staff to be "actors" rather than "observers" and to recognise the effects of the emotional demands placed on them in their work with children. Other core components are authoritative parenting and attunement.

8 Framework for PSNI Response to CSE

The PSNI and/or criminal justice response to young people missing from 'Looked After' placements and at risk of CSE is framed by a range of legislation, policy and procedures. Key amongst these are:

The Sexual Offences (NI) Order 2008

While there are a range of contact sexual offences such as rape, sexual assault and sexual activity with a child which fall under the umbrella term of child sexual exploitation, there is no specific offence of CSE per se. Nonetheless, the Sexual Offences (NI) Order 2008 includes a range of offences which recognised the grooming, coercion and control of children which is at the heart of abuse and CSE. These include the offence of:

- arranging or facilitating a child sex offence (child under 16)
- meeting a child following sexual grooming (child under 16)
- paying for the sexual services of a child
- causing or inciting child prostitution or pornography
- controlling a child prostitute or a child involved in pornography
- arranging or facilitating child prostitution or pornography
- trafficking into, within or out of the UK for sexual exploitation

Child Abduction

Article 4 of the Child Abduction (NI) Order 1985 and Article 68 of the Children (NI) Order 1995 make it illegal for a person to take or detain any child under the age of 16 and under the age of 18 respectively, without a legal authority or reasonable excuse. Specifically, Article 68 of the Children (NI) Order 1995 includes reference to inducing, assisting or inciting a child to run away or stay away from the responsible person where they are the subject of a Care Order, an Emergency Protection Order or a Police Protection Order.

Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2013)

The aim of this Protocol is to ensure that key partner agencies work together effectively to ensure that the best interests of the child underpin every aspect of child protection work. Investigating social workers and police officers must use this Protocol for Joint Investigations.

Whilst interagency meetings and reviews took place and were generally well attended, joint assessment of the impact of multiple missing episodes and concern over CSE, appeared to be primarily about information sharing and reiterating emergency responses. They did not appear to be routinely about the planning and progressing of strategic case management in a way that brought PSNI and Social Services agencies together with others, to proactively address CSE. Without an analysis and agreement on the implications of identified risk factors for the dynamics of a case, the strategic case management necessary to plan and implement an intervention cannot be pursued effectively through Child Protection or 'Looked After Children' Reviews. This is particularly so where what is required is a combined approach, providing for a young person's safety and welfare and at the same time investigating, disrupting and prosecuting those who would sexually exploit them.

Areas for Improvement:

C1. Use of UNOCINI as a means of capturing not only the depth and breadth of need (including multiple adversities) as it develops and changes over time but also the identification and assessment, in particular of CSE, risk factors and their implications for the dynamics of a case.

C2. Use of Child Protection Registration and of 'Looked After Children' reviews to identify CSE risk factors gleaned from across Social Services, health and education and their implications for the dynamics of a case.

C3. Making explicit the use of ARC, Social Pedagogy, CARE, MAP and Sanctuary in assessing the implications of CSE risk factors for strategic case management.

C4. Offender profiling and intelligence led network analysis to identify and analyse links amongst adult perpetrators and amongst young people and the relationships between the two groups.

C5. Use of a regionally agreed CSE Assessment Tool, with an emphasis on scaling and analysing risk, to underpin multidisciplinary collection and collation of relevant information and its analysis at case management and strategic management levels.

C6. Proactive use of H&SCT and PSNI specialist interviewers under the Protocol for Joint Investigation by Social Workers and Police officers of Alleged and Suspected Cases of Child Abuse – NI (2013).

D

Strategic mobilising of services to meet young people's needs and to prosecute sexual exploiters

As has already been stressed, the young people subjected to CSE must be the central concern but those that exploit them must be the key focus of efforts to disrupt and prosecute. A common theme in the professional workshops convened for this Review was the need to focus more on disrupting potential offenders and not just focus on the behaviours of the young people.

Accordingly, where CSE is agreed as being at the core of a case, the focus must be on mobilising services which can not only protect and support the young person but also achieve the identification, disruption and prosecution of suspected perpetrators. Health and social care agencies that lead on meeting the needs of young people with multiple and complex psycho-social needs, must work closely with those public safety agencies, primarily the PSNI, tasked to prevent crime and to prosecute.

In regard to the experiences of the ten young people being reviewed here, although agencies were generally compliant with policies, procedures and guidance and identified the range of risks including CSE, the care histories and reported outcomes make it clear they were limited in terms of their overall effectiveness. Despite the provision of a wide range of services and access to therapeutic support, the young people continued to exhibit an array of challenging and risky behaviours which escalated over time before, in some cases, beginning to de-escalate. Across the cases there was a sense of professionals missing opportunities in the pre-'Looked After' period for preventative and early intervention work and then, when faced with the very challenging behaviours of the 'Looked After' phase, repeating the same responses to the same behaviours with an air of resignation, based on the experience of there being no likelihood of change and no alternative approaches to achieving it. Given the difficulty of effecting change during the 'Looked After' phase and the existence of identifiable adversity indicators in these young people's early family lives, the case for early intervention and preventative family support is compelling.

By the time they 'teenaged' into being 'Looked After' the young people were well on the way to being not only beyond the care and control of their parents but beyond the reach of what staff were trying to offer, including containing their behaviour (see Box 9: powers of staff in non-secure residential units). Attempts to do that did not provide a safe space in which therapeutic work could be carried out but triggered a cycle of admissions from residential care to either JJC or secure accommodation, back to residential care only to return back again to secure accommodation and so on. Typically it would be recognised that a young person was extremely vulnerable but also viewed as 'hard to reach'. The response, at high points of concern about their safety and wellbeing, was to place them in an open residential Intensive Support Unit, then the Secure Accommodation Centre for short periods, along with periods in the JJC resulting from behaviours which were criminal. When in secure accommodation, physical safety was relatively assured, behaviours were more manageable and some of the young people reported that they felt "safe and able to engage with services". However, these short term gains, whilst important in themselves, were not carried through on return to open residential settings. Physical safety could be secured but not what has been termed 'relational security' and 'psychological security' (Shuker, 2013), requiring longer term work with victims of CSE.

9 Powers of Staff in Non-Secure Residential Units

CHILDREN (NI) ORDER 1995 Guidance and Regulations Volume 4 Residential Care

The use of accommodation to physically restrict the liberty of any child
This is prohibited except in accordance with Article 44 of the Children Order and the Children (Secure Accommodation) Regulations (see Chapter 15 and Annex G). Locking external doors and windows at night time in accordance with normal domestic security is permitted. The use of locked doors should not be an easy means of saving staff time or keeping their numbers inappropriately low. Staff should find ways of keeping each child safe which minimises the need for physical control and restriction of liberty. On no account should children be locked in their bedrooms at night, whatever their age and competence. However, in some circumstances, close night time supervision may be required. Responsible authorities should give clear, written guidance to staff about the extent to which the home, or any part of it, may be locked as a security measure. Similarly, refusal of permission to go out, that is, "grounding", short of measures which would constitute restriction of liberty, is not forbidden.

Use of physical presence by staff
This refers to actions which reinforce a member of staff's authority or concern. At its simplest level, a staff member's presence should be a deterrent to misbehaviour. A look or a gesture may send out signals to children which help to keep behaviour within acceptable limits. Acceptable limits can include standing in the way of a child who is ignoring instructions or losing control and may be reinforced, for example, by placing a hand on the child's arm. The effect of this may be to restrict a child's movement without the use of (forceful) physical restraint. This is acceptable only so long as the duration of the restriction is not prolonged. Its effectiveness may depend upon the respect that the child has for the particular staff member.

The use of an adult's physical presence:
- must be likely to be effective by virtue of the overall authority carried by the staff member and not simply his physical presence;
- must be used in the context of trying to engage the child in discussion about the significance and implications of his behaviour; and
- should not be persisted in if the child physically resists. In this case a decision will need to be made about whether another form of intervention is justified.

Running away, restraint and secure accommodation
Staff should recognise that there are practical limitations on their ability to prevent young people running away from an open residential unit, if they are determined to do so. The use of physical restraint in these circumstances cannot become a substitute for secure accommodation. Where there is concern for a child who is likely to run away and suffer significant harm or inflict injury, then consideration should be given to whether the criteria for placement in secure accommodation can be satisfied.

It would appear that within the group of ten, the effectiveness of services in ensuring safety and security for the young people, along with disruption and prosecution of the exploiters, was hampered by a number of key factors:

- a reactive, crisis driven response fuelled by the high number of missing episodes and that more than one young person might be missing from the same unit at any one time;
- professionals finding it extremely difficult to build the relationships necessary to effectively engage young people with services;
- the complex and challenging nature of young people's emotional and behavioural responses to their experiences of multiple adversities;
- lack of viable alternatives to the existing secure provision and delays in obtaining secure accommodation when needed; and
- insufficiently proactive management oversight which could open up a more strategic approach to exploring alternatives to repeating the same failing responses.

This is not to say that all professional efforts were without success and it was evident from the records that residential and other staff continually tried to engage with the young people, in an effort to maintain some degree of stability and positive influence in their lives. It was also evident that on more than one occasion in those cases where the young people were engaging in extreme self-harming, including suicidal behaviour, it was the continuing care and monitoring by staff that saved their lives. However, while staff were able to effectively manage certain risks, for example when young people were returned to the unit under the influence of alcohol and/or drugs, they were unable to prevent future 'going missing' episodes and the associated likelihood of risk taking behaviour. It was not apparent how the various therapeutic approaches adopted by the H&SCTs were being used to engage with these situations. The same point applies to Therapeutic Crisis Intervention (TCI) and restorative justice approaches, both of which are used in conjunction with the therapeutic approaches. This suggests the need for further evaluation of the effectiveness of these approaches in general and in regard to CSE in particular.

Case file reviews indicated that the Social Services' response when young people went missing was appropriate and they shared the required information with the PSNI and the young person's family. In line with the therapeutic aspirations and training of the residential staff, (McDonald et al., 2012) they tried to encourage young people to stay in the unit through verbal negotiation and use of their physical presence to discourage the young person from leaving, for example by standing in their way. Therapeutic Crisis Intervention in which all staff are trained and which includes physical restraint, to ensure the safety of young people, was not used. If a young person left without agreement, some staff would take down the registration numbers of cars they had got into, follow them, check known addresses of family or friends and phone local taxi firms to obtain information about the young person's possible location. They also watched over the young people when they returned to the unit, particularly when they were under the influence of alcohol and/or drugs. However, it was clear that they had limited ability to prevent the young people from repeatedly

'going missing' without authorisation, either by not returning to the unit having being out during the day, or by leaving it at night. Whilst 'going missing' at night was of particular concern it was also worrying during the daytime.

In terms of CSE, the risk posed to the young person through their circumstances engaging them in sexual and other risky behaviours was clearly identified by staff. There were repeated efforts to mitigate the sexual health impact through ensuring the young people received appropriate sexual health and contraceptive services. Through the efforts of residential staff and voluntary organisations, attempts were made to provide advice and guidance around sex education and risk taking behaviour. However, placing the onus on the young people to change their behaviours, showed limited success and for the required combined approach to CSE suggested too much focus on them and their behaviour, in comparison to focusing on the extent to which they were being sexually exploited and by whom.

Similarly, while the PSNI were effective in locating and returning the young people and where necessary dealing with their criminal behaviour, evidence of the PSNI trying to establish the identity of the perpetrators the young people had been in the company of, or take a proactive approach to disrupting potential offenders was limited and inconsistent. Return home interviews were often not completed, especially where repeat episodes of 'going missing' were frequent. Those that did take place did not shed much light on the reasons for the young person being missing, what happened when they were missing and what would prevent them 'going missing' again. This was not surprising, given the inability to engage the young people in a meaningful exchange. Generally there appeared to be a lack of strategic planning about how to manage, as opposed to how to react, to future missing episodes. There appeared to be no sustained attention to identifying and considering the case management implications of the relationships the young people were known to have with other 'Looked After Children', nor to connections amongst those involved in sexually exploiting the young people. Drawing together information from across cases could have provided intelligence of the sort Operation Owl appeared to have, suggesting networks of abusers and young people. Such information would strengthen the disruption and prosecution side of a necessary CSE combined response.

It is important to recognise just how reluctant and in some cases afraid, the young people were to engage with the PSNI and Social Services staff in providing relevant information about the people they had been with or by disclosing that an offence had been committed against them. The lack of injured party or witness statements was seen by the PSNI as a major barrier to more proactive policing, although it was acknowledged that greater use could have been made of more proactive disruption and investigation techniques. Despite these difficulties a number of case files did show evidence of the PSNI conducting investigations into alleged offences against the young people but prosecutions have not been forthcoming. Harbouring notices against suspected offenders were issued in seven of the cases but to limited effect. Equally, while the PSNI were generally very effective in locating the young people and returning them to the residential unit, records relating to assessment and the procedural requirement to conduct 'Safe and Well Check' interviews with the young people indicate that these were not always done and were generally limited in content. Missing that opportunity to gain further information and to advance case management objectives was compounded by the lack of 'Return Interviews' being undertaken by field social workers, or some other independent person of the young person's choice as required by procedures.

Overall, in terms of case management, the PSNI response was generally restricted to locating and returning young people who had 'gone missing', rather than pursuing options to disrupt and pursue prosecutions. This narrow interpretation of their responsibility led to them focusing primarily on the young person rather than any alleged or potential offenders. The Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2013) was not generally initiated. There was the impression that police officers saw the problem of 'going missing' to be about young people being out of the control of the residential staff, who should have had responsibility for them, without fully exploring the nature of the risk or the extent to which the sexual activity they engaged in, was consensual or exploitative.

Nonetheless, it was also apparent that the PSNI response improved significantly with the inception of Operation Owl and considerable improvements have been made over the past few years, in terms of interagency co-operation. This theme was highlighted time and time again in the professional workshops and professionals across a range of disciplines commented on improved interagency working and communication. The assignment of a named police officer to individual residential units was also reported as a particularly valuable development, which enabled the PSNI to build relationships with the young people and develop better awareness of their needs and backgrounds.

Case files evidenced the provision of a wide range of services beyond residential Social Services and the PSNI, including therapeutic support from across a number of statutory and voluntary agencies. Services included: secure accommodation; specialist foster placements; Multi Systemic Therapy; Youth Justice provision; the specialist CSE project; Child and Adolescent Mental Health Services; psychological services; educational support; community nursing; and befriending and advocacy. Despite this range of provision, CSE and the related risk behaviours was not prevented or dealt with. A number of case file reviews noted that the efforts of well-intentioned and conscientious staff were often thwarted by an inability to get beyond the difficulties some of the young people experienced, in accepting help or engaging with professionals. Many of the desired outcomes were not achieved, although staff continued to persevere, often over a number of years and throughout periods during which the young people regularly went missing.

In some cases, delays in accessing secure accommodation was highlighted as the problem, it was also noted that although provision of a number of services such as anger management and CAMHS were discussed in meetings, they were seldom acted on for reasons that were not apparent. Some File Reviewers actually raised a question about the number of services involved; an issue which was reiterated in the workshops, with a number of professionals highlighting the need to better manage the number of agencies/services young people are involved with. The aim must be to provide a secure base from which a young person can reach out for various forms of support, not be flooded by offers of services. It also seemed evident that there was a need for greater oversight by operational managers, in order to develop alternative strategies, when young people refused to engage, where risks remained high and service provision had limited impact. Services needed the flexibility to respond rapidly to changing intensity and types of need.

Areas for Improvement:

D1. Provision of family support through access to integrated preventative services, alongside proactive early and sustained authoritative intervention with families where childhood adversity indicators are identified.

D2. Community based diversion and policing involving a wide range of people (youth workers, park wardens, taxi drivers, bar and hotel staff) to restrict perpetrators' opportunities for CSE and to provide alternative opportunities to young people vulnerable to CSE, to get support.

D3. Proactive placement choice to directly address repeated 'going missing' as part of case management in order to deliver on actions and consequences of safety planning, including use of forms of secure accommodation, specialist fostering and arrangements developed to meet the specific needs of individual young people.

D4. Proactive case management to provide physical safety, relational security and psychological security using identified residential therapeutic approaches along with CAMHS and other health and education services in order to address individual and group needs, including maintaining continuity of positive relationships with family and friends.

D5. Ensure that Return Interviews are consistently undertaken by staff who young people have been given the opportunity to choose and focus on advancing strategic case management objectives.

D6. Proactive policing response to repeated 'going missing' with an emphasis on gathering evidence of CSE for assertive disruption and pursuit of prosecution, making full use of Safe and Well Checks.

E

Enhancing relationship based practice with young people

Central to staff effectively ensuring the safety and promoting the wellbeing of 'Looked After Children' and young people exposed to CSE, is the ability to help them at the times when they need it most, but are least open to it. Despite staff efforts, young people often found it too difficult to be part of a positive working relationship with them. This negative response to professional support would be encouraged by those who were actively exploiting or abusing the young people concerned. At times that included young people being aggressive, abusive and physically violent towards staff. At certain points in most of the cases, resistance seemed a more apt term than non-engagement.

Residential staff regularly sought the views of the young people in their care and involved them in 'Looked After Children' Reviews and other planning, but were unable to get them to engage in addressing their 'going missing', drug and/or alcohol use, self-harming and risk taking behaviours.

Not only did the young people not share the professionals' view of the risk they were exposed to, but they saw themselves as being in control of their lives, 'consenting' to the activities they were caught up in. The use of 'grooming' and violence, the offer of material rewards and the role of peer pressure are increasingly understood as the means by which such 'abusive consent' is manufactured (Pearce, 2013). Of equal concern however, is the risk of abusive 'condoned' consent through professional negligence where there is failure to recognise CSE as a form of sexual abuse. Mistakenly, CSE is seen as a problem located in the young person, as 'acting out' behaviour, promiscuity or being 'street wise'. Whilst some of the ways in which the young people's behaviour was presented had an element of that, it did not seem to be the block to effective practice with this group of ten. What seemed to be absent was the consistent and sustained application of a shared theory of change (Whittaker et al 2015), which combined in depth support for the young people with investigation, disruption and prosecution of those sexually exploiting them.

The absence of an explicit theory of change was surprising, given the significant commitment there has been to building up the therapeutic understanding and skills of generic residential care staff in Northern Ireland. This has involved supporting and evaluating a set of approaches which have been chosen by the H&SCTs (Macdonald et al., 2012). Whilst each H&SCT has its own approach, (see Box 7) they all share working assumptions that chime with what is known about effective engagement with the impact of CSE. These are: recognition that young people in residential care have suffered trauma and disadvantage; encouragement of staff to understand and address the needs and emotions underlying challenging behaviour, rather than simply responding to the behaviour; and providing both staff and young people with techniques for being aware of and regulating, their responses to stressful situations. Each of the models also emphasises to some degree, the importance of staff understanding how their work has an impact on them and vice versa.

In an evaluation of the implementation of the models in Northern Ireland (Macdonald et al., 2012) staff reported that their introduction had improved consistency in the practice of both individuals and staff teams. They talked about becoming more able to reflect on their own emotions and their views of others and how this had had a positive impact on their practice in a way that helped them make more considered, constructive and consistent responses. It equipped them to deal more successfully with stressful situations and with less emphasis on sanctions and more emphasis on negotiating with the young person. Incidents became less personal and were seen as opportunities to work with the young person on self-awareness and self-management. The shared use of the language of the models in written reports and logs was reported as further enhancing the consistency of practice within teams.

Despite what was reported in the general evaluation, in the ten cases considered here, it was not apparent how the various therapeutic approaches were being used to engage with these situations of CSE. This raises questions about the levels of skilled application of the approaches as well as their content. However, staff did report in the evaluation that the models did not provide them with sufficient tools to deal with physically aggressive behaviour. All of the units were still practising either restorative practice or Therapeutic Crisis Intervention (see Box 10), alongside their chosen models. Staff reported selecting the best tools from the range of models they were trained in, to deal with any given situation.

10 Therapeutic Crisis Intervention and Restorative Practice

Therapeutic Crisis Intervention (TCI)
The purpose of the TCI system is to provide a crisis prevention and intervention model for residential child care organisations to assist in:

- Preventing crises from occurring
- De-escalating potential crises
- Effectively managing acute crises
- Reducing potential and actual injury to children and staff
- Learning constructive ways to handle stressful situations
- Developing a learning circle within the organization

Restorative Practice
Restorative practice involves holding restorative conferences after incidents between young people within the unit, or after more serious incidents where young people have been charged with a criminal offence. These take place outside the unit, with an independent chair. In either setting, the aim is to reduce re-offending and repair the damage caused by a crime, whether the victim is another young person, a member of staff or someone in the community.

Whilst quite appropriately, the restraining techniques of TCI were not used to prevent young people leaving open units, it was not clear how other aspects of the intervention, such as emotional de-escalation, were being used to help manage disputes over leaving the units or failing to return. Previous research in Northern Ireland (Kilpatrick et al., 2008 cited in HSCB, 2014) highlighted how staff and young people alike struggled with the issue of when restraint is appropriate and how it should be undertaken. Staff wanting to prevent young people from leaving the residential unit, to place themselves in 'at risk' situations, felt constrained in the actions or sanctions they could use and the decision to use physical restraint was set alongside concern by staff about automatic suspension, if a complaint was made against them.

Despite the general picture just described, some young people did engage at different points and expressed a desire to find a way out of the circumstances they were caught up in. It would appear from the case files that young people tended to engage more with professional staff whilst in secure accommodation, the JJC or a high support therapeutic residential unit that led to more effective engagement and a reduction in risk. But none of these settings were able to generate sufficient momentum for change for the young people to sustain the advances they made, when they returned to open units.

In all settings, professionals made considerable efforts to maintain a relationship with the young people and provide some degree of a stable influence, a 'safe space' in their lives, throughout chaotic and turbulent times which, in many cases, lasted a period of years. At the points when the young people were held in secure accommodation or the JJC, staff from the open residential units would visit regularly to maintain contact. Staff also provided watchful care and monitoring where there were concerns that the young people were caught up in extremely risky, self-harming and suicidal behaviour – in some cases probably saving their lives. At the more mundane level, so important to effective parenting, it was staff who ensured hot meals and clean laundry and saw that dental appointments and health checks were arranged and attended.

However, while staff were able to effectively manage certain risks, for example when young people were returned to the unit under the influence of alcohol and/or drugs, they were unable to prevent them from repeatedly 'going missing' from care and being vulnerable to CSE. There were also concerns about the role of social networking in facilitating CSE. Attempts to keep open communication by mobile phone when they had gone missing provided some limited reassurance as to their safety and facilitated their return. But the pattern of engagement, as with other areas of professional response, can best be summarised as a considerable effort to little effect, certainly in the short-term.

As the young people got older and in some cases had children of their own, it did seem that they were able to fall back on the store of professional support they had received. Despite its weaknesses, the experiences of being 'Looked After' appeared to play a role in the cessation or reduction in the young people's exposure to CSE. In some cases this was reinforced by staff efforts to maintain family contacts, not only with the young person, but also with Social Services. The risk here was over optimism about families having the motivation or capacity to provide positive reinforcement for the young person's engagement in change.

Where the young person remained in exploitative situations, having access to dependable adults, who continued to provide practical, emotional and social support with the intention of securing their well-being, did seem to have benefits. Whilst turnover of staff mitigated against long term personal relationships, in some cases they did exist over a number of years and proved a major asset. The professional workshops highlighted the importance of relationships between staff and the young people in their care as being central to protecting and ensuring their wellbeing; being there for them when they were ready to look for help. So although a snapshot across the cases when the young people were aged 14-16 years would give a negative impression of the effectiveness of these relationships, over time, professionals did seem able to engage the young people more purposefully as their perceptions of their own needs changed.

Areas for Improvement:

E1. Building and maintaining relationships between young people and staff, focused on developing and advancing their care/pathway plans together and with family and other informal support.

E2. Clarifying the use of physical restraint as part of the TCI approach to ensuring physical safety in open units - not to increase capacity to curtail freedom of movement.

E3 Use of adopted therapeutic approaches, including appropriate use of authority, to contain young people emotionally and physically within a 'safe space' and making full use of the Return Interview following incidents of 'going missing' as part of strategic case management.

E4. Dealing with social media both as an essential and generally positive aspect of group living in residential care and as a risk factor providing opportunities for initiating and facilitating CSE.

E5. Development of specialist CSE provision based on experience of existing specialist CSE services, of 'wraparound' services and 'safe spaces', with particular attention to the views of young people as to what worked to meet their needs.

F

Continuous learning and development

There is at present a very strong sense of a momentum for change having been built up in regard to CSE, which is clearly having a positive impact on services for children in Northern Ireland. For over a decade there has been a developing framework of relevant legislation and policy (see Box 11) that has now been copper fastened by the Marshall Report (2014).

This Thematic Review adds to that, specifically in regard to 'Looked After Children' who are 'going missing'. The growing recognition of CSE, particularly during the period 2010 to 2013, was noticeable in the case files as the concept and its implications became more apparent, not just for the ten young people, but as a wider social policy challenge . This was strongly registered in the practitioner workshops and meetings held with the RQIA, the H&SCTs, the H&SCB, the DHSSPS and the PSNI. There is an active engagement with CSE as an aspect of the lives of a proportion of 'Looked After Children', in particular those in residential care, a readiness for exchange around new policy as it is emerging and most importantly for learning about more effective practice based on the experience of young people themselves and those that care for and about them; both practitioners and family.

11 Key Legislative and Policy Developments 2005-2015 Underpinning the Practice Response to 'Looked After Children', 'Missing' and CSE.

2005	**Legislation, Policy & Procedures** **The Children's Homes Regulations (Northern Ireland)** – this guide covers process and practice in respect of all aspects of children's homes, broadly covering the welfare of children, staffing, records, premises and management.
	DHSSPS (2005) produced **"Guidance on Restraint and Seclusion in Health and Personal Social Services".**
2006	DHSPSS published the **"Child Protection Inspection Report"** Introduction of a single assessment tool for children in need in Northern Ireland **"Understanding the Needs of Children in Northern Ireland".**
	The Bamford Review (2002 – 2007) examined law, policy and service provision for people with mental health needs and those with a learning disability. The report **"A Vision of a Comprehensive Child and Adolescent Mental Health Service" (2006)** provides guidance for the development of a responsive, integrated CAMHS with the aim of safeguarding the mental health of children and young people, including those "Looked After".
2007	DHSPSS consultation on **'Care matters in Northern Ireland: a bridge to a better future'** was launched – this set out a strategy that considered how to support young people in and on the edge of care to achieve their full potential and was endorsed by the NI Executive in 2009.
	A **Regional Implementation Team (RIT)** was established to address the recommendations from the Child Protection Inspection Report of 2006. Each Trust was required to develop an action plan which included a process for carrying out interviews with "Looked After" Children (LAC) on return from going missing with a focus on CSE.

2008	**The Sexual Offences (NI) Order 2008 –**this outlines a range of contact sexual offences such as rape, sexual assault and sexual activity with a child as well as a number of offences which would fall under the umbrella term of child sexual exploitation.
	DHSSPS provided funding for Barnardo's NI Safe Choices (Missing from Care) project which aims was to reduce the risk of CSE. Funding responsibility transferred to HSCB in 2011 which extended the service.
	DHSSPS issued guidance **"Child Protection Policy for Children's Homes"** to assist staff management of suspicions or disclosures of abuse in relation to children in residential care.
	Public Protection Arrangements for Northern Ireland were established which placed a legal duty on a range of agencies, e.g. police, probation and social services to work together to manage the risks posed by violent and sexual offenders, on release from prison.
	DHSSPS invested £1m to enable Trusts to train residential staff in **therapeutic approaches to working with children in care**.
2009	DHSSPS awarded project funding (£142k) to Barnardos NI for research project investigating the prevalence of CSE in Northern Ireland and the links with children going missing from care'. The final report **'Not A World Away'** was published in October 2011.
	DHSSPS published a **"Families Matter" Strategy** which outlined plans to intervene early in children's lives to reduce adversity and build children's and families' resilience. **"Regional Guidance: Police Involvement in Residential Units; Safeguarding of children Missing from Home & Foster Care (DHSSPS, 2012) –** first issued by DHSSPS 2009 and revised in 2012. This guidance was agreed jointly between the HSC trusts and PSNI and set out an agreed procedure for responding to children and young people who go missing.
2010	PSNI issue a service procedure outlining the key disruption strategies available to police in terms of **Harbourer's Notices and Child Abduction** prosecutions.
2011	DHSSPS publish **'Transforming Your Care'** which presented a new vision for the future of health and social care in NI. Section 12 focuses on family and childcare.
2012	**"Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures, and the provision of pre-trial therapy" (DoJNI, 2012).** This provides practitioners with detailed guidance in relation to the conduct of investigative interviews. First issued in 2003, it has been revised several times.
	DHSSPS publish policy guidance **'Child and Adolescent Mental Health Services (CAMHS): A Service Model'**, with the aim of ensuring consistency in mental health services for young people across NI.

	The HSCB issued regional **Residential Child Care Policies** which included a specific section on CSE.
	In September The Safeguarding Board for Northern Ireland (SBNI) was established to bring together a number of member organisations from the statutory, voluntary and community sectors to work together to safeguard children and promote their welfare. One of the SBNI's key priorities has been to tackle CSE.
2013	**Operation Owl** established.
	Protocol for Joint Investigation by Social Workers & Police officers of Alleged &. Suspected Cases of Child Abuse in Northern Ireland (HSCB & PSNI, 2013). Northern Ireland introduced its first 'Protocol for Joint Working' between the RUC (CARE units) and Social Services in 1991. The Protocol has been reviewed and amended a number of times, most recently in 2013 (HSCB & PSNI, 2013).
	Northern Ireland's first **Sexual Assault Referral Centre (SARC)** opened to PSNI referrals**.**
	SBNI publish **"Sexual Exploitation: A Guide for Parents/Carers of children and young people"** and **"Sexual Exploitation: A Guide for those working with children and young people.**
	Amendments were made by HSCB to its reporting requirements of HSC Trusts to require trusts to report each **Untoward Event** for each episode of a child or young person being 'missing' for more than 24hrs.
2014	The HSCB issued an interim **CSE Assessment Tool and Guidance.** The tool was reviewed in October 2014 to include the Safeguarding Board's regionally agreed definition of CSE.
On-going	**'Co-operating to Safeguard Children' (DHSSPS, 2003)** provides the policy framework for child protection in NI and outlines the roles and responsibilities of various agencies and professionals. This is currently being revised.
	Draft **Fostering Placement and Fostering Agencies regulations** have been developed to bring fostering agencies within the scope of inspection and regulation by the Regulation and Quality Improvement Authority (RQIA).

In order to capitalise on this momentum for change and promote the growing confidence, respect and trust between staff working across agencies in this difficult area, it will be important to promote a culture of continuous improvement in practice and service provision. The focus now needs to be on demonstrating that more effective intervention with better outcomes for these young people can be achieved. However, a narrow approach to 'tick box' limited, targeted outcomes, based on the advances that have been made will not be sufficient. The multiple and complex needs of the young people and the still limited understanding of the profile of the perpetrators and how they operate, requires a more open, critically reflective approach.

Provision for 'Looked After Children' is one of the most closely managed and regulated areas of activity within Social Services and within it residential care, the most closely monitored. This need not stifle innovation but rather provide a means for constant review and development. Within each H&SCT, there are a significant number of reporting mechanisms both internally and externally which allow for operational and strategic managerial oversight of residential units, in which young people are 'going missing' and becoming vulnerable to CSE. If a child within residential care places themselves or others at significant risk, statutory notification is required to the H&SCB and to the RQIA. Similarly, a young person 'going missing' from a unit for a period of over 24 hours will trigger the requirement to notify the H&SCB. H&SCTs are able to collate information on such young people being reported missing and meet with the PSNI at a local level on a regular basis to consider all these episodes with a view to identifying trends and associations. Structures such as the Strategic Liaison Group (HSCB/PSNI, 2012) have been specifically set up to develop collaborative strategies, based on information sharing and analysis.

H&SCTs also have to comply with a number of routine reporting mechanisms which also generate useful information. They have to produce both a delegated statutory functions report and Corporate Parenting reports. Those require information on young people 'going missing' and being placed at risk. In addition to that all residential units are inspected at least on a twice yearly basis by the RQIA; one announced, one unannounced. A report is written, based on each inspection and includes a Quality Improvement Plan. This is forwarded to the Registered Manager of the home and to the relevant H&SCT's Assistant Director who is responsible for informing the units. Police also report to the Policing Board who hold them to account for the delivery of the Policing Plan. CSE is included in the Policing Plan.

All of these arrangements are indicative of the capacity within and across agencies to contribute to gathering, reviewing and acting on information with a view to continually improving the management and understanding of 'going missing' and CSE - as long as the focus on it is held and takes place in the context of learning organisations. Learning organisations are those in which staff at all levels are expected, encouraged and enabled to take responsibility for questioning learning from evidence informed practice, with a view to exercising and taking responsibility for professional judgments. As the influential Munro review of child protection (2011) has pointed out: "Mechanisms for improvement have been pressure on professionals to try harder; reducing scope for individual judgement by adding procedures and rules; and increasing the level of monitoring to ensure compliance with them." What is actually required is "a move from a compliance to a learning culture" (quoted in Pearce, 2014: p131).

A major asset in promoting continuous learning about CSE within the 'Looked After' population is the significant commitment there has been to training and supporting the therapeutic understanding and skills of residential care staff in Northern Ireland. The therapeutic approaches adopted by the H&SCTs provide a set of approaches which share working assumptions that chime with what is known about the critical reflection needed for effective engagement with the impact of CSE on young people. That includes: recognising that young people in residential care have suffered trauma and disadvantage; encouraging staff not just to react to challenging behaviour but to understand and address the needs and emotions underlying it; providing both staff and young people with techniques for being aware of and regulating their responses to stressful situations.

This therapeutic perspective clearly shifts practice away from being rule driven, backed by the use of sanctions as a means of managing difficult behaviour. Instead, a range of relationship based strategies are used to advance a programme of care, based on an assessment of the needs of the young person and the competence of staff. The therapeutic approaches being adopted, provide staff with both an explanatory framework with which to understand particular behaviours such as 'going missing', alcohol and drug misuse, inappropriate sexual activity, outbursts of anger and also a clearer sense of strategic case management, within which to make difficult judgments about appropriate responses to high risk situations.

When the programme of new approaches was externally evaluated (Macdonald et al., 2012) the response of staff to them was generally positive but a number of respondents commented that the change from sanctions to relational consequences resulted in some workers feeling disempowered, as they had to surrender some of their ascribed authority. This reinforces the importance of leadership in effecting culture change within units, to ensure that authority is not lost but acquires a different more effective source in the quality of relationship between staff and young people.

To be effective, implementation of the therapeutic approaches also required opportunities for reflection to be built into individual and team supervision. The evaluation highlighted good supervision as providing opportunities for reflection as a necessary time to digest the new ways of working and incorporate them into practice and to monitor and manage strengths and weaknesses in implementation. Some staff also commented that effective implementation depended on having greater emotional support available to them. The approaches demand high levels of emotional awareness from staff and require them to reflect on their own lives and experiences. Whilst the aim of that is to increase staff insight and understanding into the dynamics of their exchanges with young people, it can lead to them feeling exposed and vulnerable. Again strong operational management and leadership are required.

The introduction of the therapeutic models is not only important because it has gone some way to introducing coherent and shared methods of working, but because it has illustrated the importance of high quality supervision, continuous training, regular review of impact and periodic formal evaluation. Most importantly, it has underscored the importance of leadership, especially at operational management level. All those features need to be integrated into the required learning culture. It also needs to be emphasised that in regard to CSE, this learning culture must be interdisciplinary and interagency.

Areas for Improvement:

F1. Developing interagency practice leads through co-location of experienced senior practitioners to collate, disseminate and promote best practice through consultation and teaching.

F2. Ensuring optimum use is made of routinely gathered information to identify 'hot spots', such as residential units under pressure and 'log jams' such as waiting lists for secure places and 'dark corners', and inform insufficiently understood aspects of sexual exploitation.

F3. Clarifying the levels of strategic information sharing within and across agencies and the means to link analysis with strategic planning in a way that clearly gives feedback to operational managers and practitioners.

F4. Ensuring supervision and staff support that focuses as much on staff wellbeing, critical reflection and insight in regard to strategic case management, as on the very necessary compliance with guidelines and procedures.

F5. Requiring assessed induction, 'top up' and advanced training in the therapeutic models and policing strategies being used plus other areas such as the relationship between CSE, Going Missing and Multiple Adversity Indicators; attachment theory; motivational interviewing; and e-safety.

F6. Linking routine monitoring of cases with evaluation of the impact along with research into the effectiveness of the various therapeutic approaches and policing strategies in responding to CSE.

G

Conclusions and Areas For Improvement

The terms of reference set for this Thematic Review posed four questions with a view to drawing out key learning points and opportunities for improvement. The four questions in regard to the welfare and safeguarding of this particular group of 'Looked After Children' with a record of 'going missing' along with serious concerns about CSE were:

- Had action been taken in accordance with policy, procedures and guidance?
- Had action taken been effective?
- Had communication and co-operation been effective?
- Had relationships with the young people been of a quality that had been effective?

Underlying those questions, the terms of reference identified a number of key issues to be considered: assessment; care planning; risk management; provision of care; reported absences; response to criminal offences against the young people; reporting and information sharing; involvement and the support of senior managers.

Those questions and the key issues which informed the five preceding sections are summarised here in this last section. This is done firstly by an answer to each question. A table is then presented which draws together the Areas for Improvement, linking them to the Key Issues noted in the terms of reference and to relevant recommendations from the Marshall Report (2014). In addition, one overarching recommendation is made to ensure that the focus that now exists on tackling CSE in the lives of 'Looked After' children is consolidated and taken forward.

In answer to the first of the four questions, action relating to this group of young people, in general, had been taken in accordance with policy, procedures and guidance. There was however, some variance across and within cases and at different phases of the cases. Such variance is to be expected and whilst not to be condoned, is part of the reality of managing demanding work in a highly regulated field. However, in cases of such multiple and complex needs as these were, either from first contact, or as they became over time, it is important to be reminded that full compliance to policy, procedures and guidance is essential and needs to be firmly managed.

In regard to the second question, for significant periods and with significant consequences for the young people, action taken to ensure their protection and promote their wellbeing was not effective. That was not the case across all aspects of the young people's lives nor at all times nor to the same extent in different cases. Indeed it was notable that even in those areas where intervention seemed least effective, such as dealing with self-harming, substance abuse and CSE, there was evidence of staff action mitigating adverse effects, in some cases to the point of being life-saving.

The third question is about the effectiveness of communication and co-operation within and across agencies. Information in the main was shared appropriately and whilst there were some tensions and also too limited engagement at particular points, individuals and agencies generally worked well together. However, it would be wrong to term their working together as effective, given that all the young people were reported as 'going missing' frequently and there were major concerns about CSE. What appeared to be missing was agreement within and across agencies about whether or not CSE was the determining dynamic in the case, requiring the dual approach which combined an aggressive pursuit of those who were doing the exploiting along with authoritative care and control of the young people. Although systems of communication and co-operation between

staff within agencies and across agencies was very active, it was not effective in disrupting and prosecuting perpetrators or in meeting the needs of the young people.

The fourth question addresses an issue at the core of effectively meeting the safety and welfare needs of these young people - the quality of relationship between them and those who care for and protect them. These young people needed the secure base that all young people require if they are to confidently explore and manage the pleasures and pain of being young and growing up. An overwhelming impression from these cases was just how difficult it was to provide them with the physical safety, emotional security and relational belonging they needed. For periods of their lives neither their parents nor their 'Corporate Parent' were able to provide that. It was also all too clear how vulnerable that made these young people, to those who would use their insecurities and circumstances, to sexually exploit them.

It cannot be overstressed how important it is to find ways of using law enforcement and public safety arrangements to disrupt and prosecute those who would sexually exploit young people. At the same time, that must be done in a way that is not alienating but rather empowering for the young people themselves. At the times when they were most vulnerable to CSE, in themselves and in their circumstances, the young people considered here seemed not just 'hard to reach', but reluctant to engage with those trying to offer them help. Services have to find ways to more effectively use the therapeutic approaches and the support services that exist to offer such young people the help they need, at the time they need it and in a manner that they can use. It should always be to the fore that ensuring a sustained effort to disrupt and prosecute those who would sexually exploit them is a crucial part of achieving that help for young people. It must include working creatively with young perpetrators to prevent further victimisation. It also addresses the possibility that young victims may themselves become perpetrators, or that peer groups dynamics may condone peer on peer exploitation and abuse.

'Looked After Children' are just one group known to be vulnerable to CSE. They can expect to benefit from the general advances being made to galvanise support for tackling CSE in Northern Ireland, through implementation of the Marshall Report Recommendations. However, they are also a special case particularly that relatively small number who are likely to have the multiple and complex needs of the type and number found in the group being discussed here. As a 'Corporate Parent', Social Services, Health, Education, public safety and all statutory services must pay 'Looked After Children' special attention. This is not to argue for a separate agenda. Rather, the needs of these children and young people, especially those where there are indicators of high risk, must be kept sharply in focus as part of the emerging changes that are underway. The 'Areas for Improvement', highlighted at the end of each of the previous sections, have been identified to help ensure that happens.

The Marshall Report (2014) established that CSE was a wide ranging societal and social policy challenge in Northern Ireland. Strategic advance in tackling it requires prevention strategies to be put in place and the impact of the abuse being managed. Attention has to be given to the

identified needs of particular groups of children and young people, so that specific areas can be focused on which pick up on key issues that are relevant more widely in tackling CSE. 'Looked After Children' with multiple and complex needs are one such group. In order to provide the necessary focus on the needs of such children and young people, Box 12 below lists in the central column all the 'Areas for Improvement' under four themes: assessing need and identifying risk of CSE; strategic mobilising of services; enhancing relationship based practice with young people; continuous learning and development. The left hand column lists Key Issues within the Thematic Review's Terms of Reference that link to the 'Areas for Improvement'. The right hand column notes Recommendations from the Marshall Report to which the 'Areas for Improvement' can be related to.

For 'Looked After Children' as a group, significant change has already been achieved in the recognition now given to the importance of 'going missing' as an indicator of CSE. In responding to repeated incidents of 'going missing' there is a much sharper focus on strategic interagency case management, supported by interagency strategic collaboration. However, it is not yet clear whether these changes are making for more effective outcomes for young people. Nor is it clear whether these and other changes to come, will be sustainable under competing pressures for resources.

It is important to answer those two questions and to consolidate and test the advances being made in how 'Looked After Children' affected by CSE are supported and protected. Accordingly, an overarching recommendation is that in twelve months' time there should be a Regional Benchmarking Thematic Audit of responses to those children and young people being 'Looked After' on a specified date with a record of repeated 'going missing' where there are serious concerns about CSE. The aim of this exercise should be to identify, consolidate and review the effectiveness of responses to the needs of those children and young people.

Given the learning from this Thematic Review such an exercise is likely to have as its focus a relatively small number of young people with multiple and complex needs and should be carried out in depth, reporting within three months of its commencement. It will need to take account of the further developments that will have come from implementing the Marshall recommendations, along with other relevant UK initiatives. Particular attention should be given to the direct involvement of young people and their families.

This exercise should be under the leadership of the SBNI with such support as it requires from the RQIA, the Criminal Justice Inspectorate Northern Ireland and the Education and Training Inspectorate.

The ten young people who were prepared to have their cases opened to the examination and evaluation of this Thematic Review have allowed their experiences to help clarify and focus on what needs to improve to effectively respond when 'Looked After Children' with multiple and complex needs are at risk of or subjected to, CSE. The challenge now is to stay focused.

Box 12

Key Issues from Thematic Review Terms of Reference	**Areas for Improvement from Thematic Review**	*Relevant Recommendations from Marshall Report*
Section C - Assessing need and identifying risk of CSE		
Assessment **Risk Management** **Response to criminal offences against the young people** **Reporting and information sharing**	C1. Use of UNOCINI as a means of capturing not only the depth and breadth of need (including multiple adversities) as it develops and changes over time but also the identification and assessment in particular of CSE risk factors and their implications for the dynamics of a case C2. Use of Child Protection Registration and of 'Looked After Children' Reviews to identify CSE risk factors and their implications for the dynamics of a case from across Social Services, health and education C3. Making explicit the use of ARC, Social Pedagogy, CARE, Sanctuary and MAP in assessing the implications of CSE risk factors for strategic case management C4. Use of offender profiling and intelligence led network analysis to identify and analyse links amongst adult perpetrators and amongst young people and the relationships between the two groups. C5. Use of a regionally agreed CSE Assessment Tool, with an emphasis on scaling and analysing risk, to underpin multidisciplinary collection and collation of relevant information and its analysis at case management and strategic management levels. C6. Proactive use of H&SCT and PSNI specialist interviewers under the Protocol for Joint Investigation by Social Workers and Police officers of Alleged and Suspected Cases of Child Abuse – NI (2013)	Supporting Recommendation 6: The HSC Board should ensure that child protection issues are consistently and skilfully addressed in 'Looked After Children' and disability settings, where these are separate from specific child protection processes. Key Recommendation 9: The Department of Justice (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 57: SBNI should ensure that as part of its information sharing protocol consistency of terminology is pursued as an aid to effective information sharing

Section D - Strategic Mobilising of Services

Reporting and information sharing **Care planning** **Risk management** **Provision of care** **Reported absences** **Involvement and support of senior managers**	D1 Provision of family support, through access to integrated preventative services alongside proactive early and sustained authoritative intervention with families where childhood adversity indicators are identified. D2 Community based diversion and policing involving a wide range of people (youth workers, park wardens, taxi drivers, bar and hotel staff) to restrict perpetrators' opportunities for CSE and to provide alternative opportunities to young people vulnerable to CSE, to get support. D3 Proactive placement choice to directly address repeated 'going missing' as part of case management in order to deliver on actions and consequences of safety planning, including use of forms of secure accommodation, specialist fostering and arrangements developed to meet the specific needs of individual young people D4 Proactive case management to provide for physical safety, relational security and psychological security, using identified residential therapeutic approaches, along with CAMHS and other health and education services in order to address individual and group needs, including maintaining continuity of positive relationships with family and friends. D5 Ensure that Return Interviews are consistently undertaken by people who young people have been given the opportunity to choose and focus on advancing strategic case management objectives and where there is evidence of a criminal offence having been committed, the Protocol for Joint Investigation by Social Workers and Police officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2013), should also be considered, including the use of the specially trained ABE interviewers (PSNI and Social Services) D6 Proactive policing response to repeated 'going missing' with an emphasis on gathering evidence of CSE for assertive disruption and pursuit of prosecution, making full use of Safe and Well Checks.	Key Recommendation 7: The NI Assembly, through the OFM/DFM, should re-affirm its commitment to strategic, long-term and sustained funding of services for prevention and early intervention 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 Key Recommendation 3: The DHSSPS in conjunction with the 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 49: HSC Trusts should consider how best to address the appropriate availability of social workers for Achieving Best Evidence interviews under the Joint Protocol (2013) process

Key Issues from Thematic Review Terms of Reference	**Areas for Improvement from Thematic Review**	***Relevant Recommendations from Marshall Report***
E - Enhancing Relationship Based Practice with Young People		
Care planning **Provision of care** **Risk management** **Involvement and support of senior managers** **Reported absences**	E1 Building and maintaining relationships between young people and staff focused on developing and advancing their care/pathway plans together and with family and other informal support E2 Clarifying the use of physical restraint as part of the Therapeutic Crisis Intervention approach to ensuring physical safety in open units - not to increase capacity to curtail freedom of movement E3 Use of adopted therapeutic approaches, including appropriate use of authority, to contain young people emotionally and physically within a 'safe space' and making full use of Return Interviews following incidents of 'going missing' as part of strategic case management. E4 Dealing with social media both as an essential and generally positive aspect of group living in residential care and as a risk factor providing opportunities for initiating and facilitating CSE E5 Development of specialist CSE services based on experience of existing specialist CSE services, of 'wraparound' services and 'safe spaces', with particular attention to the views of young people as to what worked to meet their needs	Supporting Recommendation 26: The HSCB 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 Key Recommendation 6: The DHSSPS, along with the HSCB and H&SCTs, 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 As above Key Recommendation 6

F - Continuous learning and development

Assessment

Care planning

Provision of care

Risk management

Involvement and support of senior managers

Reported absences

Response to criminal offences against the young people

Reporting and information sharing

F1 Developing interagency practice leads through co-location of experienced senior staff to collate, disseminate and promote best practice through consultation and teaching

F2 Ensuring optimum use is made of routinely gathered information to identify and respond to 'hot spots', such as residential units under pressure, 'log jams', waiting lists for secure places and 'dark corners', to inform insufficiently understood aspects of sexual exploitation

F3 Clarifying the levels of strategic information sharing within and across agencies and the means to link analysis with strategic planning in a way that clearly gives feedback to operational managers and practitioners

F4 Ensuring supervision and staff support that focuses as much on staff wellbeing, critical reflection and insight in regard to strategic case management, as on the very necessary compliance with guidelines and procedures

F5 Requiring assessed induction, 'top up' and advanced training in the therapeutic approaches and policing strategies being used plus areas such as the relationship between CSE, going missing and multiple adversity indicators; attachment theory; motivational interviewing; e-safety

F6 Linking routine monitoring of cases with evaluation of the impact along with research into the effectiveness of the various therapeutic approaches and policing strategies in responding to CSE

Supporting Recommendation 16: The HSCB's Strategic Action Plan – Children Missing from Home or Care should be revised and implemented as part of the strategic overview of CSE.

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.

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.

Overarching Recommendation

SBNI lead a Regional Benchmarking Thematic Audit in twelve months time to determine the effectiveness of responses to those children and young people being 'Looked After' on a specified date with a record of repeated Going Missing where there are serious concerns about CSE

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Appendix 1:

Ministerial Direction to carry out Thematic Review

DIRECTIONS

THE SAFEGUARDING BOARD (NORTHERN IRELAND) ACT 2011

The Safeguarding Board for Northern Ireland Exercise of Functions Directions (Northern Ireland) 2013

The Department of Health, Social Services and Public Safety(a), makes the following directions in exercise of the powers conferred on it by section 4(1) of the Safeguarding Board (Northern Ireland) Act 2011(b).

In accordance with section 4(2) of that Act, the Department has consulted with the Safeguarding Board.

Citation, application and commencement

1.—(1) These Directions, which may be cited as the Safeguarding Board for Northern Ireland Exercise of Functions Directions (Northern Ireland) 2013, shall apply to the Safeguarding Board and shall come into operation on 11 December 2013.

Interpretation

2. - In these Directions —

"the Department" means the Department of Health, Social Services and Public Safety;

"the 2011 Act" means the Safeguarding Board Act (Northern Ireland) 2011;

"Health and Social Care trust" means a trust established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991(c) ;

"fostering agency" has the same meaning as in Article 2 of the Health and Personal Social Service (Quality, Improvement and Regulation) (Northern Ireland) Order 2003(d)

"placement" means any placement of a child under Article 27(2)(a) of the Children (Northern Ireland) Order 1995(e), or under Article 75(1)(a), including placement with a person who falls within Article 27(4) of that Order and a placement by a fostering agency acting on behalf of an Health and Social Care trust;

"relevant guidance" means any or all of the following: Co-operating to Safeguard Children (2003); ACPC Regional Policies and Procedures (2005); Protocol For Joint Investigation By Social Workers And Police Officers Of Alleged And Suspected Cases Of Child Abuse –

(a) *See* S.I. 1999/283 (N.I. 1), Article 3(6)
(b) 2011 c. 7
(c) S.I. 1990/194 (N.I.1)
(d) S.I. 2003/491 (N.I. 9)
(e) S.I. 1995/755 (N.I.2)

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Northern Ireland (2013); and Regional Guidance - Police Involvement in Residential Units and Safeguarding of Children Missing from Home and Foster Care (2012);

"relevant persons or bodies" means each person or body represented on the Safeguarding Board by virtue of section 1(2)(b) and (4) of the 2011 Act, who provided services, or had responsibility for any of the 22 children who are the subject of the Review;

"relevant staff" means staff who work for any relevant person or body;

"responsible authority" means the HSC trust or voluntary organisation responsible for the placement of any of the 22 children who are the subject of this Review, pursuant to Article 27(2)(a) or 75(1)(a), (as the case may be), of the 1995 Order;

"setting" includes a "residential family centre" within the meaning of Article 2(2) of the Health and Personal Social Service (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, or a "Children's home" within the meaning of Article 9 of that Order;

"the Review" means the thematic review carried out by the Safeguarding Board under section 3(3) of the 2011 Act in relation to 22 cases of alleged child sexual exploitation in Northern Ireland;

"the Safeguarding Board" means the Safeguarding Board for Northern Ireland established under section 1 of the 2011 Act;

"the Terms of Reference" means the Terms of Reference set out in the Schedule to these Directions;

"voluntary organisation" has the meaning given in Article 74(1) of the 1995 Order; and

"work" includes work of any kind, whether paid or unpaid and whether under a contract of service or apprenticeship, under a contract for services, or otherwise than under a contract.

The function exercisable by the Safeguarding Board under section 3(3) of the 2011 Act

3.- The Safeguarding Board shall carry out the Review in accordance with these Directions and the Terms of Reference.

Duty to Report

4.- The Safeguarding Board shall report to the Minister of Health, Social Services and Public Safety on the findings of the Review and identify key learning points and opportunities for improvement for relevant persons and bodies.

Police Investigation

5.- The Safeguarding Board shall undertake the Review in a manner which does not undermine, compromise or, interfere with any ongoing police investigation or any ensuing legal proceedings into the 22 cases of alleged child sexual exploitation in Northern Ireland.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on this day 10 December 2013

E. McDaniel

A senior officer of the Department of Health, Social Services and Public Safety.

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THE SCHEDULE

TERMS OF REFERENCE

1. In exercise of its function under section 3(3) of the 2011 Act, the Safeguarding Board will examine and evaluate —

(a) the extent to which the relevant persons or bodies acted in accordance with established policy procedure and guidance governing the welfare and safeguarding of children from the first point of entry by all 22 children into the care system;

(b) the effectiveness of any action taken by the relevant persons or bodies to safeguard the 22 children and promote their welfare during their time in care, taking into account whether or not the steps taken were in accord with existing policy, procedure or guidance;"

(c) the effectiveness of communication and co-operation between the relevant persons or bodies in accordance with relevant guidance; and

(d) the effectiveness of engagement with and nature of relationships of relevant staff with young people.

2. In particular, the Review will consider the following key issues -

(a) the nature and quality of the assessments carried out in respect of each of the 22 children and how these assessments informed the initial decisions of the responsible authority to place each child in care and about where each child was to be initially placed and any other placements which may have occurred subsequent to the initial placement in care. (Consideration should be given to each child's previous life experience and any specific factors which influenced the decision to place him in care);

(b) the effectiveness of the care planning, risk assessment, risk management and review processes and how those processes took account of those factors which increase a child's vulnerability to risk of harm, including being absent from any placement or setting without permission;

(c) the adequacy and effectiveness of the provision of care, including therapeutic and specialist services, to the 22 children in any placement or setting;

(d) the adequacy, effectiveness and timeliness of the relevant persons or bodies response to any of the 22 children being reported as absent from any placement or setting without permission and their response to allegations of criminal offences being committed against any of the 22 children (including any action taken by the relevant persons or bodies to put a stop to such activities, any preventative measures which were taken and the reporting of such allegations to the PSNI)

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(e) the effectiveness of reporting and information-sharing systems employed by relevant persons or bodies and their adequacy in securing the safety and wellbeing of the 22 children who are the subject of this Review; and

(f) the involvement and support provided by senior management to frontline staff in the management of, or responses to any of the 22 children.

3. Where possible, and taking full account of direction 5, the Review will seek the views of –

(a) each of the 22 children involved, taking account of each child's willingness to participate in the Review, the need to protect their anonymity and guard their need for confidentiality;

(b) the families of the young people involved; and

(c) key staff involved in the care or protection of any of the 22 children and any other personnel who played a significant role in their lives during the period they were in care.

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