Bwrdd Diogelu Caerdydd a'r Fro
Cardiff & Vale Safeguarding Board

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Historical CPR 022019

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Reviewers:

Barbara J Firth

Melanie Roach

Bwrdd Diogelu Caerdydd a'r Fro
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Introductory Statement For Historical Child Practice Review

022019

The attached review has been completed on behalf of the Cardiff and Vale Regional Safeguarding Board by two independent reviewers.

This case of historical child sexual abuse has been well documented in the Welsh media over the past few years.

The criminal conviction of the perpetrators took place in the Autumn of 2018 and following this the Regional Safeguarding Board commissioned the review.

The purpose of a child practice review is to establish how agencies worked together to protect children that may have been at risk of harm. The process usually involves practitioners who have had direct involvement in the case and the child/children or family they have worked with. It is not an enquiry into how, or why events took place. That is a matter for criminal courts to decide. In this case, as stated above, the criminal case had concluded and established guilt on behalf of the two perpetrators

The process of this historical review was different as it covered a period which began at least 35 years ago. The abuse had taken place over several years, concluding more than 20 years ago. It was therefore impossible to involve any practitioners who had been working at the time.

The review panel therefore decided to work with current practitioners to look at changes over time and examine current practice to ensure good support and resources for professionals working with CSAE and victims now exist. The panel also agreed to refer back to the recommendations of the 2016 Multi Agency Professional Forum (MAPF) which identified learning from several linked cases of child sexual exploitation.

Discussions took place at the review panel about involving victims of the abuse but after taking advice from a range of professionals, it was decided that because of the historic nature of the abuse this would have been a very difficult experience for them to re-visit which may have caused further trauma.

The content of the review therefore concentrates on developing current practice in response to this case of historic sexual abuse.

1. BACKGROUND AND CIRCUMSTANCES LEADING TO THIS REVIEW

1.1. In October 2018 a married couple, Mr and Mrs M, were convicted of historic sexual offences against young females. The offences were committed during the 1980's 1990's and 2000's and most took place in and around Barry, although some happened out of the area. There were at least 5 identified victims all of whom had contact with the Ms family during this time

1.2. The majority of disclosures were made when the victims became adults, and the case was investigated fully as a result of these historic disclosures.

1.3. One of the victims was related to the couple whilst others were friends of the couple's family. The victims, it appears, were encouraged to frequent the family home. One of the victims was the subject of a Care Order to Derby Social Services and had moved to Barry with her long-term foster carers in 1998.

1.4. From the statements of the 5 known victims a pattern emerges of them being groomed by the Ms over a period of time. The grooming culminating in sexual abuse and exploitation. One victim talked about initially loving it at the Ms home as they allowed her to do things her parents did not, like drink alcohol and smoke.

1.5. The sexual abuse included rape and sexual assault within the family home, often after the victim had been drugged, as well as being driven to dogging sites and repeatedly raped. The accounts of the victims all refer to multiple unknown males

committing serious offences in a manner which was pre-meditated and pre-arranged.

1.6. Victims of child sexual abuse and exploitation can suffer trauma and serious impairment of their health for many years and the victims in this case are no different. However, what is also very apparent is the adverse impact on the Ms own children. Domestic violence, addictions and mental ill health feature strongly in their adult lives.

1.7. The purpose of this review is to develop current practice in response to this case involving historic organised and multiple abuse. Areas considered will be embedding improved processes, organisational attitudes and cultures in relation to these offences.

2. HISTORICAL CONTEXT

2.1. To understand the actions taken or not taken by professionals and services at the time, it is important to understand the historical context and the development of legislation and professional knowledge and practice.

2.2. In the early 1970's the primary legislation that professionals worked under was the 1948 Children Act which specified that local authorities had a duty to provide care for any child whose parents were unable to care for them, if this was in the child's best interest. The first child protection procedures came into being following the Maria Colwell Inquiry in 1973[1]. However, the focus was on physical abuse or 'non-accidental injury' as it

[1] At the age of 7 Maria Colwell was killed by her step-father after being returned home from foster care. The public inquiry that followed her death found that Maria had been failed by the child protection system.

was termed. The Children Act 1975 highlighted the importance of children's welfare. It also established the role of an independent social worker to ensure the best interests of the child during court proceedings.

2.3. During the early 1980's there was growing awareness of the existence of child sexual abuse which led to the development of joint investigative approaches between the police and social workers. Throughout the 1980's there were several high-profile child protection inquiries into child deaths, but also 'The Cleveland Inquiry' in 1988. This was commissioned to look at arrangements for dealing with allegations of sexual abuse following the removal of 121 children from their parents, based on a controversial diagnostic test by paediatricians at Middleborough Hospital. It concluded that most of the diagnoses were incorrect, although a 1997 TV documentary disputed this.

2.4. The Children Act 1989 established the legislative framework for the current child protection system in England and Wales. It sets out the paramountcy principle; that the welfare for the child should be the court's main consideration. Alongside this legislation was the first version of the statutory guidance 'Working Together', which set out the arrangements for agencies to work together to protect children. It specified the four categories of abuse, physical, emotional, sexual and neglect. Over the years this guidance has been revised and updated to reflect the changing context and the developing knowledge base.

2.5. The 1990s saw a growing awareness and understanding of child sexual abuse. South Wales Police Family Support Units (FSUs) came into being and then developed into Child

Protection Units (CPUs) dealing with both victim and offender. In turn CPUs evolved into Public Protection Units (PPUs)with a broader remit.

2.6. The Children's Commissioner for Wales Act 2001 created the first Children's Commissioner post in the UK and in 2003 the first MARAC (Multi-Agency Risk Assessment Conference) in the UK was developed in Cardiff.

2.7. In legislation grooming first appeared in 2003 when it became a crime in The Sexual Offences Act 2003.

2.8. Meanwhile following the death of Victoria Climbie[2] the inquiry report published in 2003 led to sweeping changes in child protection systems. The Children Act 2004 established Local Safeguarding Children Boards and also emphasised the duty to co-operate and the importance of partnership working to safeguard children and promote their welfare.

2.9. In 2008 the 'All Wales Child Protection Procedures' were enhanced to include separate policies and procedures on Child Sexual Exploitation, Children who go Missing and Harmful Sexual Behaviour.

2.10. In 2013 there was an independent review into child sexual exploitation (CSE) in Rochdale which examined the council's response to issues around CSE after 47 girls were identified as victims. In 2015 the Independent Inquiry into Child Sexual Abuse in England and Wales (IICSA) was officially launched to consider the growing evidence of institutional failure to protect children from child sexual abuse.

[2] The stationery Office (2003) *The Victoria Climbie Inquiry: report of an inquiry by Lord Laming*

2.11. In 2016 Cardiff and the Vale of Glamorgan Regional Safeguarding Board commissioned a Multi-Agency Professional Forum (MAPF) to identify the learning from eleven linked cases of child sexual exploitation, abused by the same perpetrator. A majority of the victims were looked after children or had experience of being looked after. The report made 17 recommendations and work on all of them has been completed. The recommendations covered:

- Reviewing the effectiveness of healthy relationship education
- Developing best practice approaches
- Advice, guidance and training for the workforce
- Raising public awareness
- Developing mechanisms to systematically consult and communicate with children suffering or at risk of CSE
- Reviewing services to meet the safeguarding and therapeutic needs of children at risk of or subject to CSE

3. THE PROCESS OF THE REVIEW

3.1. As this was a historical review in which no current practitioners or managers were involved, it was structured slightly differently from the usual Child Practice Review. A Review Panel was convened which met regularly and was chaired by the Head of Safeguarding from Cardiff and the Vale University Health Board. The Panel membership was made up of representatives from:

- Education VOG
- South Wales Police
- Children's Services, VOG
- Children's Services, Cardiff (Shadow Reviewer)
- Legal
- Probation
- Cardiff and the Vale University Health Board

3.2. At the heart of the review was a half-day virtual Learning Event attended by 19 participants from all statutory and a broad range of voluntary services. It was designed as a reflective practice event with the aim of sharing professional knowledge and experience, increasing confidence and developing thinking and practice. Participants were asked to complete a pre-event survey which asked about their experience of Child Sexual Abuse and Exploitation (CSAE); how confident they felt in working with CSAE and what might be different if this scenario happened today.

3.3. The programme for the Learning Event covered:

- The circumstances leading to the review
- The 2016 MAPF report and recommendations
- An initial reflection on if and how things have changed
- A summary of the responses to the pre-event survey
- Small group work to think about the support and resources victims need to overcome the trauma of CSAE
- Small group work to explore what support and resources professionals needed in order to be effective when working with CSAE

3.4. The material generated by the Learning Event and the discussions within the Review Panel form the basis of this report.

4. KEY LEARNING POINTS

4.1. Discussion showed a general agreement that **progress has been made in understanding, recognising and responding to CSAE** and that this has been helped by dedicated teams, able to contribute to the development of knowledge and expertise. However, not all participants felt

confident and some expressed anxiety in how to intervene effectively in order to bring about change in a situation and how best to support victims of CSAE.

4.2. **Confidence and understanding can be developed through discussions with peers** but the switch to working from home during the COVID pandemic has lessened the opportunities for this informal exchange of knowledge and experience. Given that this change in working practices is probably going to continue post-pandemic it raises the question of how to ensure ongoing support and professional discussion? Regular virtual meetings are important but encouraging professionals to phone one another to talk things over is also important.

4.3. **Attention needs to be paid to staff welfare**. They are working with difficult scenarios within their own homes and the differentiation between home life and working life can therefore, become blurred. There is also a danger that professionals will become isolated from one another and operate in silos.

4.4. A major issue for professionals is **how to move on from being reactive, i.e. waiting for a disclosure of CSAE to being proactive** and actively looking for and recognising signs of abuse. Often the local community has some knowledge about what is happening in families and peer groups. However, there is still a divide between communities and professional systems. The public's confidence in statutory services needs to be improved in order to work more closely together. Too many bad reports are publicised and the positive work undertaken by

agencies is ignored. This then damages trust and erects barriers.

4.5. A key question to address, therefore, is how and **who can bridge this divide** so that the sharing of information and concerns can be facilitated. Which community based professionals might be the 'eyes and ears'? They could include (but the list is not exhaustive) :

- Teachers
- Health Visitors
- District Nurses
- School Nurses
- Police Community Support Officers/School Liaison Officers
- Youth Workers
- Housing staff
- Adult Support Workers
- RSPCA
- WAST

Some work on this is currently being piloted in North Cardiff.

4.6. Participants were very clear about the importance of holding the 'bigger picture' and the risk that **a label can lead to a too narrow focus.** For instance, the tendency to label situations as either Child Sexual Abuse (CSA) or Child Sexual Exploitation (CSE) might result in very different pathways and responses to victims, and important aspects being lost. So using the term CSAE as a starting point can widen out assessments and lead to a holistic understanding of risks and needs.

4.7. Similarly, professionals must move away from labelling children as challenging or difficult and consider instead why they are behaving as they are. In other words, it is important

to **'think troubled, not trouble'**. A trauma-informed practice approach would greatly facilitate this.

4.8. It is important to **see and understand children and young people through a child development lens**. There can be a tendency to safeguard young people by considering their perceived maturity, (for instance they may technically be of an age to give consent), rather than their development and their circumstances. In this situation there was no consent, the young people were victims of abuse, exploitation and coercive control.

4.9. **A shift in the tolerance of sexually abusive and aggressive behaviour and exploitation in schools is required**. If this does not happen then it will lead to some young people not recognising that they are being abused or sexually exploited. There is a danger that it becomes the norm and children and young people then feeling it is something they just 'have to put up with'. Work is underway on this issue. A thematic review by Estyn is due to be published in December and The Vale of Glamorgan and Cardiff are undertaking a 'Quality Plan for Schools'.

4.10. As the situation under review showed, **the impact on victims can be profound long lasting and affect future generations**. However, it is important to recognise that the experiences of victims will be different and diverse and therefore **it is important to develop flexible resources to meet their needs** and to help them overcome the trauma they have experienced. Whatever the resource what can help is:

- Consistency of workers, so that children and young people can build trust

- Working at the child, young person's pace. They need to feel ready and able to engage with therapeutic services.

5. DEVELOPING SYSTEMS AND PRACTICE

Participants in this reflective session and discussion within the Panel identified the following areas that would help to develop systems and practice:

5.1. **Supervision and support to include**:

5.1.1. Case specific multi-agency supervision

5.1.2. Developing more peer support

5.1.3. Informal, ad hoc and readily available supervision

5.2. **Multi-agency training and development**:

5.2.1. An ongoing programme of seminars and courses. The Centre of Expertise on Child Sexual Abuse has developed slides which can be inserted into existing mandatory safeguarding training and will be available in the very near future. In addition, there will also be three new resources coming out over the next few months which will be shared with the RSB and with practitioners. These cover signs and indicators, communicating with children and supporting parents and carers. The Centre has also been commissioned by the Welsh Government to develop three training videos which will eventually be available on You Tube.

5.2.2. More input on 'Trauma-Informed Practice'.

5.2.3. Access to and sharing of relevant research and new developments in this field of work.

5.3. **Regular reporting back to the Regional Safeguarding Board** by member agencies on the work they are doing to develop practice, systems and guidance around CSAE.

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- Children & Young People Services, VoG
- Education, Vale of Glamorgan Council
- Education, Cardiff Council
- National Probation Service
- Barnardo's
- Children's Services, Cardiff
- Legal Services, Cardiff
- Cardiff and Vale University Health Board
    - CAMHS
    - Dept of Sexual Health
    - Midwifery
    - Children Looked After Team
    - Health Visiting
    - School Health Nursing
    - Primary Care
    - Emergency Department