1 Thursday, 29 October 2020
2 (10.15 am)
3 THE CHAIR: Good morning, everyone. I'm Alexis Jay. I'm
4 the chair of the Independent Inquiry into Child Sexual
5 Abuse. With me are the other panel members of
6 the inquiry: Professor Sir Malcolm Evans, Ivor Frank and
7 Drusilla Sharpling.
8 On behalf of the inquiry, I welcome you all to
9 Day 11, the final day of the substantive hearing of
10 the investigation into the response of institutions to
11 the sexual exploitation of children by organised
12 networks.
13 I want to thank the core participants, witnesses and
14 representatives for their co-operation in preparing for
15 and conducting this hearing and to thank the inquiry
16 staff for their hard work in making the necessary
17 arrangements.
18 Before we begin, some points on timing: we will take
19 a 15-minute break every hour and intend to take a break
20 for lunch at approximately 12.45 pm. We intend to sit
21 no later than 4.00 pm.
22 A simultaneous hearing transcript will be produced
23 and is available to those taking part in this hearing
24 via a web browser, and the transcript will be published
25 at the end of the day on the inquiry website. Any

1 directions arising from the day's hearing will also be
2 published on the website.
3 Participants are asked to mute their microphones and
4 turn off their camera unless they are speaking. If
5 microphones pick up noise, such as typing, they will
6 place the person on screen as if they were speaking.
7 Turning off cameras will keep the screen from becoming
8 distracting by looking too busy for those using the
9 gallery view.
10 I have made a restriction order protecting the
11 identity of complainant core participants and covering
12 the redactions and ciphers applied in this
13 investigation. For technical reasons, it will not be
14 possible to broadcast this hearing with the usual
15 three-minute delay, so all core participants have been
16 reminded of these restriction orders and of the need to
17 take great care in addressing the inquiry to avoid any
18 inadvertent breaches of these orders, and if there is an
19 inadvertent breach of a restriction order, I will make
20 an immediate further order over the evidence incorrectly
21 given. Members of the public and the press will be
22 prohibited from publishing that evidence.
23 Before we start hearing closing statements,
24 Mr Livingston will read out the timelines for children
25 in Durham, and then Ms Hill will adduce a small amount

1 of further evidence. Mr Livingston?
2 Summary of timeline of WITNESS CS-A50 (read)
3 MR LIVINGSTON: Thank you, chair. I will start with CS-A50.
4 The evidence suggests that CS-A50 was assessed as being
5 at risk of sexual exploitation from early 2018. She was
6 being moved between the care of different relatives.
7 There was a history of domestic violence and she had
8 multiple missing-from-home episodes and periods where
9 no-one knew her whereabouts. She was known to CAMHS and
10 her attendance at school was poor. A known registered
11 sex offender was charged with raping her when she was
12 aged 13. She was also groomed by a violent older male
13 who was an associate of the registered sex offender who
14 raped her. She became looked after and was matched to
15 a suitable foster carer. The timeline covers a period
16 from 2018 to 2019.
17 When she was aged 13, a CSE risk assessment recorded
18 that CS-A50 was seen getting into cars with older males
19 and had social media contacts with strangers.
20 A strategy meeting was held. Crimes were recorded for
21 sexual activity with a child. However, this was closed
22 with no further action as no suspects could be
23 identified. The overall CSE risk was graded as medium,
24 although the highest risk box was also ticked.
25 A profile was created on the police's Red Sigma computer

1 system for A50, which recorded the key word "CSE" and
2 noted the tactics to be followed. She was residing in
3 another council area with a relative, who reportedly did
4 not understand the risks associated with the child going
5 missing and associating with unknown adult males.
6 About a month later, a further CSE assessment rated
7 the risk to A50 as medium. Two ERASE meetings were held
8 over the next two months with the risk level remaining
9 as medium.
10 Still aged 13, a few months later, A50 was recorded
11 as the victim of a breach of a Sexual Harm Protection
12 Order. A police community support officer conducted
13 a welfare check on A50 and noted a registered sex
14 offender leaving the address. This led to a further
15 investigation during which A50 disclosed having been
16 raped at the age of ten and referred to more recent
17 sexual activity by the person who she said had raped
18 her. Following investigation, the offender was arrested
19 and charged with a number of offences and remanded into
20 custody. A multi-agency strategy meeting was held,
21 which agreed that a section 47 child protection
22 investigation should be carried out.
23 Around two months later, a multi-agency meeting
24 recorded that a man had been charged with raping A50.
25 The man subsequently pleaded guilty to breaches of the

Sexual Harm Protection Order and to sexual activity with a child. The allegation of rape remained on file, meaning that he was not prosecuted for that alleged offence. He was a high-risk sex offender. It was also reported that the child was being groomed by an adult male who lived near her. The child was living at that time with a relative. A strategy meeting was held regarding the alleged grooming, which agreed that there should be a single-agency investigation by the local authority. It was noted that care proceedings were to be instigated by the local authority and that a CAWN, a child abduction warning notice, could not be issued for the male until then, as A50's parents were not supportive of it. A CSE review meeting noted that the police had identified the adult male as a CSE suspect and were to make enquiries about referral for potential dangerous person status and a Sexual Risk Order. A strategy meeting agreed that a section 47 investigation would be carried out.

Around the same time, it was recorded that A50 had disclosed harmful sexual behaviour, rape, by a male who was a couple of years older than her and was then targeted by the male's peers and associates. The case was closed with no further action due to evidential difficulties. There was no single adult taking

responsibility for her safety and well-being at this stage. She was spending time with a registered sex offender. Her CSE risk grading had been high for some time. The local authority applied for an interim care order which was granted.

I note here, chair, that Durham Council have informed us in relation to the evidence that I just read that A50 only made allegations of rape against one perpetrator during this period, rather than two. However, as the evidence in support of that has not been provided yet, I just flag it at this stage to be considered in due course.

Continuing on with A50, when aged 14, shortly after becoming a looked-after child, A50 moved into a permanent foster placement. She was considered to be at high risk of CSE. A choice of placements was available, enabling the placement that best suited her needs to be selected and she was involved in the selection of her foster carer.

Within two months of that placement, it was noted that the assessed risks of sexual exploitation had been reduced to low. A range of services continued their support, including a CSE worker from the ERASE team, therapeutic support and an allocated worker from the Victim Support team. Within a year of placement, there

were no more missing episodes and it was considered that the foster placement had had a significant positive impact on her life. She was said to have progressed well and was much more confident.

When aged 15, the following year, a meeting was held at which all professionals agreed that A50 had made good progress and was at low risk of child exploitation.

Summary of timeline of WITNESS CS-A29 (read)

MR LIVINGSTON: Moving on to A29, CS-A29. The evidence suggests that A29 was sexually exploited between the ages of 13 and 15. The police received 29 missing-from-home reports during this period. She had a diagnosis of attention deficit hyperactivity disorder, ADHD. She spent 13 months in a children's home, during which time there is evidence that harmful sexual behaviour involving A29 and multiple male looked-after children occurred. There is evidence that she continued to be sexually exploited by adult males whom she met online. This timeline covers a period from 2015 to 2018.

When aged 12, a parent raised concerns to police about content on A29's computer. She had apparently been groomed online. The evidence provided by the parent suggested sexually explicit conversations and sharing of indecent photos had taken place, involving

a named male who could not be traced.

Still aged 12, concerns were recorded on a police safeguarding report that the child was buying drugs, going missing and "placing herself at risk". Children's social care were noted that they were to undertake a CSE assessment.

Shortly afterwards, CS-A29 sought help, reporting that she had taken an overdose of medication. She was taken to hospital by one of her parents.

Around the same time, an initial CSE meeting was held. A29 was assessed as being at medium risk of sexual exploitation. A disruption plan was recorded and a range of support was put in place, including from CAMHS.

A few months later, A29's parent took her to the police station after she disclosed that a 16-year-old male had sexually abused her. She was aged 13 at this time. The police interviewed the male, who denied the offence. No further police action was taken. The police at this time found sexualised conversations with other children on a device.

The following month, a CSE assessment considered A29 to be at medium risk of sexual exploitation. The police completed a problem profile, listing actions to take to protect her.

1 Three months later, A29 was reportedly groomed and
2 sexually exploited by an adult male who had previous
3 involvement with the police for alleged grooming. The
4 male claimed that he thought A29 was 16 years old. No
5 further police action was taken.
6 Shortly afterwards, a CSE review recorded that the
7 risks to A29 were being adequately managed. It was
8 considered at that point that further review was not
9 required.
10 Around eight weeks later, still aged 13, it was
11 noted that A29 was sharing indecent images with
12 a 16-year-old male. They were both given advice by the
13 police about sexting and the law.
14 The following month, aged 14, A29 was detained for
15 an alleged offence and it was agreed that she could stay
16 with a family friend because her parents were unable to
17 cope. There is evidence that, whilst with the family
18 friend, she was the victim of online abuse when a male
19 aged in his 40s exposed himself to her. The arrangement
20 for her to stay with the family friend broke down. It
21 was agreed that A29 would become looked after
22 temporarily, due to family circumstances, and she was
23 placed in a children's home.
24 At age 14, the first looked-after child review was
25 held for A29. There were concerns about her sexualised

1 behaviour and that she might have health problems as
2 well as ADHD. CAMHS agreed to do a full reassessment.
3 The plan at this point was for a short-term foster
4 placement until her parent was able to resume caring for
5 CS-A29. Her case was re-opened at CSE meetings and her
6 risk was assessed as high. She went missing from care
7 with a male child and the police later established that
8 they had spent the night with two adult males, both aged
9 in their late teens. Both males were issued with
10 CAWNs -- child abduction warning notices. A second
11 problem profile was created setting out actions the
12 police would take to protect her. 97 actions were
13 recorded on the profile over a ten-month period.
14 Shortly after these events, whilst aged 14, a risk
15 meeting was convened. A29 was noted to be very
16 unsettled in the children's home. She was repeatedly
17 going missing. When missing, she was believed to attend
18 different areas, "put herself at risk of CSE", as well
19 as misuse drugs and alcohol. A CSE assessment recorded
20 concerns about her getting into vehicles and trying to
21 visit men. She was taken into police protection because
22 the police did not consider her to be safe in the
23 children's home.
24 In the subsequent months, CSE and looked-after child
25 reviews were held regularly, with agencies trying to

1 engage with the child. The plan was to find a foster
2 placement for her but none was available. At this
3 point, she had disengaged with health support;
4 a referral to Barnardo's was not successful, but she did
5 engage with the ERASE support worker and direct work
6 with her was planned regarding CSE. Children's home
7 staff were noted to be doing work with her on sexual
8 health and relationships. Concerns about the risks to
9 her continued. She was again taken into police
10 protection due to concerns that "she was placing herself
11 at significant risk". Other male children in the care
12 home were said to have engaged in harmful sexual
13 behaviour with her and alarms were fitted to bedroom
14 doors in the home.
15 Over the next few months, aged 14 still, A29's
16 relationships with her parents were noted to have
17 improved. She had weekly contact with each of them and
18 planned overnight stays. She continued to go missing
19 from the children's home and from her overnight stays.
20 There were still reported concerns about sexual
21 exploitation. Subsequently, the children's home was
22 reported to have a much more settled mix of children.
23 Approximately eight weeks later, A29 was assessed as
24 being at medium risk of CSE. A further assessment two
25 weeks later reduced the risk to low risk. She was

1 discussed at the operational MEG meeting -- Missing and
2 Exploited Group meeting. She was described as engaging
3 well and the plan was for her to return to live with one
4 of her parents. A further meeting was not considered
5 necessary.
6 A29 then returned to the care of her parents.
7 A social worker from the looked-after team continued to
8 work with her when she left care, to provide continuity.
9 Six months later, A29 went missing for under
10 12 hours. A Return Home Interview was completed at
11 which she said that "something sexual" had happened, but
12 said "the less the police know, the better".
13 A subsequent CSE assessment recorded information
14 relating to events which took place in previous years,
15 namely, that A29 had associations with a number of adult
16 males. One, aged in his early 20s, was said to have
17 picked her up from school in a luxury car. She
18 described another as a "crackhead", who was aged in his
19 mid 30s, and disclosed sexual offences committed by his
20 friend, also aged in his mid 30s, against her. She was
21 also associated with two male children whom she had met
22 in residential care. Her father believed she had
23 contact with an adult male over the internet and was
24 advised to contact the police. On the risk indicator,
25 "contact with abusive adults", the risk was moved from

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medium to high. The risk assessment included a description of A29 from a report prepared 12 months earlier. It described her as "streetwise" and commented that "the sexual relationship" with the male in his mid 30s was "consensual". She was aged 15 at this time. The overall assessment of sexual exploitation risk was medium.

Shortly afterwards, still aged 15, A29 was discussed at the MEG meeting -- Missing and Exploited Group. She was said to be "still displaying risk-taking behaviours". A further CSE assessment noted that there had been no recent incidents and the family had not been in touch. The overall CSE risk rating was reduced to low.

Three months later, A29 was removed from the MEG meeting as the chair stated the meeting would, from this point onwards, concentrate on the five or six highest-risk cases.

Summary of timeline of WITNESS CS-A114 (read)

MR LIVINGSTON: Chair, moving on to the third child, A114.

The evidence suggests that A114 was sexually exploited from the age of 12. The timeline covers a period from 2018 to 2019.

When aged 12, A114 was graded as being at medium risk of CSE. A month later, her risk level was

increased to high. Police were later informed that she had been sexually exploited by an adult male, including "sexual intercourse".

When aged 13, it was noted that CS-A114 was pregnant and the pregnancy was terminated. She later disclosed that this was not her choice, but a decision taken by her parents. It was noted in a subsequent risk assessment that she "likely became pregnant at 12". However, police recorded it as "sexual intercourse with a female aged 13".

Ongoing CSE risk assessments graded the risk of CSE as high. A114 was referred for support due to high levels of missing episodes. Photos had been circulated showing A114 on a bed with adult males. An ERASE meeting was told that the child had disclosed the name of the male who was responsible for her pregnancy and that she had said "she was 12 at the time". He was said to be 17. The case was closed by the police as not resolved, noting that there were evidential difficulties.

Aged 13, around the same time, it was noted that A114's school attendance was very low and that her mother and school were unaware of where she was going when not in school. A114 was graded as being at high risk in a CSE matrix. The police recorded disruption

tactics and actions to take. ERASE meetings were held and two months later A114 was recorded as being at medium risk.

Around two months later, a review multi-agency CSE meeting recorded that A114 had attended a party with a male aged between 16 and 18. Police were considering a child abduction warning notice for the male responsible for her pregnancy. It was noted that the police would also speak to the child's school about strangers' cars she had been seen getting into.

Around the same time, A114's CSE risk was graded as medium. She was noted to be engaged with ERASE and her support worker. Police had identified two men who posed a risk to her. She had told her support worker that she was getting into cars with strangers.

Over the next few months, aged between 13 and 14, two child abduction warning notices were issued to two adult males in respect of A114. A114 was made subject to a child protection plan.

The following month, when aged 14, one of these adult males was charged with child abduction after A114 was located at his address. A114 was graded as being at high risk. Subsequently, the police were actioned to put a block on A114's phone number to prevent the adult male from contacting her whilst he was remanded in

prison.

Aged 14, the following month, A114 was noted to be "still in a relationship" with, and continuing to see, the adult male, who had been released from prison.

Summary of timeline of WITNESS CS-A118 (read)

MR LIVINGSTON: Chair, I move on to the fourth child, A118.

The evidence suggests that CS-A118 was groomed and sexually exploited throughout 2018, when she was 15 years old. The timeline covers events in 2018. The child had ADHD and other health and behavioural issues.

Throughout the year, there were multiple missing-from-home episodes. A profile for A118 created on the police's computer system recorded concerns and tactics for disruption.

During this period, when aged 15, A118 was: reported missing by her mother on numerous occasions; reported to have been driven in the car of a delivery driver in his early 50s; found at an address with several men, with a CAWN being issued to the householder; and found with another missing child in the home of an adult male aged in his early 20s and on whom a child abduction warning notice was served. A118 was on an antisocial behaviour escalation procedure. She had also reported harmful sexual behaviour by another young person known to her. A family friend in his late 20s stayed overnight with

1 A118 in her bedroom; the next day, she had what was
2 believed to either be a "love bite" or a cigarette burn
3 on her neck. A male in his 50s was cautioned for child
4 abduction by driving A118 to another area whilst she was
5 missing.
6 Still aged 15, A118 was assessed as being at high
7 risk of CSE. A118's missing episodes continued and
8 there were more than 20 instances where the police were
9 contacted. There were issues of escalating self-harm.
10 A118 was assessed by CAMHS. Symptoms of depression and
11 behavioural symptoms of ADHD were identified. A care
12 intervention plan was developed by CAMHS to manage the
13 situation in a collaborative way. The police expressed
14 concerns that she was associating with adults believed
15 or known to be involved in grooming, and other children
16 thought to be at risk of sexual exploitation. It was
17 recorded that an older male family friend was buying
18 things for her. Child abduction warning notices had
19 been issued against two adult males considered to be
20 a risk to A118. A118 was made subject to a child
21 protection plan.
22 When aged 16, A118 was diagnosed with ADHD and
23 a treatment plan put in place. An ERASE CSE assessment
24 recorded that she was still going missing from home,
25 offending and misusing alcohol. She had been excluded

1 from school. A118's parent had reported that she was no
2 longer going to the area where it was believed she had
3 been exploited and was coming home on time. The youth
4 offending team were working with her and a child
5 protection case conference was due to take place. The
6 multi-agency CSE meeting would no longer monitor A118 as
7 the meeting, as I have mentioned before, noted that it
8 was, in future, to concentrate on the five or six
9 highest-risk cases.
10 Summary of timeline of WITNESS CS-A51 (read)
11 MR LIVINGSTON: Chair, moving on to the fifth child, A51.
12 The evidence suggests that CS-A51 was groomed and
13 sexually exploited from the age of 16. She had ADHD and
14 particular communication needs. The timeline covers
15 a period from 2018 to 2019.
16 When aged 16, A51 was assessed as being at high risk
17 of CSE. A strategy meeting was held due to concerns
18 about A51 leaving home and tactics employed to reduce
19 the risk of her moving into a hotel. The previous year,
20 a CSE matrix had been completed due to concerns about
21 exploitation by a male in his mid 20s. A disclosure
22 suggested that this was ongoing. Crime reports were
23 created for allegations of sexual grooming and sexual
24 activity with a child. The latter case was closed with
25 no further action due to evidential difficulties -- the

1 former as the identity of the suspect could not be
2 confirmed.
3 Aged 16. A51 was reported to have spent several
4 days in a hotel outside of Durham with a male in his
5 mid 20s. Police from that area attended, but considered
6 that they were not able to intervene as the child was
7 over 16.
8 When aged 17, an initial CSE assessment was carried
9 out. It was noted that, when aged between 14 and 15,
10 A51 had been coerced by another pupil to send indecent
11 photos which had been circulated and that she had been
12 groomed via social media.
13 Aged 17, a multi-agency ERASE meeting agreed to
14 carry out checks on the male in his mid 20s.
15 Aged 17, over the next seven months, A51 was
16 assessed as being at medium risk of sexual exploitation
17 during two reviews. The following month, concerns were
18 raised that A51 continued to be in contact with the male
19 in his mid 20s. Since that earlier ERASE meeting, the
20 male had been imprisoned for violent and property
21 offences and A51 was informed of those offences.
22 During the time when A51 was 16/17, it was noted
23 that she had worked with a CSE social worker.
24 Summary of timeline of WITNESS CS-A43 (read)
25 MR LIVINGSTON: Chair, finally, CS-A43.

1 The evidence suggests that CS-A43 was at high risk
2 of sexual exploitation and was sexually exploited at the
3 age of 15. Exploitation was primarily taking place, or
4 contact was initially taking place, via the adult dating
5 app Grindr. The timeline covers a four-month period in
6 2018/2019.
7 When aged 15, it was reported that a male aged
8 between 16 and 18 from another area had stayed with
9 CS-A43 for several nights. A43 told his parents that it
10 was a former schoolfriend, but they became suspicious of
11 the male's background and discovered photos of the pair
12 presenting as a couple. A43 came out to his family as
13 gay.
14 A43 then made contact with a male in his late 20s
15 through Grindr and a week later met him at the adult's
16 home. The evidence suggests that A43 was sexually
17 abused at the home of this male. A43 was interviewed by
18 the police and disclosed the address he had been taken
19 to but did not know the male's name. The police
20 identified a suspect, who was investigated and
21 interviewed under caution in relation to the offence.
22 The case was subsequently closed by the police due to
23 evidential difficulties. The police also discovered
24 that the child was making contact of a sexualised nature
25 with, and making efforts to meet, a large number of

1 adult males via Grindr. He had been in contact with
2 a number of males and had been offered payment in return
3 for certain types of photographs. Officers spoke with
4 A43 about the risks of sexual encounter and contact, and
5 work was to be undertaken with A43 in terms of sexual
6 exploitation, in parallel with counselling arranged by
7 the school.
8 Whilst still aged 15, A43 was assessed as being at
9 high risk of sexual exploitation. He said that he was
10 being offered money for sex over the internet. He was
11 referred to a specialist LGBTQ+ support service. Over
12 the next two months, minutes recorded that another CSE
13 meeting would not be held. However, the CSE work would
14 continue. Two months later, a CSE matrix recorded A43
15 as being at low risk.
16 Chair, that concludes the Durham timeline. I now
17 pass over to Ms Hill, who will adduce some evidence.
18 Thank you.
19 THE CHAIR: Thank you, Mr Livingston.
20 Housekeeping
21 MS HILL: Thank you, chair. Chair, by way of housekeeping,
22 I would like to formally adduce a list of further
23 statements and exhibits that have been received since
24 the last day of these hearings. This list was provided
25 to the core participants yesterday and all of

1 the material on it has been disclosed or is being
2 progressed for disclosure to core participants and any
3 further material that is so received by the inquiry will
4 similarly be disclosed.
5 Chair, as you know, certain issues have been raised
6 in the media since the last day of these hearings,
7 largely as a result of interviews with one of the core
8 participants. We would like to respond to some of those
9 issues, not least because we consider the position has
10 been misrepresented in the reporting in some respects.
11 However, it seems sensible, chair, to do this at the end
12 of the hearing, as some of those issues may well also be
13 addressed in the closing statements. Chair, you may now
14 wish to hear closing statements from the core
15 participants who wish to make them.
16 THE CHAIR: Thank you, Ms Hill. We begin with Ms Harrison.
17 Closing statement by MS HARRISON
18 MS HARRISON: Good morning, chair and panel. Chair and
19 panel, you heard the powerful evidence of our client
20 CS-A2 on Day 5 of this hearing. She told you about the
21 appalling sexual exploitation and abuse suffered by her
22 daughter, CS-A1. She described to you the long battle
23 she and her husband had to fight to persuade the
24 authorities to be proactive in recognising the real and
25 imminent risk of CSE to their daughter. She described

1 to you how, even after her daughter was recognised as at
2 high risk, which in reality meant she was already being
3 seriously sexually exploited, she and her husband had to
4 battle to persuade the authorities to take effective
5 action to protect her daughter. Concerns were raised in
6 advance around the suitability of placements where the
7 local authority placed their daughter, which resulted in
8 further sexual exploitation.
9 Police disruption tactics were ineffective, and not
10 all police procedures were deployed.
11 This case clearly demonstrates that, whilst written
12 policies existed, exact and specific measures to prevent
13 and protect their daughter from CSE were not effectively
14 implemented in practice.
15 Until IICSA decided to include Warwickshire in this
16 investigation, our client felt that there was no real
17 accountability for the failings of both the local
18 authority and the police in her daughter's case. She
19 and her husband had, for many months, been trying to
20 ensure that there was effective oversight and
21 accountability. They asked the Local Safeguarding
22 Children's Board for a Serious Case Review. This was
23 rejected, even though the criteria were met.
24 They sent many emails and a formal complaint to the
25 local authority about their daughter being out of

1 education for almost 18 months, which made her extremely
2 vulnerable to CSE. These received no response. They
3 complained to the IOPC and followed this up again a year
4 later, and still no response, and so far, some three
5 years later, that IOPC complaint has simply gone
6 unanswered.
7 Our client asks: who is the IOPC ultimately
8 accountable to? It appears to ignore complaints which
9 are difficult or inconvenient. This certainly wouldn't
10 be tolerated in any other area of society. Is the IOPC
11 fulfilling its purpose of providing robust, independent
12 oversight of police performance? In CS-A1's case, the
13 answer is no, as there has been no material response.
14 Our client is grateful to the inquiry for examining
15 Warwickshire and hopes it will make a material
16 difference not only to her daughter's case, but to many
17 other sexually-exploited children as well. The process
18 of participating in this inquiry has, to a certain
19 extent, helped CS-A2 and her husband work through the
20 trauma that they have been through. Previously, they
21 watched helplessly as their daughter was sexually
22 exploited and abused. The ability to explain what has
23 happened to their daughter to this inquiry has been
24 a hugely constructive experience.
25 In their evidence to this inquiry, the local

authority acknowledged some of the errors they made in CS-A1's case and, to a certain extent, apologised for those errors. That acknowledgement and apology means a lot.

We also note that, despite the less than conciliatory tone of Warwickshire Police's opening statement, in the evidence they gave to the inquiry on Day 5, Peter Hill of Warwickshire Police said he accepted that there were occasions where Warwickshire Police did not get everything right. Again, this is the first time they have acknowledged this, and it took this inquiry and the scrutiny placed upon CS-A1's case study by it to extract this acknowledgement from Warwickshire Police. Without the scrutiny of this inquiry, our client feels that neither the local authority nor Warwickshire Police would have made these material acknowledgements.

This shows the importance of external review, audit and oversight, which this inquiry has provided. CS-A2 has been deeply frustrated by the lack of oversight and accountability within the statutory services in Warwickshire. Her primary motivations for raising her concerns repeatedly with those statutory services have been, first and foremost, to keep her daughter safe but, secondly, to ensure this does not happen to any other

child and that lessons are learned. CS-A2 is disappointed the inquiry did not have the time to properly interrogate the role and effectiveness of the Local Safeguarding Children's Board in Warwickshire as was. She understands that the Local Safeguarding Children's Board has now been replaced by the Warwickshire Safeguarding Partnership. However, she wants the inquiry to understand that, despite being an educated and informed person, she was completely unaware of the existence of the Local Safeguarding Children's Board until she met with her MP to raise her concerns about her daughter's case and he suggested she make contact with it, and he also provided information around Serious Case Review criteria.

This indicates a worrying lack of transparency about structures of accountability. The practical point is that parents like her simply don't know how to raise concerns when they arise because the route to raising concerns is simply not clearly set out to them, especially at a time when their lives are in turmoil.

It felt more like a tangled web that CS-A2 and her husband had to navigate and persevere with, rather than a clear path to follow in order to be able to articulate their concerns. This simply cannot be right. Even when contact was made with the Local Safeguarding Children's

Board, it was disturbing to discover that the board was completely unaware of her case. In fact, following this meeting, and at the request of the Local Safeguarding Children's Board, my client forwarded the email she'd received from the police some six months earlier where the detective inspector stated that he had prepared a referral to the Local Safeguarding Children's Board.

Therefore, our client read with interest the witness statement of Elaine Coleridge-Smith, the independent chair of Warwickshire Safeguarding Partnership, the successor body to the Local Safeguarding Children's Board. At paragraph 28 of her statement, she explained:

"Having just completed the strategic thematic review on exploitation of children and adults, we have identified areas of excellence and best practice. However, there are gaps in governance, policy and procedures, identification and early intervention, lived experience and partnership and information sharing, which suggests an urgent need to progress our work with RiPfA to develop an overarching exploitation strategy and corresponding procedures. Returns suggested a confidence of working with CSE but a real need to have broader understanding of wider aspects of exploitation amongst professionals working with children and adults.

Our client hopes that the new Warwickshire Safeguarding

Partnership will be more effective than the Local Safeguarding Children's Board which showed a complete and worrying lack of any oversight.

As our client stated in her evidence, one of the reasons the local authority and the Local Safeguarding Children's Board gave for not conducting a Serious Case Review into CS-A1's case was it was very similar to a previous case they had within the local authority and which had, itself, apparently been the subject of a Serious Case Review. This rang alarm bells for CS-A2 as, firstly, if there was such a similar case necessitating a Serious Case Review, then why haven't lessons been learned in that case to avoid repetition of any mistakes or patterns in CS-A1's case? Secondly, how can CS-A1 be the most challenging case authorities have had to deal with, a phrase that has been used a lot about CS-A1 during the course of this investigation, if there has been another similar case like hers? Finally, if a 13- or 14-year-old girl, even one being seriously sexually exploited, such as CS-A1 was, is so challenging that she was both seemingly always a few steps ahead of huge numbers of professionals in both the local authority and in particular the police, who deal with serious criminals and organised crime, then we should be very worried indeed.

It is simply not good enough to label a child as challenging or the most challenging child they have had to deal with, in order to say that more could not be done. These are highly-trained professionals who should be able to deal with these issues and keep children safe.

CS-A2 believes that the attitude of the police was reactive rather than proactive. There was an over-reliance on the use of CAWNs at the expense of proactively using surveillance and other techniques to keep CS-A1 safe and securing prosecutions of perpetrators in her daughter's case.

It is clear from the disclosure that there were many other enforcement options open to the police which were not used in CS-A1's case. CS-A2 has not received an adequate explanation as to why these were not used. When Superintendent Peter Hill was asked the question about using a recovery order, he simply replied that a recovery order was something for the local authority to apply for rather than the police. This may well be the case, but it felt, in that part of his evidence, that the buck was being passed rather than grappling with the very real issue that the police were not proactive enough in protecting CS-A1 and prosecuting those who abused her. Working Together, a multi-agency

co-operation, is not effective if one statutory service simply passes the blame to another. The disclosure has also revealed that, in respect of two of the perpetrators alleged to abuse CS-A1, one went on to allegedly abuse another girl and another went to prison for sexually exploiting and abusing another child who was known to CS-A1 after abusing CS-A1. This is very upsetting to think about. Had these perpetrators been prosecuted before they went on to abuse again, then other victims could have been spared.

Throughout the course of this inquiry, our client has also heard evidence from witnesses about other potential disruption tactics which could have been used in addition to CAWNs, such as Civil Recovery Orders, Sexual Risk Orders, a CSA disruption notice, amongst others. We have also heard, from other national witnesses giving evidence to this inquiry, that CAWNs should not be used as the only tool for disruption of CSE but should be used alongside a proactive prosecution strategy. Our client agrees wholeheartedly and reiterates that, in her daughter's case, the strategy was reactive, not proactive, was inadequate and there did not seem to be any coherent strategy for prosecution of alleged offenders.

I turn now to the recommendations you might make.

Prosecutions should be possible where there is a high degree of digital and other physical evidence supporting that prosecution, even where the alleged victim is not willing or able to provide a statement. This is particularly vital in child sexual exploitation cases. As you are well aware, victims often don't see themselves as victims because of the grooming process, and this, combined with fear, trauma, their young age and shame, often prevents them from co-operating with any prosecution.

If we are truly serious about tackling child sexual exploitation and prosecuting offenders, we have to grapple with this reality, and adapt the legal processes accordingly. Our client considers that law reform is necessary to recognise the unique factors in tackling CSE cases, to prevent repeat offenders going on to abuse multiple children and, crucially, to enable alleged perpetrators to be brought to justice. Complacency about our criminal justice system is dangerous and simply leads to offenders being able to commit the most hideous of sexual crimes against vulnerable children in the knowledge that it is highly unlikely that there will ever be any serious consequences. That cannot be right and is not a state of affairs that we, as a society, should accept.

This inquiry has heard a lot from organisations and institutions regarding child sexual exploitation by organised networks in the five geographical areas. It has also heard from victims and survivors in other geographical areas and from some national witnesses, many of whom have given powerful evidence.

However, it remains the case that the only witness who has been able to directly challenge the institutional narrative of one of the five geographical areas from her own practical experience as a parent of a victim of CSE has been CS-A2. The chair and panel have simply not had the benefit of hearing the other side of the story in respect of any of the other geographical areas and case studies in the same way. The level of forensic detail which CS-A2 was able to provide to the inquiry we say is invaluable in presenting a real check and balance to the institutional narrative that the inquiry has heard for the preceding ten days of this hearing.

This speaks to a more general concern that policies on paper can look efficient and robust, but, in practice, are either not being enforced consistently or simply do not work. It cannot be right that multiple Ofsted reports into Warwickshire paint a positive and competent picture of its approach to CSE at the very

time that our client and her daughter have had such a different and traumatic experience in that very geographical area. The inquiry should be careful to conclude that all is well in the absence of any real and direct counterweight to institutional evidence in any geographical area or case study.

Our client is aware that the sexual exploitation of her daughter as detailed in her witness statement was not able to be reported in full due to the scale of her exploitation and has real concerns that her daughter is not the only child to have experienced institutional failings as a victim of CSE. It has been through the tenacity and perseverance of both CS-A2 and her husband that they continued to push for answers into CS-A1's care and protection from harm and continued to raise the alarm when things were broken and falling over. She remains very keen for there to be oversight, accountability and scrutiny, in order that lessons can be learned by both the local authority and the police. She fully recognises that many parents of victims of CSE are not in the position that she is in of having the time and the ability to speak up, speak out and demand answers when things go wrong. Many parents will simply feel confused, overwhelmed and intimidated by the system. They and, most importantly, their children,

deserve better than this.

Finally, chair, it is clear that society has come on in leaps and bounds in its understanding and attempts to tackle CSE over the last decade. However, it is vital that this acknowledgement does not lead to complacency that the progress that has been made in recognising and tackling CSE means that all is working well. It is clear that, on the ground, there remain real problems that need to be tackled and we look forward to the inquiry's recommendations in this area, which we hope will better protect children in the future, as every single child has the right to be protected from child sexual exploitation. Thank you, chair.

THE CHAIR: Thank you, Ms Harrison. Mr Chapman?

Closing statement by MR CHAPMAN

MR CHAPMAN: Chair, panel, we act for the charity PACE -- Parents Against Child Exploitation. Gill Gibbons, the chief executive officer of PACE, gave oral evidence before you on Day 10, as you may recall, and we also supported the witness CS-A12, who gave oral evidence on Day 2, and she was particularly brave to do so.

If I may outline my approach, which will be to summarise some of the salient features, as we see it, of the evidence; secondly, the essential nature of the problem in this strand of the inquiry, as we see it;

and, three, recommendations for the future.

If I may start with the summary salient features of the evidence, the first observation we make is about the paucity and quality of the data. The gap between the reality of sexually-exploited children's experiences in recent years and the bureaucratic response by statutory services is probably vast. We, frankly, do not know, because the data is so poor, it is blighted with poor collection, definitional problems, and a diversity of approach across the country.

If you accepted the overall tenor of the police evidence, you would think that there was little evidence of organised networks, however defined, involved with CSE in the six regions and even less CSE that is accompanied by serious threats of violence. That contrasts so starkly with the reported experiences on the front-line that we suggest that should give you grave cause for concern.

I do not have to remind you, chair, of course, about Rotherham, Rochdale, Oxford.

The next point and salient feature is the lack of resources at the front line and the failure to recognise the key role of parents, schools and third-party non-statutory organisations like the Angelou Centre, Apna Haq, youth centres and, indeed, PACE.

Why? Because they are the best ones placed to spot CSE early. They are the ones in whom a child is most likely to confide. They are the ones who are best placed to influence and curb their child's access to perpetrators fast, and they are the ones who are best able to provide key forensic information to the authorities to disrupt the activities of perpetrators.

Contrast that, we suggest, with the very great powers the state already has to confront child sexual exploitation, and they include taking children into care, but too often out of their home area. They include placing them in secure accommodation, but too often it is an unregulated bedsit. It includes the detection and prosecution of offenders who have already committed terrible crimes, but the process is brutal for children who have to give evidence. These are blunt, expensive, impersonal instruments. When exercised, it is already an explicit admission of failure. For children who have already been traumatised, it represents further trauma and, too often, no end to what they have suffered. They may end up separated from their parents, stigmatised and exposed to further abuse. Children's homes, we know, are targeted by organised perpetrators. You heard from the parent of CS-A2 about her bruising experience with the police and

1 Social Services, and PACE's own report from November 29
2 shows a slow response by statutory services is typical.
3 On occasions, it has reminded us of Ronald Reagan's
4 quip, "The nine most terrifying words in the English
5 language are: 'I'm from the Government and I'm here to
6 help'". Far from helping parents help their children,
7 parents were treated like the enemy.
8 I turn, chair, to the nature of the problem, and the
9 first observation we make is that, whatever acronyms we
10 use, this is not a new problem. Child sexual
11 exploitation has been ever present in societies in one
12 guise or another and what you have heard about
13 children's experiences differs little, except in its
14 graphic detail, from adult predation on children
15 described by Charles Dickens in Oliver Twist in 1837,
16 before we even had a national police force. We are so
17 much richer. We have a national police force. We have
18 extensive social services. We think ourselves so much
19 more enlightened. And yet you heard CS-A12 describe her
20 only too-recent experience:
21 "I was called a liar, a rebellious, out-of-control
22 teen and told that I was the problem."
23 When she was placed in care, it turned out to be
24 just as dangerous as at home. "It has high rape", she
25 said, "child abuse, drugs, violence, everything, as high

1 as it can be". Staff knew what was happening. It was
2 happening in plain sight. Police called her a child
3 prostitute. The only physical contact she had was
4 physical restraint. It's hardly surprising that CS-A12
5 became increasingly dependent on her abusers. She said:
6 "I had such conflicting feelings because, to
7 a certain degree, I loved these men. They were my
8 family."
9 When she finally sorted her life out, it was largely
10 on her own. The trial process was protracted and awful.
11 It was five years from her first complaint to police and
12 the end of the trial.
13 That essential story is repeated with cruel
14 variations across the country. Perhaps 40,000 children,
15 estimated by one Sheffield University study in 2016,
16 involved in CSE. Each generation of children must run
17 the CSE gauntlet -- it blights the children, of course,
18 their parents and their wider family. The offending is
19 such that online child sexual abuse and exploitation is
20 recognised by the UK Government to be a national threat,
21 with the reports about the volume, severity and
22 complexity of the online threat being made to the
23 National Security Council.
24 It is happening in plain sight. You will have read
25 Jon Wedger's statement, the former Metropolitan Police

1 officer, who said that the awareness of child
2 exploitation by the Metropolitan Police and local
3 authorities has always been very high, partly as much of
4 the abuse is fairly easy to detect, but also because the
5 abuse is frequently and repeatedly reported. The
6 exploitation of children in London is, therefore, very
7 much in plain sight as far as policing is concerned; the
8 same is true nationally.
9 Speed and technology. This is another salient
10 feature, because the speed with which a child falls
11 under the coercive control of a sexual predator is
12 alarming. The main reason, we suggest, for that is
13 internet technology. The relevance of cheap
14 communication technology for organised networks is
15 obvious. In virtually all cases of CSEN, mobile phones
16 are being used to control and co-ordinate offending.
17 You noted in the internet strand how the internet was
18 used to groom children, building a relationship with
19 them to gain their trust for the purpose of sexual abuse
20 or exploitation. You noted that the move from
21 establishing online contact with a child, to meeting in
22 person and physically abusing them, can happen very
23 quickly. You note the extent of mobile phone use:
24 99 per cent of 12- to 15-year-olds spend 20.5 hours
25 online per week and 83 per cent of them have their own

1 smartphone. You can gather the importance of mobile
2 phones to perpetrators by the extent to which
3 perpetrators often give their victims mobile phones. It
4 is the perfect grooming tool. It is a gift and it
5 enables the abuse to be co-ordinated and continued.
6 Technology is simply one example of how fast the
7 nature and methods of CSEN change. But there are
8 others. Perpetrators may appear to come from one
9 homogeneous ethnic group in one locality, but it will be
10 different in another. We heard how the nature of
11 criminal gangs in CSE in Tower Hamlets is quite
12 different, for example, from the experience in Hackney.
13 A single child can experience a multiplicity of abuse.
14 It is inevitable, where the police adopt one disruption
15 tactic, a new model of exploitation will emerge.
16 So it is for those reasons that we say the focus
17 should be on parents, schools and non-statutory third
18 parties. With that raw experience of CSE -- the speed,
19 the use of modern technology, its shape-shifting nature,
20 and apparently in plain sight of those charged in law
21 with caring for children, we have at times doubted the
22 efficacy of an academic debate on the precise definition
23 of CSE and organised networks. Glossaries of acceptable
24 and unacceptable use of language by professionals that
25 appear to have been unread and unimplemented and in one

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case the policy document suggests alternative language that entirely removes an important component of the abuse. There needs to be more than just cosmetic changes in the attitude of professionals working with CSE. We have doubted what benefit to children there has been in the public wrangling between the police and CPS about who is responsible for the low prosecution of reported sex offences, or indeed in the aspirational policy documents we saw rendered meaningless because there's no way of measuring outcome because no-one has agreed the definitions.

The goal, you might think, is a simple one. Every parent, however troubled, would agree: their child should not be drugged, raped or beaten by known predators, in plain sight of the authorities. That is the essence of the relational safeguarding model adopted by PACE, an approach that assumes that parents and carers want to have the capacity to protect their child unless there is evidence to the contrary. The goal is emphatically not for national institutions to sing their virtue and good intent while assuming little.

I will turn briefly to the recommendations, chair, because I am running short of time. But our first recommendation is that parents must come first and, to that end, there should be a rolling national campaign of

information and advice to parents about CSEN and the resources available to provide support to them that is consistent with the government's categorisation of CSEN as a national security threat. Those resources should include independent, non-statutory bodies who can liaise with the statutory bodies. You may wish to consider,for example, the provision in each local authority area of specialist, independent family support similar to the role of independent sexual violence advisors as successfully deployed in Rotherham.

Secondly, we suggest that there should be a dedicated national force of CSE disruptors with similar powers to the police but whose primary purpose will be the disruption, not the prosecution, of CSE networks. This would encourage strong leadership by individuals with a passion and dedication to the task. It would enable staff in this organisation to make a career out of this work, rather than being moved on, as we heard was often the case with police officers.

It would more easily incorporate the softer skills provided by organisations like Catch22 and PACE, and it would enable a greater depth of experience to be acquired.

If five out of the six police forces in this inquiry reported no current CSEN problem, that suggests: one,

local inexperience, at the very least; and, two, that CSEN springs up in unexpected pockets across the country.

Two, we recommend that there should be limitations on the access to mobile phones by children. There should be advice to children about that unfettered access. We suggest you, chair, revisit your conclusions in the internet strand and consider the merits of restricting ownership and use of mobile phones by children under the age of 16. No doubt that will be controversial with teenagers, but most parents see the sense of it and would be assisted by clear guidance and a legal framework surrounding the use of mobile technology by children.

Secondly, it is quite clear that technology providers of mobile phones in particular have not done enough to enable parents to monitor and restrict the use of their child's mobile phone. It is not in their interests to do so.

As far as the definition is concerned, we would ask you to recommend an agreed national definition, a broad one, similar to that proposed in this inquiry. Whether it is precisely right or wrong is less important than having a definition that can be used to capture and monitor progress.

Finally, we say this: all of these proposals we accept have cost implications, but they are nothing relative to the cost of harm that could be avoided as a result. The majority of sexually-exploited children by organised networks or otherwise live at home. That is where it starts. That is the place to stop it.

Thank you, chair.

THE CHAIR: Thank you, Mr Chapman. Mr Jacobs?

Closing statement by MR JACOBS

MR JACOBS: Chair and panel, I act for two prominent retired detectives, Jon Wedger and he confirms in his evidence that CSE happens in plain sight. I also act for Ms Oliver, who campaigns for CSE victims through her foundation. Both of my clients are retired detectives who specialised as police officers dealing with CSE by organised networks. They are actively involved in dealing with the issue today and bring considerable expertise to this investigation.

We will submit detailed written submissions in due course, but in the time available to me today, I wish to address two themes which have arisen from the evidence. Firstly, there are predominantly two types of organised networks. The first of these is the Rochdale/Rotherham-type grooming gang which is prevalent across the towns and cities of Northern England. We

heard that Oxford is another example. This is typified by the harrowing account of "Daisy", which Ms Benfield read out on Day 1. A particular feature of these gangs is that they are predominantly comprised of men of a similar ethnic and religious background. These gangs use similar patterns of exploitation in which a so-called older boyfriend will shower a victim with gifts and attention. The abuser will then provide access to drugs, alcohol and take-away food. Other children will be manipulated to exercise peer pressure to force a new victim to engage in sexual activity with the so-called boyfriend.

Ultimately, the child will be passed on to other members of the gang for sexual abuse, often believing they're still in a relationship with the primary abuser. One of the most disturbing aspects of the trial of the Rochdale abusers was the presence of the British National Party at Liverpool Crown Court and the provocative displays of racism which were subsequently taken up by the English Defence League, but it is not race that defines these perpetrators. It is the desire of a small minority of men within respectable communities in a number of northern towns and urban cities to exploit children for sexual gratification. So it is completely unacceptable to blame these communities

for the conduct of these criminals, as the racist groups have done.

Chair, it is also unacceptable to shy away from an uncomfortable truth. There is a need to understand why there is a problem in particular communities and how the police can work more effectively to eradicate that problem. I refer to the words of Mr Papaleontiou from the Home Office, who said, on Day 9, there must be no misplaced critical sensitivities in addressing CSE wherever it takes place. Child protection has to be paramount. As CS-A2 said at the conclusion of her evidence, every child has the right to be protected from CSE. This is an issue which we say the inquiry must address. A circuit judge who tried the last three cases of such organised abuse at Oxford Crown Court said on Tuesday that work in this area would be aided immeasurably by qualified analysis in these cases. He went on to say the IICSA is uniquely equipped to do that. We will develop this further in our written submissions but ask that the inquiry deals with the Rochdale/Rotherham phenomenon in some detail in its report and recommend that further research is undertaken to enable institutions to properly understand how to engage with this difficult and sensitive issue.

Chair, the other type of organised CSE exists within

county lines networks. Wendy Ghaffar of Ofsted stated, at paragraph 16 of her statement, plugging -- which is inserting drugs into intimate body parts -- is a common feature of county lines activities and a clear example of CSA and CSE. She also says, at paragraph 53, that often sexual exploitation is a form of initiation into a gang. In his oral evidence on Day 9, Simon Alexander from the Civil Service also confirmed that children involved in drug trafficking across borders across the county lines are being sexually exploited. County lines activities are growing at an alarming rate and institutions have not kept pace with this dynamic and complex phenomenon. Mr Papaleontiou acknowledged in his evidence before you on Day 9 that police forces have been on a learning curve in relation to county lines. We understand that research has recently been commissioned by the National Police Chiefs' Council and the National Crime Agency, and that police chiefs are looking to target county lines activities in permanent exploitation hubs based in regional organised crime units.

We ask that the inquiry recognises the significant risk of CSE that is posed by county lines activities and acknowledges that further research is urgently needed to throw light on what may amount to a substantial and very

deeply hidden risk. Chair, it is a major concern that we have no idea of the true scale of problem because the current data is inadequate. It is clear that the scale of CSE from the organised groups is substantial. Ms Hill told you in opening that the big picture is that many thousands of children are sexually exploited each year. Ms Langdale, for the Department of Education, referred on Day 9 to statistics that say that 18,720 cases in 2018 to 2019 identified CSE as a relevant factor.

However, CSE is under-reported, under-recorded and under-identified. The 2019 HMICFRS report found that police can miss complex or less obvious risks of CSE. The true scale of the problem is simply not known. Mr Papaleontiou confirmed in his evidence on Day 9 that ONS data does not adequately distinguish between CSA and CSE and fails to reflect the prevalence of CSE in local areas. Ms Langdale, for the Department of Education, said, on Day 9, there's still "a long way to go in terms of gathering data and evidence and filling data and evidence gaps, including linking data".

In terms of failing to identify CSE, Mr Papaleontiou, the Home Office witness, stated that there is still a lot to do in terms of understanding offending parts and therefore -- and understanding what

interventions are needed for different forms of offending. My clients maintain that if the institutions responsible do not know the true scale and the true scope of the problem, it is impossible for them to do anything meaningful about it. It is a critical issue that you should address and we would ask that you make findings on in your final report and recommendations, or in this report.

The second issue on which I would wish to address you is victim blaming. This issue features strongly in the evidence of both of my clients. The inquiry has heard from a number of witnesses that victim-blaming language still prevails within institutions. We heard evidence of its recent use -- phrases such as "taking risks through sexualised behaviour" or "known to have been sexually active from a young age", to cite two examples from Durham- and Swansea-connected evidence on Days 3 and 4. It is clear that institutions throughout this jurisdiction still lack awareness and have a long way to go before victim blaming is eradicated.

The witness from the Metropolitan Police accepted on Day 7, in answer to questions from the chair about underlying attitudes, that there is a cultural shift and we are in the midst of it. She stated that, even today, officers have to be put on action plans to address

victim blaming. Mr Frank pressed the commander on this and when the shift might ever be completed. But, chair, she could not give a timescale.

Chair, in my opening submissions, I referred you to the case of Amber. Amber was one of the victims in the Rochdale grooming cases. She was interviewed by the police as a victim of repeated exploitation by organised paedophiles, but told that she would not be called to give evidence at the trial of her abusers. Astonishingly, instead, the police and the CPS chose to add her to the indictment as a member of the Rochdale grooming gang. Amber was never told that she had been added to the indictment, and not only was she hugely traumatised when she eventually found out, but she nearly lost her own children to Social Services care as a result.

CTI put Amber's case to Gregor McGill of the CPS and asked him to explain the actions of the CPS. Mr McGill responded in his third statement of 20 October. In that statement, chair, it is clear that the Crown Prosecution Service did, and continues to, blame Amber for her abuse. They say she was a willing participant. But, chair, Amber was 15 years old when she suffered horrific sexual abuse and rapes. At all material times, Amber was a terrified and coercively-controlled child victim

of a grooming gang. She was simply never a member of a grooming gang. It is quite shocking that, as Mr McGill admits, Amber was not informed that she'd been named on the indictment.

Chair, Mr McGill's third statement provides an astonishing, current and appalling example of institutional victim blaming. The lead witness from the CPS entirely fails to engage with our point that every sexually-exploited child is a victim of crime, not complicit in, or responsible for, the crimes committed against them. Mr McGill says that there is no CPS guidance which endorses naming the child on an indictment in this way, but it would appear, he says, that this was a fact-specific decision taken in the case to ensure that the role played by Amber was understood by the jury.

Chair, this evidence, we say, is truly compelling because it represents brazen victim blaming from a major institutional core participant in this investigation today. The CPS continues to demonstrate, and continues to seek to justify, institutional, embedded victim blaming. Chair, not only are the victims blamed, they are criminalised. CWJ's client "Daisy" classically exemplifies this. She was arrested, charged repeatedly, often directly connected to the appalling abuse she was

suffering. As Ms Gallagher told you in her opening submissions, these are not outlier, extreme stories. This is the culture that must now change. As Mr Frank's question to the Metropolitan Police witness highlighted, it is this cultural shift that is needed now.

My clients ask you to find that the evidence demonstrates that we are still miles away from a child-centred approach to child sexual exploitation. It is no longer acceptable that institutions continue to treat children as complicit in their exploitation and abuse by organised networks.

To conclude, this investigation is important because the issues raised in it are not historic but are happening today on a huge scale and, as my client says, and as the witness for Barnardo's has confirmed, CSA has always and is continuing to take place in plain sight.

We say that the inquiry must look at the phenomenon of the Rochdale/Rotherham-type grooming gangs and deal with the difficult (interference) and it is ideally placed to do this. We say it is a matter of urgency that institutions understand the scale of the problem, particularly in respect of CSE within county lines activities.

It is also a matter of urgency that the embedded culture of blaming and criminalising children, an issue

1 fully detailed in both my clients' statements, is
2 finally brought to an end. We ask that you make strong
3 recommendations in your report on these crucial points.
4 Chair, unless I can assist further, those are my
5 submissions.
6 THE CHAIR: Thank you, Mr Jacobs. We will now take our
7 morning break and return at 11.45 am.
8 (11.30 am)
9 (A short break)
10 (11.45 am)
11 THE CHAIR: Ms Gallagher?
12 Closing statement by MS GALLAGHER
13 MS GALLAGHER: Thank you, chair and panel. I make this
14 statement on behalf of the Centre for Women's Justice,
15 and CWJ endorses and supports much of what you have
16 already heard this morning in the powerful closing
17 statements by Ms Harrison, Mr Chapman and Mr Jacobs, and
18 we will develop this further in our detailed written
19 submissions. Those written submissions, chair and
20 panel, will, of course, address all matters of concern
21 to CWJ and, importantly, detail the practical
22 recommendations which we seek.
23 But in my short submissions orally today, we wish to
24 focus in particular on one of the underlying thematic
25 issues which has emerged from the two weeks of evidence,

1 and some of CWJ's key concerns about the criminal
2 justice system's response to CSE, including in
3 particular our response to Mr McGill's and
4 Mr Papaleontiou's evidence received in the last number
5 of days.
6 At the outset, however, I am asked to note that CWJ
7 has made clear its concerns regarding the methodology in
8 this strand on many occasions, and in particular the
9 absence of direct evidence from victims and survivors in
10 any of the six geographical areas. CWJ's view, as you
11 know, before this hearing, was that, without the voices
12 of victims and survivors, the evidence from institutions
13 about their victim-centred policies could not be
14 properly probed and tested by the real-life experiences
15 of survivors, and, despite the extensive efforts of CTI
16 and STI, CWJ's view remains that those concerns have
17 been borne out by this hearing, and CWJ critically does
18 not consider that the reading of timelines concerning
19 individual children, prepared by lawyers from papers
20 provided by the institutions themselves, addresses this
21 fundamental gap. These are not children with agency,
22 with involvement in the process. This is not hearing
23 the voice of the affected child, protected by article 12
24 of the UN Convention on the Rights of the Child, which
25 gives children the right to have their views given due

1 weight in all matters affecting them. This strand could
2 not be more important. It affects children across the
3 country, it affects adults who were exploited as
4 children and were often criminalised rather than
5 protected, and remain blighted with criminal records for
6 long-abolished offences of what was termed at the term
7 child prostitution, and their voices, CWJ says, have
8 simply not been given due weight in this strand.
9 Now, those are issues we address in more detail in
10 our written submissions, but it is important that these
11 profound concerns of the CWJ are on the record today.
12 I mentioned underlying thematic issues. In our
13 written submissions we develop that further. But there
14 is one key theme we wish to highlight today, and that is
15 the mismatch between policies on paper and what happens
16 in practice.
17 CWJ submit that this is a key issue in this strand
18 which involves exploitation in plain sight, to use the
19 phrase Mr Chapman used earlier, despite the existence of
20 extensive policies, and we note that Ms Sharpling in
21 particular pressed a number of witnesses on this in her
22 questioning.
23 We ask you to closely consider the Children's
24 Commissioner's findings on this issue in
25 Sue Berelowitz's report in 2013; Harriet Wistrich, the

1 director of CWJ, her statement, particularly at
2 paragraph 125; and the evidence of Dr Beckett, who
3 described in her statement how she and her colleagues
4 continue, in 2020, to observe a gap between policy,
5 guidance and practice on the ground.
6 When Dr Beckett was asked about this gap and how it
7 could be plugged during her oral evidence, she said:
8 "The policy isn't bad in terms of its stated
9 intentions for young people who experience harm, but the
10 training and information sharing was necessary to
11 properly implement those policies."
12 But she cautioned, importantly, that, "By training,
13 I don't simply mean put them on a course, make them read
14 something; I mean training that gets to the attitude and
15 the things behind what's getting in the way of doing
16 this".
17 Now, we emphasised this point about the mismatch
18 between policy and practice on Day 1 of this hearing in
19 our opening statement, telling you that, all too often,
20 in other strands you've heard evidence from
21 institutional witnesses about their policies or
22 practices, how victim-centred they are, how effective
23 their systems are, only for those claims to, frankly,
24 fall apart when confronted with real-life cases and
25 witnesses who say, "This description on paper bears no

1 relation to my experience in practice". This precise
2 trend could be seen in relation to Warwickshire. As
3 Ms Harrison highlighted earlier, the one area of six
4 which came the closest to having direct evidence from
5 a survivor, hearing powerful evidence from CS-A2,
6 a parent of a survivor, on day five. Her evidence laid
7 bare that mismatch. She said, in relation to both
8 Warwickshire Council and Warwickshire Police, that the
9 procedures appeared adequate and comprehensive on paper,
10 but in practice they did not work, they did not keep her
11 daughter safe from harm. She described there being
12 a wealth of procedures in place, but they simply did not
13 transfer into the practical and simply did not protect
14 her daughter.
15 We make three points arising from this which overlap
16 substantially with Ms Harrison's submissions this
17 morning. First, we say it is notable that the only
18 complainant witness from one of the inquiry's selected
19 geographic areas -- that's CS-A2 -- gave clear evidence
20 of the gap between institutional policy and practice on
21 the ground, and the local authority witness then frankly
22 accepted that there was such a gap.
23 In circumstances where no evidence along those lines
24 was heard from complainants from the other geographic
25 areas, the inquiry is invited to be cautious and

1 sceptical when reviewing the evidence of institutions in
2 which they applaud their myriad policies for tackling
3 CSE, when the reality of how those policies are put into
4 practice on the ground has not been tested in
5 a meaningful way in the way it was in Warwickshire.
6 Second, and also notable, we say, is that CS-A2 was
7 an articulate mother who clearly fought very hard for
8 her daughter to be given proper support by
9 Social Services and the police. She was proactive, she
10 was informed. This was an area with a good Ofsted
11 report, as Ms Harrison highlighted this morning. This
12 begs the mind-boggling question: what hope is there for
13 children without parents like CS-A2 in areas with poor
14 Ofsted reports if this is the picture painted in
15 Warwickshire?
16 Third, we say a hint of that mismatch between policy
17 and practice could even be seen within some of
18 the institutional evidence. For example, in Mr McGill's
19 statement -- and CWJ entirely endorses and supports
20 Mr Jacobs' description of the third witness statement
21 from Mr McGill as being an astonishing example of
22 institutional victim blaming. And another example is,
23 on Day 6, you heard evidence from Mr Leivers of
24 St Helens Council who gave extensive evidence about the
25 steps the council is taking to eliminate victim-blaming

1 language -- see page 57 of the transcript -- but went
2 on, in his own evidence, moments later, to use precisely
3 such language himself about a young person placing
4 themselves in situations of vulnerability and placing
5 themselves at risk -- see pages 85 and 112 of the same
6 transcript.
7 But turning to the key issue for CWJ today, the
8 criminal justice system. We will set out for you in our
9 written submissions detailed analysis on a range of
10 points, including what we see as a lack of victim
11 through-care during the criminal justice process and
12 post trial, on which you've heard substantial evidence.
13 In those written submissions, we will address in detail
14 why we consider the evidence from Mr McGill of the CPS
15 on that victim through-care issue was deeply
16 unsatisfactory and failed to grapple with the findings
17 of frequent dissatisfaction in Dr Beckett's research.
18 He responded to a question from Ms Hill on this issue by
19 citing ground-breaking changes over the past 30 years,
20 and he unfortunately did not acknowledge or address
21 Dr Beckett's research and findings, also echoed in the
22 evidence of Harriet Wistrich, Maggie Oliver,
23 Sarah Champion, Catch22 and even the inspectorate,
24 HMICFRS, amongst others. He also suggested any
25 dissatisfaction was an inevitable by-product of

1 the adversarial and brutal criminal justice system,
2 a phrase which Rosie Lewis of the Angelou Centre rightly
3 described as disturbing.
4 In respect of Amber, we will also address you in
5 further detail in writing, but may I say this: we agree
6 with Mr Jacobs' submissions on behalf of Maggie Oliver
7 in respect of Amber and you will be aware, chair and
8 panel, that CWJ represent Amber in civil proceedings
9 against the CPS. Frankly, they are appalled at the lack
10 of apology for her brutal treatment, and are also
11 appalled by what is a narrow, formalistic approach by
12 Mr McGill describing her both in his oral evidence and
13 in his latest statement as not being criminalised
14 because she was not prosecuted.
15 We say this: Amber was a victim of multiple rape by
16 organised networks of men when still a child. The
17 police were notified of this but failed to protect her
18 and eventually arrested her, aged 16, for pimping,
19 despite knowing she was a victim of abuse. When
20 a subsequent police investigation sought her assistance,
21 she agreed to co-operate on condition she would be
22 treated as a victim, but the CPS reneged on their word
23 and put her on the indictment as a co-conspirator
24 alongside the very men who'd abused her. During the
25 trial, she was nicknamed "The Honey Monster", portrayed

1 as a pimp or madam who had procured other young girls
2 for the abusers, and no charges were brought or crimes
3 recorded in respect of the sexual crimes against her
4 personally. She did not even discover she was named on
5 the indictment until months after the trial and the
6 reasons for that were never formally explained to her.
7 When Ms Hill asked Mr McGill about that issue, whether
8 she'd been informed that she was on the indictment, he
9 couldn't tell you in his oral evidence whether she'd
10 been told in advance that she was named, but in his
11 third statement, received this week, at paragraph 13, he
12 now accepts she was not informed, and he's also failed
13 to address the broader issue raised by Ms Hill of
14 anonymity for those named in this way on the indictment.
15 So a narrow, formalistic, "she wasn't prosecuted"
16 simply doesn't grapple with those key issues.
17 Today, we want to highlight three particular issues
18 about the criminal justice: criminalisation of victims
19 of CSE; flawed CPS policy and practice on prosecution of
20 rape cases, including CSE; and the use of children as
21 covert human intelligence sources and the inadequacy of
22 the Home Office's response to this.
23 Firstly, criminalisation of victims of CSE. Now,
24 this was raised by CWJ in opening and has been borne out
25 by the evidence. There are multiple examples which you

1 have heard over the course of this hearing: "Daisy";
2 CS-A12; Jennifer, referred to by Rosie Lewis; CS-A71 in
3 St Helens; CS-A32 in Bristol. It is clear from these
4 examples that victims continue to be criminalised for
5 behaviour linked to their abuse by individual police
6 forces and by the CPS.
7 Now, when Mr McGill was asked about this issue, he
8 said, "There are sometimes really difficult decisions,
9 sometimes amongst the most finely balanced decisions,
10 that prosecutors have to make".
11 The key question for you is whether the police and
12 CPS get this difficult balance right, and the examples
13 that you have heard suggest they often do not, and the
14 police often do not.
15 On that balance question, on Day 9, the Home Office
16 witness, Mr Papaleontiou, said the government is very
17 clear that those who have been criminally or sexually
18 exploited are victims and should be treated as such,
19 rather than perpetrators.
20 But to probe whether the balance has been correctly
21 struck, using Mr McGill's phrase, or whether the
22 government's very clear view, to use Mr Papaleontiou's
23 phrase, it is key that data is gathered. Without data,
24 these are simply untestable assertions and policy is
25 being made in an information vacuum. But, regrettably,

1 this data is not being gathered.
2 Take section 45, the Modern Slavery Act 2015, which
3 came into force in 2016 and provides a statutory defence
4 for children accused of criminal offences for conduct
5 arising from their abuse. It is a critical piece of
6 legislation, a key statutory vehicle by which the UK can
7 comply with its obligations under the Council of Europe
8 Convention on Action against Trafficking. But the 2019
9 independent review of that Act found that there was
10 evidence that victims continued to be prosecuted for
11 offences they were forced to commit, in breach of
12 section 45. That review also highlighted the lack of
13 data regarding the use of section 45, noting that it was
14 therefore difficult to understand how the statutory
15 defence has been used or potentially misused.
16 It is also not the first time concerns about lack of
17 data had been raised. It was also raised in 2017 by
18 HMCPSI. Despite this issue, when asked about data,
19 Mr McGill has said in his latest statement at
20 paragraph 32 that the CPS does not gather data on
21 occasions on which section 45 has been deployed, let
22 alone disaggregate it for CSE cases by race or gender,
23 and he has no intention of doing so.
24 He suggests that, because section 45 applies in such
25 a broad range of circumstances, any data is unlikely to

1 present a complete picture. We agree. But it would
2 present a partial picture, which is currently missing,
3 with a statistical objective underpinning.
4 The Home Office was also asked about this topic and
5 overnight we have received their statement, and they
6 said at paragraph 4:
7 "The Home Office does not collect data on the use of
8 section 45. However, we continue to engage with the
9 police and the CPS to monitor and assess how it is being
10 used in practice."
11 Plainly, that's inadequate, given that the CPS
12 doesn't collect or record the data and has no intention
13 of doing so.
14 Now, Mr Papaleontiou referred in his statement to
15 the balance that the current legislation strikes, and
16 draws on the independent review as suggesting that the
17 legislation achieves the right balance. But there is an
18 element of the dog that didn't bark in the night, if
19 I can put it this way, because what his statement is
20 silent on is a key aspect in the independent review:
21 recommendation number 78, which recommended that, as
22 a priority, the police, the CPS and HM Courts and
23 Tribunal Service record data on how the statutory
24 defence is being used, and it highlighted that the
25 accurate collection of data is vital. We have had no

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1 answer from the Home Office as to why they have failed
2 to comply with that recommendation from 2019 and we ask
3 you to repeat that recommendation and ask them to now
4 collect that data.
5 Criminalisation, of course, also continues into
6 adulthood and we address in our written submissions why
7 the Home Office's response on that is inadequate and we
8 ask you to make recommendations to clear the records of
9 those individuals convicted, wrongly, for offences which
10 arose from their exploitation.
11 In relation to the lack of prosecutions for rape and
12 other sexual offences, the CWJ in opening statements and
13 in our questions which we put, through rule 10, through
14 your counsel have highlighted the precipitous decline in
15 rape prosecutions and, in summary, we say that
16 Gregor McGill's evidence on this was deeply
17 unsatisfactory. We highlight three short aspects now.
18 First, it's clear from Mr McGill's second written
19 statement that he is now backtracking on the language he
20 inappropriately used in the Lambeth strand. Claiming,
21 as he did in the Lambeth strand during the summer, that
22 the CPS is more successful than ever is simply not
23 correct and tends to mislead. In his second statement,
24 there was rather a U-turn, he describes sharing CWJ's
25 concern about the drop -- very different language, but

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1 quietly on paper; it wasn't an acceptance that he made
2 frankly in his oral evidence.
3 Second, he deflected attention in that second
4 statement and his oral evidence from the concerns
5 emphasising the whole system issues and the fact that
6 police decision making also revealed a drop. We agree.
7 Both the CPS trend and the police trend are deeply
8 concerning and we suggest they're linked, as per
9 Dr Cockbain's powerful academic evidence.
10 Third, Mr McGill was, on occasions, contemptuous,
11 for example, of Dr Cockbain's detailed and careful
12 academic analysis. When asked a rule 10 question about
13 her evidence, he complained about the lack of
14 specificity, saying, "It's so vague as to be almost
15 impossible for me to be able to comment on. I would say
16 that I don't understand what point is being made there.
17 What I will do, I will make a statement -- comment in
18 a further statement, but with the caveat that I'm not
19 sure what I can say because there is a lack of any real
20 tangible data or evidence that I can go to to rebut what
21 is said there". We say two things in relation to that,
22 chair and panel. First, he said he was unable to answer
23 the question because he didn't know the particular
24 prosecutors who Dr Cockbain, a respected academic, had
25 spoken to. Dismissing anonymous whistleblower concerns

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1 raised to a respected academic is simply not acceptable.
2 But, secondly, we draw to your attention, panel, the
3 fact that similar concerns in relation to the CPS's
4 approach to charging decisions in rape and serious
5 sexual offences generally have been raised by identified
6 and named senior police officers and reported
7 extensively in the media. We highlight ACC Ben Snuggs
8 of Hampshire Police, DCC Sarah Crew for the NPCC, and
9 DCC Sara Glen of Hampshire Police and we have provided
10 your team with the links.
11 So saying there is a lack of any real tangible data
12 because there's no names does not address this. These
13 are not anonymous critics. They are senior police
14 officers who have gone on the public record. Why has
15 Mr McGill failed to address their concerns?
16 Finally, chair and panel, and very briefly -- we
17 will address this in further detail in writing -- we
18 wanted to address you very briefly on the issue of the
19 use of covert human intelligence sources. A Home Office
20 minister writing to a House of Lords Committee in 2018
21 said:
22 "Given that young people are increasingly involved,
23 both as perpetrators and victims, in serious crimes,
24 including terrorism, gang violence, county lines drugs
25 offences and child sexual exploitation, there's

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1 increasing scope for juvenile CHIS -- covert human
2 intelligence sources -- to assist in both preventing and
3 prosecuting such offences."
4 That House of Lords Committee expressed grave
5 concern about the use of children undercover in these
6 contexts, and highlighted the serious risks which they
7 would face.
8 Now, the Home Office witness, Mr Papaleontiou, was
9 asked, at CWJ's request, whether the Home Office
10 considers it appropriate to permit the use of children
11 undercover in child sexual exploitation cases. We found
12 the answer vague and evasive and, concerningly, going
13 back to a point we made earlier, the answer referred to
14 children not being asked to be involved in criminality
15 that they aren't already involved in. Now, that in
16 itself, we say, is entirely inappropriate language,
17 again suggesting that children in a CSE context are
18 criminals, not victims.
19 So that is precisely an example of the mismatch
20 which we have highlighted and which those who spoke
21 before us have highlighted.
22 For all those reasons, chair and panel, we ask you
23 to look very carefully at the evidence and the
24 assertions and the statements which were made by
25 institutional witnesses which, when you probe below the

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1 surface, simply fall apart and, for that reason, we ask
2 you to make practical recommendations to secure real
3 change in this vital area of CSE in organised networks.
4 Thank you.
5 THE CHAIR: Thank you, Ms Gallagher. Mr Suleman?
6 Closing statement by MR SULEMAN
7 MR SULEMAN: Thank you, chair. Chair, my client is the MP
8 for Rotherham. Chair, you will know only too well that
9 Rotherham was, a number of years ago, identified as the
10 source of significant and high-profile child sexual
11 exploitation. Similar highly-publicised cases of child
12 sexual abuse and exploitation were found in Oxford,
13 Peterborough, Derby, Rochdale and Huddersfield to name
14 a few. This inquiry chose not to examine any of those
15 areas as part of its investigation. In our submission,
16 that was a mistake. It prevented the inquiry from
17 discerning the commonalties between methods adopted by
18 organised networks in each of those areas and it
19 deprived the inquiry of important evidence of what was
20 done by authorities to disrupt (interference) CSE and
21 change the organisation. As a result of this approach,
22 the oral evidence we heard from institutional witnesses
23 was, unfortunately, largely predictable. The tenor of
24 the evidence was that the institutions did far too
25 little historically to protect children from harm, they

1 universally consider that they have taken significant
2 strides forward and they all consider that there is, of
3 course, more to do.
4 At least one of the institutional witnesses appeared
5 to be reading from a script.
6 In the meantime, the survivors watching the hearings
7 will have identified that, in each of the key areas we
8 raised in opening submissions, the need for proactivity,
9 the danger of preconception and the importance of
10 collaboration, children continue to be failed.
11 The most important points were these. First, in
12 relation to proactivity. We heard a significant amount
13 of evidence on local authorities' risk profiling of
14 children and the importance institutions attribute to
15 establishing the factors that place some children at
16 greater risk of CSE than others. These approaches
17 ignored the simplest principle of all, that all children
18 are vulnerable. To quote Dr Helen Beckett from Day 2 of
19 the public hearings, a child isn't exploited because
20 they're vulnerable, a child is exploited because there
21 is someone there who wants to exploit them.
22 There needs to be an increased focus on
23 perpetrators, and a thematic change in the attitude of
24 law enforcement from catching those responsible for CSE
25 to the protection of the public. As Katherine Riley for

1 HMIC noted, there needs to be a shift from demand
2 management to addressing the underlying causes. If this
3 doesn't happen, the same failings will be made over and
4 over again.
5 The need for proactivity extends beyond just
6 targeting criminals to their arrest and, ultimately,
7 their prosecution. As Dr Hallett put it, for young
8 people, CSE is often not separate from other things
9 going on in their lives. We heard other evidence that
10 it is often part of a spectrum of offences being
11 committed by organised networks. As Ms Sharpling
12 identified when questioning Ian Critchley, it is
13 important that the police consider a range of different
14 methods to protect children, including arresting and
15 charging perpetrators with alternative offences, like
16 drug dealing or supplying alcohol to a minor or
17 trafficking. Indeed, who could fail to have been moved
18 by the brave evidence of CS-A371 relating to the
19 horrific experience she endured at the trial of those
20 accused of exploiting her, and who could fail to have
21 been astonished by the acceptance by Gregor McGill of
22 the CPS that an adversarial system will always be
23 brutal, however mitigated, and is bound to leave victims
24 bruised. That simply isn't acceptable.
25 For these crimes to be prosecuted, victims need to

1 come forward in the first place to give evidence. We
2 need to find new ways to ease the burden on survivors
3 and law enforcement and the CPS need to take the
4 initiative to charge and prosecute offences that do not
5 need vulnerable victims to relive their trauma in court.
6 It was CS-A371 herself who put this point most
7 powerfully. She said:
8 "If something was to happen similar or like that
9 again, I wouldn't report it because I wouldn't want to
10 go through a trial again."
11 Not supporting victims and survivors leads to
12 offenders not being prosecuted.
13 Second, with respect to preconception, we heard
14 clear evidence that victim-blaming language persists in
15 institutional documentation across the country. Local
16 authority witnesses took counsel to the inquiry through
17 individual policies governing the use of language, but
18 none could explain why such language was still used in
19 recent documentation, or indeed the evidence of
20 charitable organisations that such language is often
21 found in referrals even today.
22 From Dr Beckett we heard perhaps a partial
23 explanation: societal intolerance towards adolescents;
24 a preconception that they are more likely to be the
25 cause of trouble than its victim. As we heard from

1 Jim Leivers for St Helens Borough Council, these
2 attitudes exist in respect of male victims in particular
3 whose CSE concerns are more likely to be dealt with as
4 child criminal exploitation and who are more likely to
5 be identified as youth offenders. These pathways shape
6 their lives in very different ways and can have
7 significantly different and detrimental results.
8 Shockingly, we heard evidence that preconceptions
9 that CSE only affects young white girls continue to
10 impact those from BME communities. Zlakha Ahmed of
11 Apna Haq in Rotherham and Rosie Lewis of the
12 Angelou Centre agreed that useful tools have been
13 developed for white girls but don't deal with critical
14 issues such as honour-based violence, forced marriage or
15 the impact of parental relationships on victims.
16 Professor O'Brien of St Helens Borough Council noted:
17 "We have not completed specific work to improve the
18 accessibility and sensitivity of child sexual
19 exploitation services to children and young people from
20 BME communities."
21 Proactivity with respect to searching for CSE in BME
22 communities appears to be lacking. Gregor McGill said
23 he simply thought it was unfeasible to break down the
24 recording of cases prosecuted according to ethnicity and
25 gender. We don't accept that position.

1 As you're aware, chair and panel, it was a source of
2 some significant concern to all noninstitutional core
3 participants that the inquiry itself was marginalising
4 the evidence of representatives of BME victims and
5 survivors. Ultimately, following our urgent application
6 in week 1, chair, you agreed to allow two
7 representatives of such organisations to give evidence
8 on the final day. That meant that the only two
9 witnesses in this inquiry speaking directly to issues
10 specific to BME survivors were rushed into a short slot
11 in a single afternoon, and, in our submission, more
12 needs to be done if BME victims and survivors are to be
13 confident that those in authority are doing more than
14 simply paying lip service to the issues they raise.
15 Finally, with respect to collaboration, we heard
16 from police and local authorities that, in general
17 terms, they had systems in place to collaborate for the
18 purposes of disruption and early intervention; that HMIC
19 found that "the police and their partners cannot
20 continue to do the same things in the same way with any
21 real expectation of improving the lives of children in
22 meaningful and sustained ways". The Home Office said
23 that the problem lay at a local level rather than with
24 central government. Local authorities disagreed.
25 Ofsted noted that, in particular, the use of

1 unregistered care homes and the low supply of suitable
2 local placements were issues that could only be resolved
3 at a national level.
4 Finally, local authorities, and indeed the experts,
5 spent some significant time explaining how they
6 distinguish CSE, while the CPS noted clearly that it
7 approaches CSE essentially as indistinct from child
8 sexual abuse and blamed the police for the low number of
9 referrals and the impact of that on prosecutions. There
10 was no debate at all on the effect of exclusion from
11 schools, which is one of the points we raised in
12 opening.
13 Notwithstanding the confidence of the local
14 authorities and police, the evidence highlighted just
15 how many gaps still remain and identified few solutions.
16 With respect, chair and panel, this is where you come
17 in. Only bold and decisive action now has a hope of
18 leading to substantive and lasting change, and, in our
19 submission, the following ten steps now need to be
20 taken.
21 First, we need to follow the Children's
22 Commissioner's lead and recommend that unregulated care
23 homes be banned for children under the age of 18.
24 Second, advocate a movement away from viewing
25 children as a source of risk. Children are vulnerable

1 because they are children, and their vulnerabilities
2 would never be realised without perpetrators taking
3 advantage of them. Promote, instead, a shift in focus
4 to prevention and early intervention and monitor closely
5 the effectiveness of local safeguarding partnerships.
6 Look out for harms, not risks.
7 Third, consider closely what CS-A2 said. She said:
8 "What was bad was, despite having procedures in
9 place, a wealth of procedures in place that I've seen,
10 they did not transfer into the practical, into practice
11 of preventing my daughter experiencing and suffering
12 severe harm."
13 Recommend regular auditing on the ground. Require
14 that those not following the spirit of a child-focused
15 approach be retrained but also swiftly held to account.
16 Fourth, promote closer interaction between police
17 and the CPS with a view to identifying means of
18 disrupting CSE that do not require victims to sacrifice
19 their mental health by giving evidence in court or
20 repeating the same evidence to multiple agencies.
21 Fifth, do not simply accept that adversarial
22 proceedings must further brutalise victims of abuse.
23 This is unacceptable. Change the system.
24 Sixth, recommend that central government put in
25 place a nationally recognised and approved set of

triggers for the provision of further local authority support for children showing signs of harm. More is needed than a toolkit which can be interpreted and resourced by each authority as it sees fit.

Seventh, recommend that every institution dealing with CSE incorporates an understanding that children will have a range of cultural and/or ethnic backgrounds and belief systems. The panel needs urgently to deal with the perception that tools are designed for non-disabled white girls, but do not deal with real and pressing issues affecting disabled, LGBTQ+ or BME children. The panel needs to deal with what Rosie Lewis described as an institutional lack of cultural competence and understanding of bias.

Eighth, require that every local authority take urgent steps to improve the accessibility of child sexual exploitation services to children and young people from BME communities and to deal with the specific issue of under-reporting of CSE within those communities.

Ninth, seek an immediate review into the frequency with which special measures are requested to assist victims of abuse to give evidence in court but are refused by the presiding judge and the reasons for any such refusals, including cost.

Tenth, CSE needs to be viewed through a gendered lens. Without this approach, the power imbalance will never be properly understood and corrected.

These steps can redeem childhoods and rescue families across the country. Don't wait until you have finalised your report into this investigation. You need to step in now, so, please, make interim recommendations pending your final report.

In questioning Sue Williams, Mr Frank made a very important point: this is not a new subject. We agree. Children have waited long enough for the culture to shift. It is time to stop waiting. Child sexual exploitation is a crime and the target must be to defeat it, not mitigate it. Defeating child sexual exploitation is not just about identifying victims and getting evidence from them, using them as a commodity, it is about focusing on prevention and disruption. What are the motivators for perpetrators: sex, power, initiation, habit. How are they recruited? This inquiry has done little to examine these key issues and so we urge you to consider them now. Abuse isn't inevitable. It can be stopped and you need to stop it. Thank you, chair.

THE CHAIR: Thank you, Mr Suleman. Mr Ford?

Closing statement by MR FORD

MR FORD: Chair, panel members, as you know, I appear for Durham County Council. In her opening submissions, counsel to the inquiry said that, following this hearing, the idea was that the panel would "seek to make effective, forward-looking recommendations for change". In these brief submissions on behalf of Durham, I will outline what Durham suggests are some areas of good practice that the inquiry has heard about in evidence that it is hoped will assist the inquiry in that task. We will, as others have indicated they will, put in written submissions after the hearing which puts some flesh on the bones of what we say briefly now.

We will address these submissions to the various themes around which the questioning of witnesses was structured during the hearing and, in particular, those themes that formed the focus of the questioning of Mr Pearce, Durham's corporate director of children and young persons services, whom you heard from on Day 3.

The first of those themes, chair, is that of empathy and concern for child victims, and you heard evidence about a guide prepared in 2020 jointly by Durham and Investing in Children, a Durham-based children's rights community interest company, called "Language that Cares". For your note, the URN is DUC000812.

The aim of this guide, chair, was to encourage the use of clear and straightforward language when children and young people were being both spoken and written about, and, in particular, to address the issue of victim-blaming language, a subject which was specifically dealt with in chapter 3 of that guide, and the guide gives examples of language that should be avoided and should be challenged if used by others; for example, the concept of lifestyle choices and children putting themselves at risk and other phrases that might imply some responsibility on the young person.

As you were shown, the guide also includes an A to Z of more appropriate language for words and phrases which have been traditionally used in the care system in wider contexts than CSE.

That guide, chair, was developed with significant input through workshops and group activities from children and young people who had been in the care system in Durham, and, in our submission, it is a positive initiative.

More generally on this theme, empathy and concern, the panel heard evidence about the following initiatives. Firstly, that Durham now has a former victim of CSE co-delivering its training to staff, and I think you were shown the slides in relation to that,

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1 and that training is available to all professionals
2 working with young people across the county.
3 Secondly, you heard that young people for whom
4 English is not their first language have access to
5 interpreters, and that all CSE workers in Durham receive
6 equality and diversity training.
7 Third, you heard that feedback from young people had
8 resulted in a male worker joining the ERASE team to
9 allow for more choice of worker based on gender.
10 And, fourthly, that there is a commissioned service
11 for LGBTQ+ young people through Humankind, and the panel
12 heard evidence in relation to A43, a child who was
13 referred to that service with positive results.
14 But Durham recognises, of course, that in the area
15 of empathy and concern, as with all other aspects of its
16 work around CSE, good practice is a work in progress
17 where improvements can always be made, and you've heard
18 both this morning, when the timeline was read out, and
19 in evidence that there is still, until comparatively
20 recently, examples of inappropriate language being used.
21 I think the most recent example you were taken to
22 was July 2018, and Mr Pearce was asked about this and he
23 said that, although he was confident that the use of
24 language now by the CSE specialists within Durham, for
25 example, the members of the ERASE team, which I will say

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1 more about in a moment, was of a high standard, there
2 was still embedding work to be done at other levels.
3 You know from Mr Pearce's most recent statement that
4 that embedding work is now in hand.
5 The next theme I want to address is that of disabled
6 children, theme 6. The panel heard evidence about how
7 practice concerning the understanding of CSE risks posed
8 to children with disabilities had developed across the
9 county in the recent past. You were taken to a 2017
10 version of the ERASE risk assessment, which is the
11 primary tool that is used. The URN for that was
12 DHP000481, where there was a box identifying that the
13 young person had a disability but that fact was not
14 a specific risk-identifier in the rest of the form. The
15 evidence was that, in November 2019, that form was
16 revised to ensure that disability was identified
17 specifically and considered as a risk factor amongst the
18 other domains that are identified -- going missing,
19 mixing with abusive adults, and so on.
20 But the position now, as a result of Durham's
21 participation in this inquiry, is that the intention is
22 to review that assessment in order to include disability
23 as a specific risk domain on its own, and that would
24 make it consistent with the child vulnerability
25 exploitation tracker, which you have also heard about,

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1 which specifically identifies and scores disability as
2 a risk factor.
3 Other recent developments under this theme that you
4 heard about in evidence include the fact that now any
5 child identified as being at risk of CSE, who has
6 a learning disability or difficulty, is now
7 automatically referred to children's services.
8 Secondly, you heard that in June of this year
9 a presentation was delivered by the Durham SEND team to
10 the strategic Child Exploitation Group, or CEG as it has
11 been referred to, which highlighted the link between
12 learning disability and risk assessment, and that
13 presentation has now been delivered to all teams across
14 children's services.
15 Thirdly, in terms of liaison between the various
16 agencies, you heard that a SEND worker is now a member
17 of the CEVT team and attends those meetings and also
18 that the strategic manager for SEND now attends the
19 strategic CEG meetings.
20 On two occasions, chair, in the evidence that you
21 heard, Mr Pearce said that the understanding of the risk
22 posed to children with disabilities of CSE is
23 a developing area in which Durham would welcome guidance
24 from this inquiry. He said that recent developments
25 such as those I have referred to would have helped to

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1 understand problems in cases like A29, who you heard
2 suffered from ADHD, but, more positively, he was also
3 taken to an example of good practice in the case of A50,
4 whose autistic spectrum condition was specifically taken
5 into account in the way she was spoken to and dealt
6 with.
7 I move, thirdly, to the topic of theme 7,
8 partnership working. As you have heard, the principal
9 vehicle for multi-agency working within Durham is the
10 ERASE team. This started life in 2015 as a pilot
11 concept involving the county council, the police and
12 Barnardo's. It developed and expanded over the next
13 four years and underwent a major restructuring
14 in November of last year, when its remit was expanded to
15 include all forms of child exploitation. Daily meetings
16 were instigated to ensure an immediate response in all
17 cases of concern and a decision was taken to recruit
18 a missing coordinator, who I will come back to in
19 a moment.
20 The panel have also heard how steps have been taken
21 since 2016 to co-ordinate by the ERASE team work not
22 just between the police and the Social Services, but
23 also with education and health, it having been
24 identified in 2015 that there were low levels of
25 referrals from those agencies.

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1 There is evidence of progress in that respect
2 because, in the 2017 CQC review of health services for
3 children looked after in Durham, INQ004293, you saw that
4 they noted good engagement between health services and
5 ERASE and "effective relationship" between ERASE and the
6 school nursing services, which you heard have recently
7 been reprocured by the same provider, but with a new
8 specification to ensure greater integration with ERASE
9 and close liaison between ERASE and the substance abuse
10 team.
11 In response to a question from you, chair, Mr Pearce
12 told you at the end of his evidence that there was now
13 close liaison between the designated -- between schools
14 and the safeguarding partnership because the designated
15 safeguarding leads group attends safeguarding
16 partnership meetings.
17 Finally, on the subject of theme 4, missing children
18 and Return to Home Interviews, the panel heard that all
19 children looked after by Durham have RTHIs after
20 a missing episode. Those interviews include details
21 about where the child was found, the reason they went
22 missing, the risk of CSE. Those interview forms are
23 received into the ERASE team and an ERASE analyst uses
24 the information from the forms to identify hotspots or
25 potential CSE networks. That is an area where Ofsted,

1 in 2019, identified good practice:
2 "The strength of the local authorities and partners'
3 response to missing children and children at risk of
4 exploitation is helping to reduce risk, disrupt the
5 activity of perpetrators and protect children. Children
6 who go missing from home or care are routinely offered
7 Return Home Interviews. Information is well shared and
8 well used. Actual and potential risks are carefully
9 considered, regularly reviewed and closely monitored."
10 That was, in fact, in September 2019, but, as
11 Mr Pearce told you, at around that time Durham
12 identified a flaw in the coordination of RTHIs, those
13 carried out by ERASE team members he said were of a high
14 standard but those by other teams less so. As I have
15 indicated, in November 2019 Durham agreed to fund and
16 recruit a missing person coordinator and that individual
17 was appointed in April of this year.
18 The role of that person is to undertake RTHIs for
19 all children in care and to provide quality assurance
20 and oversight in respect of all other missing
21 interviews, and there's daily liaison between that
22 individual and their opposite number, the police missing
23 coordinator. Mr Pearce told you that that initiative
24 had resulted in improvements in the quality of RTHIs and
25 what could be learnt from them.

1 Chair, those are our brief submissions. In
2 conclusion, we hope the documents we have submitted and
3 the evidence we have given will assist the inquiry in
4 their task of making recommendations and we will, of
5 course, assist, if we can, in the future, in any way
6 possible. Thank you very much.
7 THE CHAIR: Thank you, Mr Ford. Mr Payne?
8 Closing statement by MR PAYNE
9 MR PAYNE: Over a two-week period, the inquiry has heard
10 evidence from police forces and other statutory bodies
11 operating in different areas across England and Wales
12 and to the challenges they face in safeguarding
13 vulnerable children from grooming and sexual abuse.
14 Amongst other matters, the breadth of evidence obtained
15 by the inquiry as to the experiences of public
16 authorities across the country has served to illustrate
17 the extent to which dangers posed to children vary
18 depending on the characteristics of the different
19 geographical group.
20 In particular, the evidence heard suggests that in
21 largely rural areas, such as County Durham, crime groups
22 have very limited involvement in organised sexual
23 exploitation of children, with child offending being
24 largely interfamilial or carried out by individuals
25 within organised groups but not by the group itself.

1 This picture can be contrasted with the dangers arising
2 in large urban areas, where there is greater evidence of
3 concerted child exploitation action by organised groups.
4 These differing police environments have led police
5 forces to develop and focus on disruption measures
6 designed to mitigate the different risks of harm faced
7 by vulnerable children within their areas. In this
8 regard, there has been an undoubted benefit for the
9 different police forces involved in this strand of
10 the inquiry in hearing evidence as to how other forces
11 have sought to respond to child sexual exploitation, the
12 strategies and measures adopted and the success or
13 failure of different approaches. It has given each
14 force the opportunity to learn from the experience of
15 other forces and to consider how their response to child
16 sexual exploitation could be improved by adopting
17 measures which have had success in other areas of
18 England and Wales.
19 The inquiry has also heard evidence from a range of
20 individuals and characters with particular experience as
21 to the impact on children of the state system. Their
22 views, together with any recommendations made by the
23 inquiry, will inform and help the force develop and
24 improve its strategies to better respond to the needs of
25 children its officers strive so hard to protect.

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1 A further feature of the evidence heard by the
2 inquiry has been to highlight the inherent tension that
3 can arise between the police's obligation to protect
4 society from crime and the need to support those
5 vulnerable to abuse. Some of the difficulties that this
6 can create were apparent from the timelines produced by
7 the inquiry. There was a feature of a number of
8 the cases that the children who the police were seeking
9 to protect were not only victims of abuse, but were also
10 suspected of committing crimes and, on occasions, many
11 crimes.
12 Turning to Durham Constabulary, nobody who heard the
13 evidence of Deputy Chief Constable David Orford can have
14 been left in any doubt as to the force's wholehearted
15 commitment to safeguarding children and improving and
16 developing the force's response. Indeed, this
17 commitment was specifically recognised by HMIC in the
18 report it published in March 2020 following an in-depth
19 investigation into Durham Constabulary.
20 HMIC recognised that child protection and wider
21 vulnerability was a priority for Durham Constabulary and
22 referred to the force's clear commitment to improving
23 its services for children.
24 The inspection undertaken by HMIC recognised many
25 positive aspects on the approach taken by the force.

1 For example, the very positive contribution made by
2 policies introduced to promote child-centred policing
3 and early intervention, the many instances of good work
4 done by dedicated front-line officers and the evidence
5 of the force working well with partner agencies. At the
6 same time, however, as Mr Orford fully recognised, HMIC
7 identified a number of important areas where improvement
8 needed to be made. In this regard, HMIC acknowledged
9 the force's willingness to engage with the
10 recommendations, stating that they welcomed the response
11 of the constabulary, its engagement with HMIC and its
12 willingness to act quickly to address areas of concern.
13 As is clear from Mr Orford's evidence, the force has
14 acted quickly in responding to the recommendations,
15 accelerating the introduction of changes that were
16 already in the process of being made, as well as
17 introducing additional measures to address the concerns
18 identified.
19 So, for example, where HMIC raised concerns as to
20 training -- an issue identified in particular in
21 relation to officers in the Neighbourhood Police Team --
22 the force has introduced College of Police accredited
23 training, as recommended by HMIC.
24 Where the concern was lack of resources, the force
25 has brought in additional officers and staff. For

1 example, the force have doubled the number of specialist
2 officers from the public protection unit to act as
3 points of contact to advise and support the
4 neighbourhood police team.
5 To address the specific concerns surrounding the
6 resourcing of safeguarding investigations, the force
7 who, as it happened, were already in the process of
8 expanding the resources given to these investigations,
9 have now added four highly experienced detective
10 sergeants, together with seven additional civilian
11 investigative officers and two ARMS assessors. In
12 addition, by the end of January 2021, the force will
13 have introduced a further ten detective constables to
14 the safeguarding investigations team.
15 This very significant increase in the resources
16 allocated to safeguarding investigations reflects the
17 force's desire to ensure that the service provided to
18 children meets and, wherever possible, goes beyond the
19 expectations of HMIC.
20 In relation to the concerns raised as to the force's
21 procedures and record keeping, the timing of HMIC's
22 inspection coincided with the final stages of the
23 introduction of the force's new IT system, Red Sigma,
24 which has now, in large part, replaced the previous
25 system, Sleuth. The force introduced Red Sigma by way

1 of a staged process with various IT components being
2 gradually transferred to Red Sigma. During this
3 transitional phase, the two systems operated in parallel
4 which, as noted by HMIC, caused some difficulty in the
5 recording and accessing of information. With Red Sigma
6 now almost fully operational, officers record and access
7 information through a single system thereby eliminating
8 the difficulties arising from having two systems running
9 in parallel.
10 Moreover, the Red Sigma system represents a quantum
11 leap in technology as compared to Sleuth, making it much
12 quicker and easier for officers to enter information and
13 access data held by the force, as well as providing them
14 with access to a ground-breaking mapping system which is
15 able to link individuals, objects and locations to help
16 officers when investigating crime.
17 As the inquiry heard, an important feature of
18 the new system is that each officer is now provided with
19 a mobile device, essentially, as the inquiry was shown
20 by Mr Orford, a small touchscreen tablet computer. This
21 device is integrated with, and gives the officers full
22 access to, the force's operational policing system. In
23 practical terms, that means that now, when an officer is
24 responding to an incident or comes across an individual,
25 they can carry out checks on the spot. They can look at

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intelligence reports held on the force's system and, importantly, they can immediately record information into the force's data system and make referrals without delay.

The improved access to information is invaluable in helping officers to make informed decisions as to the appropriate response to the situations they encounter. Similarly, the ability to update and input information in real time as opposed to, as was previously the case with Sleuth, having to do so at the end of the shift on return to the police station, has greatly improved the recording of the information.

Red Sigma, therefore, provides a practical and effective response to HMIC's concern as to the delay in recording information potentially relevant to safeguarding issues.

In terms of HMIC's concerns relating to the force's response to missing persons, changes have been made to the relevant procedures, with staff now being required, as a minimum, to grade all reports of missing children as medium risk. In practical terms, this means that all reports for missing children are now dealt with as a priority response, with the earliest available resources being allocated to find the child.

The force has also taken steps to assess whether the

various changes made in response to the recommendations have been effective. To this end, the force carried out an audit on 51 missing children cases reported in 2020 and the findings of this audit were extremely positive, with more than 90 per cent of cases correctly risk graded, safe and well interviews recorded in over 80 per cent of cases and, significantly, 100 per cent of cases correctly closed.

At the same time, the audit identified areas of further improvement, for example, it identified that cases where there was no record of a safe and well interview often related to incidents where the child had returned of their own accord. In relation to the areas of improvement identified in the audit, recommendations with clear timeframes were made and the force can confirm that the recommended steps are being implemented.

In parallel with these improvements, the force has continued to make full use of the broad range of initiatives recognised by HMIC as examples of good practice. So, for example, the force has continued working alongside the local authority and partners to reduce missing episodes as part of the successful Philomena Protocol which was commended by the NPCC.

In addition, the force continues to use and develop

the child exploitation tracker to ensure a wider perspective is taken on the initial risk assessment around child sexual exploitation and that, importantly, consideration is given to issues such as any disability that those at risk might have.

The tracker has proved to be of real benefit in ensuring continuity of information and in helping officers bring together the "wider picture" and thereby to consider how best to respond to the individual child's broader needs, whether directly or by signposting concerns to partner agencies.

The inquiry's objective in this module is to help bodies, public bodies, improve the way in which they respond to, and deal with, child sexual exploitation. One of the ways in which this objective can be achieved is by identifying past failings; another lies in recognising the positive steps that have been taken by organisations so that these examples of good practice can be shared with, and implemented by, other organisations.

In the case of Durham Constabulary, the inquiry has the benefit of the very recent HMIC report which, following a very detailed investigation, identified the key areas where improvement is required. In these circumstances, where the areas of concern have already

been identified, it is submitted that the inquiry's objective of improving the force's existing procedures is better served by focusing on the effectiveness and the steps taken by the force in addressing the areas of concern and how, in light of these changes, the force currently responds to child sexual exploitation and what measures can be taken to further enhance the protection afforded to vulnerable children.

Given the nature of media reporting, the focus is always likely to be on the failings of institutions. However, a constant stream of critical reports of failings risks undermining the confidence victims have in the very institutions they need to be able to trust. It is for this reason that acknowledging the positives as well as the negatives is important and why we say the public interest is better served by the inquiry acknowledging where respective steps have been taken and identifying areas where more work needs to be done.

In conclusion, Durham Constabulary has demonstrated an unequivocal willingness to respond to independent recommendations as to how it should improve its approach to safeguarding children, and the inquiry can rest assured that precisely the same committed approach will be taken with respect to any recommendations made by the inquiry.

From the force's perspective, the absolute priority is protecting children, and the force recognises that this can be best achieved by developing and improving how it responds to ever-changing child protection risks and, in this regard, by taking on board lessons learned by other forces and recommendations made by independent bodies such as the inquiry and other experts.

Thank you, chair.

THE CHAIR: Thank you, Mr Payne. We will now take our lunch break and we will return at the slightly earlier time of 1.30 pm. Thank you.

(12.45 pm)

(The short adjournment)

(1.30 pm)

THE CHAIR: Good afternoon, everyone. We will now continue with the closing statements with Ms Leek.

Closing statement by MS LEEK

MS LEEK: Chair, as I said in my opening remarks, the Chief Constable of Warwickshire welcomes the inquiry's examination and scrutiny of the institutional responses to child sexual exploitation in England and Wales. The officers in Warwickshire, including Superintendent Pete Hill, who, you will recall, gave evidence to the panel, found it particularly valuable to hear evidence from other police forces as to how they respond to child

sexual exploitation in their area, the challenges they faced and the lessons they have learned. It has also been useful to hear from institutions such as the Home Office and HMICFRS as well as noninstitutional witnesses such as the NWG and PACE.

Chair, Warwickshire Police have noted with particular interest the complex issues that the evidence in this inquiry has thrown up. It is clear from the evidence given by witnesses such as Dr Hallett and Dr Beckett, Barnardo's, the CPS, Apna Haq and the Angelou Centre that there remain divergent views on key issues, including the following: the definition of child sexual exploitation and the concept of exchange; the notion of risk versus harm and the problems inherent in the risk assessment model used by some professionals; the understanding of CSE as often occurring in the context of other forms of abuse; and the delicate balance that institutions are often required to strike in their decision making in exploitation cases.

Discussion of the organised networks aspect of such abuse has further highlighted the difficulties in coming to clear, brightline conclusions and definitions. As Superintendent Hill explained in his evidence to the inquiry, often what the police see is not an organised network, as such, but, rather, "loose associations,

friendships changing frequently and groups being organised in the loosest possible sense through friendship groups, through interactions through social media and suchlike". These various complexities ring true to the experience of Warwickshire Police in tackling child sexual exploitation. As Superintendent Hill put it, these cases are really difficult to deal with and what the police often try to do is "get the balance right between safeguarding, evidence gathering and disruption".

CS-A1. Chair, the challenges for police in responding to and safeguarding children from exploitation were highlighted in the case of CS-A1. The inquiry panel will recall that they heard evidence from CS-A1's mother, CS-A2, who described the difficulties she and her husband have had in trying to keep CS-A1 safe. Superintendent Hill has acknowledged these difficulties and acknowledged that the Warwickshire Police team did not always get things right and that there were things that could have been done sooner or differently. As Superintendent Hill explained, however, CS-A1 was the most challenging and complex case that the Warwickshire team have ever dealt with, and what they ultimately tried to do was keep A1 safe with the resources they had available at the time.

Chair, panel, it is also important for the inquiry to understand the progress that has been made in Warwickshire in the past two to three years. Since 2017, the force has undertaken a considerable amount of work to ensure that all officers are aware of child abduction warning notices and, in June 2020, the force launched its child abuse trafficking and exploitation team with a significantly greater number of posts assigned to the team than has been the position previously.

Warwickshire continues to work in close partnership with other agencies, including children's services and Barnardo's. The police have found that they particularly benefit from being co-located with these agencies.

The inquiry is also reminded of specific initiatives in Warwickshire, such as the insertion of a dedicated social worker within the exploitation team who can work with young children as they move into adulthood and the implementation of the Philomena Protocol so as to ensure a more proactive and timely response when children go missing.

The sexual exploitation of children is a horrific and shocking crime, and the evidence that the inquiry has heard from complainants in this strand makes clear

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1 the profound effects that such abuse can have.
2 The police team in Warwickshire has sought to
3 provide all possible assistance to the inquiry in its
4 important work in this investigation. It is hoped that
5 the evidence gathered and heard in the course of this
6 particular strand will enable the inquiry to make
7 practical and achievable recommendations as to how
8 institutions should respond when sexual exploitation
9 occurs and, perhaps more importantly, how institutions
10 can best protect children from such exploitation so that
11 fewer children are subjected to it in the first place.
12 Thank you.
13 THE CHAIR: Thank you, Ms Leek. Mr Sharland?
14 Closing statement by MR SHARLAND
15 MR SHARLAND: Good afternoon, chair and panel members.
16 Warwickshire County Council is grateful for the
17 opportunity to make brief oral submissions at the end of
18 the inquiry. The county has listened carefully to the
19 various witnesses during the two weeks of evidence. We
20 are particularly grateful to CS-A12 and CS-A371, who
21 bravely gave evidence from the victim's perspective,
22 which we believe is essential to consider when drafting
23 the report and making recommendations.
24 Dr Beckett and Dr Hallett's evidence was also
25 extremely valuable and it's led the county to reflect on

1 certain aspects of its practice.
2 The county is of the view that it can best assist
3 the inquiry in its closing submissions by focusing on
4 suggested recommendations. Some suggested
5 recommendations are derived from what we regard as the
6 county's good practice, some recommendations, however,
7 concern areas where the county is of the view that
8 improvements are needed but, to achieve them, support,
9 whether financial or otherwise, is needed from central
10 government or other public bodies.
11 We suggest the panel should make recommendations in
12 the following areas, amongst others. Firstly, risk
13 assessments. Secondly, victim-blaming language.
14 Thirdly, the approach of CAMHS. Fourthly, support for
15 social workers. Fifthly, national recording of missing
16 episodes. Sixthly, placements. Finally, disability.
17 Turning to the first of those recommendations, risk
18 assessments. As Mr Minns explained, the county has
19 radically rewritten its risk assessment pro forma since
20 2017. The new pro forma, which was developed in
21 conjunction with Coventry University, no longer adopts
22 a scoring approach. Instead, a narrative approach is
23 adopted, requiring the social worker to complete the
24 assessment to address his or her mind to various domains
25 relating to the family living environment, the child,

1 the locality and the wider community. The narrative
2 approach enables social workers to address the
3 particular child's unique circumstances, including, for
4 example, how any disability that they may have impacts
5 on their vulnerability to CSE.
6 The pro forma also reflects Dr Hallett and
7 Dr Beckett's evidence and the importance of not solely
8 addressing the position in terms of risk. Paragraph 7.1
9 of the pro forma has a section entitled "Identified risk
10 or harm". This enables the social worker carrying out
11 the risk assessment to identify the fact that the child
12 in question is currently being harmed, rather than
13 merely at risk of harm, if that is the case. However,
14 it also enables the social worker to record the level of
15 risk if the evidence suggests that the child is not
16 currently being harmed.
17 We believe that such an approach reflects good
18 practice and there will be benefit if such an approach
19 was utilised across the country.
20 Turning to the second topic, victim-blaming
21 language. Second recommendation. The inquiry heard
22 evidence of the use of inappropriate victim-blaming
23 language in each of the six local authority areas that
24 are being considered. It is clear that, while such
25 language is widely recognised as inappropriate, it

1 remains relatively common in documentation. The county
2 challenges such language and regularly provides training
3 to reinforce the importance of using appropriate and
4 empathetic language.
5 As Mr Minns fairly acknowledged, this is not just
6 a problem that Warwickshire or any county council has
7 solved. It will require continuous vigilance and focus
8 going forward.
9 However, as Mr Minns explained, whilst it is
10 important that social workers and other practitioners
11 use appropriate non-victim-blaming and empathetic
12 language, the language used in documentation should
13 clearly and accurately identify what is happening to the
14 child in question. It is important not to replace
15 victim-blaming language with vague and uninformative
16 statements. As Mr Minns pointed out in his evidence,
17 some of the suggested language used in guidance on
18 appropriate language is unnecessarily vague.
19 Whilst professionals should, of course, avoid
20 language such as "Offering child A drugs in return for
21 sex", some of the suggested replacements, such as "the
22 child is being sexually exploited" or "the child is
23 being sexually abused" omit any reference to the use of
24 drugs by the perpetrators. Such an omission is
25 problematic, as the subsequent social worker or other

professional looking at the social work records will not know what mechanism the perpetrator is using to exploit the child. The county would, therefore, ask the panel to make a recommendation that suggested replacement language retains the necessary specificity.

The third suggested recommendation concerns CAMHS. It is clear that children at risk of, or being harmed by, CSE often have significant mental health difficulties, either as a result of childhood trauma prior to the CSE or as a result of the CSE itself. Such children need swift and effective mental and emotional well-being support. Unfortunately, often children are unable to access such support when they need it. CS-A2 explained the practice of CAMHS to decline to help children who use alcohol or drugs or who have a chaotic lifestyle. Of course, this excludes a significant proportion of children at risk of, or currently being harmed by, CSE. As the panel heard, perpetrators frequently use alcohol and drugs to sexually exploit children. Such children often regularly go missing and, unfortunately, rarely lead stable lives. However, such children are often the most in need of mental health support and it's simply not good enough that such children are regularly denied the support they so need.

The county would therefore ask that the panel

recommend that CAMHS alter its practice and prioritise support for children subject to or at risk of CSE rather than simply focusing on the least-challenging cases so that all children and young people in need of mental health intervention receive it.

The next suggested recommendation concerns support for social workers. The county, like many areas, has a high turnover of social workers. Approximately a third of social workers leave every two years. Whilst the county has worked hard on retention, the challenging nature of the role inevitably leads to professionals moving on with a degree of regularity. Our experience is that social workers find working with children subject to CSE the most challenging work of all. Whilst the county seek to manage individual social workers' caseloads, having responsibility for a complex CSE case inevitably takes a toll on the individual social worker and increases the likelihood of burnout.

We are of the view that it is essential that social workers' well-being is supported to ensure that they are emotionally resilient. We would ask the panel to make a recommendation that the DfE carry out research and, following the conclusion of such research, develop a strategy that supports retention and resilience of social workers nationally.

The next suggested recommendation concerns national recording of missing episodes. A child or young person going missing is a powerful and significant signal that something is wrong in their lives. A timely and careful response is needed to understand the reasons for the missing episode. We think that it would be beneficial if each local authority was required to include in its children in need annual return to the DfE the number of children generally who were reported missing, the number of children in care who were reported missing, the number of children who had a Return to Home Interview and the number of children who were identified as at risk of CSE or other exploitation linked to a missing episode.

The existence of such national data would enable the DfE, Ofsted and local authorities to gain a clearer picture about the extent of missing episodes and enable everyone to understand how a particular local authority is performing. The publication of such data would increase transparency and promote a performance culture within this area of work.

The ultimate recommendation concerns placements. The county is confident that if someone in a similar position to CS-A1 came to its attention in 2020, rather than 2016, the county, utilising its updated risk

assessment, would immediately identify the fact that she was at risk of CSE from the outset. However, one of the issues that CS-A2 so powerfully raised in her evidence was the number of placements that her daughter had had and the fact that some of them were not appropriate to meet her needs, either because of the location, the lack of experience of the foster carer or the fact there were other children at risk of CSE at the placement who might introduce her to their networks of perpetrators.

Unfortunately, securing appropriate placements for children at risk of, or currently being harmed by, CSE continues to be very challenging. Whilst the county has never had recourse to unregulated placements such as B&Bs that some counties have used, there continues to be a significant shortage of specialist placements that meet the needs of children at risk of, or being harmed by, CSE.

Warwickshire, like the majority of the country, has a dearth of foster placements generally. The shortage is even more acute in relation to foster care placements that specialise in children at risk of, or being harmed by, CSE. Foster carers are often unable or unwilling to care for such children, who often pose significant behavioural challenges. Similarly, private providers of

residential placements, because of the shortfall, are
usually able to pick and choose which children they look
after. Inevitably, such providers select the
less-challenging children, meaning those in greatest
need of a safe specialised placement often do not
receive it.

The county would therefore welcome any
recommendation that the panel felt able to make that led
to an increase in the number and range of placements
available to children requiring care generally and those
at risk of or being harmed by CSE in particular.

Additionally, we would ask that the panel recommend
that the forthcoming independent care review in England
and Wales consider the issue of placements for children
at risk of or being harmed by CSE.

The final recommendation concerns the issue of
disability. It is clear from the evidence that the
inquiry has heard that there is a systemic issue in
relation to the identification and consideration of
disability in a context of children at risk of, or being
harmed by, CSE. Whilst, as explained by Mr Minns, the
county has put in training to improve social workers'
understanding of the concept of disability under the
Equality Act 2010, and how any disability should be
taken into account in assessing the risk of CSE, the

county is of the view that, given its systemic nature,
the panel should recommend that the DfE produce guidance
that addresses this matter.

At present, the DfE does not appear to fully
understand the relevant equality legislation. For
example, the children in need census 2019 to 2020
published last October refers to persons being disabled
under the Disability Discrimination Act 2005, rather
than the Equality Act. I'm very grateful for our time.
Thank you very much, panel and chair.

THE CHAIR: Thank you, Mr Sharland. Mr Dunlop?

Closing statement by MR DUNLOP

MR DUNLOP: Thank you, madam. St Helens is grateful for
having had the opportunity to be involved in this
inquiry. St Helens has learnt from listening to the
evidence and from the questions, and no doubt will learn
from the report.

The focus of this strand is forward looking and to
that end I will focus my closing submissions on the
current position and the position for the future.

I will address in turn the themes which the inquiry
focused on in relation to St Helens. I won't,
therefore, give any time to theme 1, problem profiling,
as that wasn't the focus of the investigation in
relation to St Helens, no doubt because, according to

the last census, 98 per cent of St Helens was white
British.

Before I turn to those themes, it may be helpful to
begin by looking at where St Helens was a few years ago,
compared to where it is now. I mentioned in opening
some of the challenges that St Helens faces, for
example, as a result of having areas in the top
1 per cent most deprived in the country, and it was not
unconnected to that that Social Services in St Helens
a few years ago were struggling.

This led to the report of 4 November 2019 by Ofsted
where they judged St Helens inadequate for
Social Services. As Mr Leivers explained in his
evidence, this was a wake-up call for St Helens. It led
to a huge amount of investment and recruitment.

In the last 12 months, there has been a 28 per cent
increase in resources. Mr Leivers, who, himself, is one
of the new recruits, said that 80 per cent of his
front-line managers and more senior managers have been
in St Helens for less than a year. St Helens had, in
his words, bucked the trend of the country by recruiting
more front-line social workers. Caseloads for those
social workers are now only 15 to 18, which is pretty
good compared to other local authorities.

As part of that investment, St Helens created

a complex safeguarding team, a team with no caseload of
its own, which is there to provide specialist advice in
relation to CE and CSE to front-line workers.

Even the staff who are still at St Helens now and
were at St Helens before have now been better trained,
better managed and better audited. The result is that
social work practice in St Helens now is not what it was
even 12 months ago. Please bear that in mind when you
come to write your forward-looking report.

Theme 2: empathy and concern for child victims. The
reason why the inquiry has rightly focused on this theme
is not to test that professionals always express
themselves perfectly. The reason for focusing on this
is because victim-blaming language can sometimes reveal
a victim-blaming mind-set, where children are seen as in
some way responsible for their own exploitation, and no
child should be treated as responsible for their
exploitation.

This victim-blaming language and mind-set was, until
recently, a general problem across the country and
across the county. It was not limited to St Helens.
Vikki McKenna, the witness for Catch22, said in her
statement of January 2020 that victim-blaming language
continued to be used. However, she qualified this or
clarified it in her oral evidence, explaining she wasn't

just talking about St Helens, it was an issue across the board, and she wasn't able to say whether any of the more recent instances of victim blaming came from St Helens.

The evidence shows that, before 2020, there were instances in reports where professionals used language that could be seen as blaming the victim, and perhaps the most extreme example in the St Helens records is an instance where a minute taker described a child as "promiscuous". Mr Leivers, in his evidence, stressed that that sort of language was not appropriate when dealing with children or vulnerable young people.

Mr Leivers was criticised by Ms Gallagher, my learned friend, counsel for CWJ, for using the phrase "putting themselves in a situation of vulnerability" on two occasions in the course of his evidence.

If you go back to the context of the instances that were seized upon, you will see that Mr Leivers was not blaming children or holding them responsible for their exploitation. On the contrary, the context on each occasion was Mr Leivers explaining why the absence of good quality establishments led to missing episodes and to children being at risk. He was not blaming the children, he was blaming the quality of the establishments.

It would be very unfair to take from those two sentences, snipped out of context, some sort of suggestion that Mr Leivers or St Helens has a victim-blaming mind-set. If you listen fairly to Mr Leivers' evidence, it is quite clear that St Helens has, through training and audit, energetically and effectively worked to eliminate any kind of victim-blaming mind-set.

He described training from research and practice in Catch22 and said that the lessons were now better embedded, and in the dip sample audits in the last three months there has only been one example of inappropriate language being found, and this was taken up with the professional concerned.

Theme 3: risk assessment and protection from harm. There is evidence in the past of some poor risk assessments. However, a few poor decisions do not demonstrate generally poor practice. The assessment of CE and CSE risks to children has never been a particular failing at St Helens, even when its Social Services Department was of a much lower standard than it is now.

Even when Ofsted assessed St Helens' Social Services as inadequate, it recognised that responses to children at risk of sexual exploitation were effective, children at risk of exploitation were identified and responded to

appropriately and management oversight was effective. The position is even better now with all the new recruitment, investment and training.

Indeed, in her evidence, Ms Ghaffar of Ofsted singled out for praise, rightly, St Helens' morning meetings from the co-located multi-agency safeguarding hub, MASH. She gave them as an example of good practice that allows prompt and informed risk assessments to be made to protect children.

There is also a subgroup called MACE, which you heard about, which meets less often and tries to identify trends and hotspots so professionals can plan what they do, and we recommend that as good practice too.

Theme 4: missing children, RHIs and looked-after children. As to the number of missing episodes, Mr Leivers explained that, although the number was relatively high, St Helens was not a standout. He explained that one cause of these missing episodes was the difficulty in finding enough establishments offering high-quality care.

He explained that St Helens has taken action, which should help. St Helens has made a decision to reduce the number of its children placed more than 30 miles away and now there are only four children placed more

than 30 miles away. That makes it less likely that children will go missing as a result of travelling back to their home area, and it also makes it easier for St Helens to check up on young persons and children when there are missing episodes.

As for the Return to Home Interviews, the statistics indicate a significant improvement in the amount that are completed. There was an increase from 44 per cent in the third quarter of the 2018/19 year to 81 per cent in the fourth quarter of that year. One of the reasons for that improvement is that St Helens made the decision to focus the resources of Catch22 on the children for whom it was responsible. Ms McKenna explains that this decision enabled Catch22 to concentrate on St Helens' children and see them within 72 hours of any missing episode.

The downside of focusing St Helens' resources on St Helens' children is that not all placing authorities have opted in to pay for their own children to have RHIs. As a result, there is sometimes an intelligence gap. However, Catch22 said they did not have capacity to go back to the old way of working.

St Helens does its best to plug the intelligence gap by monitoring in the MACE process the CSE risks to children placed by other authorities in St Helens.

Mr Leivers explained that this is sometimes difficult as the level of engagement by the placing authority is variable and CS-A27 is an example of this. He was monitored in MACE even though he was placed in St Helens by another local authority. St Helens did raise concerns with that placing authority about his care plan. Even so, the risks were not well managed, and St Helens welcomes views from the inquiry on how to best ensure placing authorities fulfil their obligations to children who are placed out of borough.

Theme 6: children with a disability. St Helens' child protection plans do now take into account all the needs of the child, and this is one of the areas which, even in 2019, Ofsted were complimentary of. Mr Leivers' evidence demonstrates the significance of disability in the broadest sense is understood in St Helens. He recognised the correlation between disability and vulnerability. He also recognised that learning difficulties create vulnerability, even if they don't technically amount to a disability. And he agreed that ADHD was not simply an educational issue.

Mr Leivers and St Helens welcome the suggestion from counsel to the inquiry that the forms that social workers use should have a specific box prompting the writer to record details of any disability or learning

difficulty. This suggestion will be taken up by St Helens with the other parties to the pan-Merseyside Protocol.

Theme 7: partnership working. The unanimous evidence of all the witnesses was that there are very good, close working relationships between St Helens and its agency colleagues and police and health. That was the evidence of Mr Leivers, Ms McKenna, Mr Critchley. Indeed, Ms McKenna, when asked, was not able to think of any improvements that could be made to partnership working in St Helens. Mr Leivers said one of his current assistant directors was a health service employee and they have a number of staff who are direct employees in health. St Helens is aware that at times there have been difficulties in getting someone from health to attend the morning meetings. However, the CCG have, even in the time since Mr Leivers gave evidence, invested in a further full-time healthcare professional to support this.

Finally, theme 8: audits, review and performance improvement. St Helens now conducts far more intensive and frequent audits to maintain its standards. This year, a system of quarterly case file audits began and, on top of that, there were monthly dip sample audits relating to children at risk of CE and CSE. That's how

St Helens knows, for example, that its training has been effective.

This investment, recruitment and training has resulted in dramatically improved performance and that has been recognised by regulatory bodies. So in their letter of 2 September 2020, Ofsted said:

"Leaders have implemented the enhanced systems and processes for quality assurances. These changes are starting to improve the response to most children who have recently come to care. The financial investment has helped reduce social work caseloads, given them more time to direct work directly with children to understand their needs and improve their outcomes."

Even more recently, in the letter of 14 September of this year, the DfE said this:

"The overarching theme identified was the commitment and dedication of all staff to improving services for the children and young people of St Helens. Despite challenges from the coronavirus, staff remain ambitious and highly motivated and are continuing to drive forward improvements. There is a very strong, positive culture within St Helens, with staff reporting effective support, training and (interference) from all levels. Senior leaders are visible and passionate about driving forward performance and take care of social workers.

Staff who previously felt overwhelmed are now feeling invigorated. QA and audit work has seen a big shift in culture over the last six months. Managers reported to understand the importance of audit and this is starting to be embedded in practice."

They conclude:

"To achieve and sustain this positive culture following an inadequate judgment is extremely difficult and we were extremely impressed with what we heard. Strong political and corporate commitment is evident with political leaders putting children at the forefront of everything the council is doing."

Thank you.

THE CHAIR: Thank you, Mr Dunlop. Mr Butterfield?

Closing statement by MR BUTTERFIELD

MR BUTTERFIELD: Good afternoon, chair and panel. The Metropolitan Police Service has welcomed the opportunity to participate in this strand of the inquiry. The inquiry, of course, heard evidence from Sue Williams, and she and others within the Metropolitan Police have been following the remainder of the hearing with interest.

In these oral submissions, I will only be making brief comments, highlighting a couple of the more significant areas where the Metropolitan Police would

1 welcome recommendations. We will deal much more fully
2 with the themes of this strand of the inquiry and with
3 the evidence relating to Tower Hamlets in our written
4 submissions in due course.
5 Child sexual exploitation and child sexual
6 exploitation by networks represents a complex and
7 dynamic threat to society and to children and young
8 people in particular. While it is a national threat, as
9 you heard from Sue Williams and as was referred to this
10 morning, it presents itself in different ways in
11 different geographical areas. The threat presented in
12 Tower Hamlets, for example, is different in nature to
13 that presented in the neighbouring borough of Hackney.
14 Child sexual exploitation is a strategic priority
15 for the Metropolitan Police Service, but what does that
16 mean on the ground? In Tower Hamlets specifically, it
17 now means a specialist, dedicated, proactive child
18 sexual exploitation team established in 2018. The team
19 works closely with, and in normal times is co-located
20 with, a specialist team from Tower Hamlets children's
21 social care, and also sits alongside an integrated gangs
22 unit, youth offending team officers, an analyst and
23 missing persons coordinator.
24 Across London more generally, it means the
25 implementation in the last few years of the basic

1 command unit model, establishing a bespoke safeguarding
2 strand for each policing area. The Metropolitan Police
3 Service is also in the process of creating a new public
4 protection plan led by Assistant Commissioner
5 Nick Ephgrave.
6 In October 2019, the Metropolitan Police launched
7 Operation AEGIS, a pilot funded by the Mayor's Office
8 for Policing and Crime, to deliver comprehensive
9 improvements around child safeguarding. The
10 Metropolitan Police have worked with consultants and
11 safeguarding mentors to identify areas for targeted
12 interventions and good practice, with a focus on child
13 sexual exploitation, missing children, child protection
14 and indecent images of children.
15 The Metropolitan Police is now considering rolling
16 out that learning from the pilot across the force.
17 The Metropolitan Police Service recognises the
18 difficulty identified by several witnesses during the
19 hearing, identified in the panel's questioning and in
20 submissions earlier today of translating policy into
21 real and sustained improvement on the ground and into
22 improved outcomes for children and young people who are
23 the victims of, or are at risk of, child sexual
24 exploitation and child sexual exploitation by organised
25 networks.

1 The creation in Tower Hamlets of the new specialist
2 proactive team working in a collaborative and
3 multi-disciplinary way was designed to address that
4 issue, and although it is in its early days, it has
5 started to achieve results which are positively
6 recognised both by the MPS and by partners.
7 Also, as part of driving this improvement, the
8 Central East Borough Command Unit, which includes
9 Tower Hamlets and Hackney, has developed a specialist
10 team to deal specifically with online child sexual
11 exploitation and indecent images of children.
12 The Metropolitan Police have welcomed the
13 opportunity to learn during this strand of the inquiry
14 how police forces and local authorities in other areas
15 are dealing with the ever-changing challenges
16 represented by child sexual exploitation and
17 exploitation by networks. One of
18 the Metropolitan Police's key priorities is to seize and
19 harness the opportunities presented by data and by
20 digital technology. The Metropolitan Police Service has
21 therefore been particularly interested to read and hear
22 about the use of the Think Family database and data
23 analytics in Bristol.
24 While recognising that not every incident of child
25 sexual exploitation can be predicted by the use of data

1 and analytics and that nothing will replace the skills
2 of police officers on the ground, the MPS is alive to
3 the fact that there are immense opportunities in this
4 area.
5 The Metropolitan Police would, therefore, welcome
6 any recommendations that the inquiry feels able to make
7 in respect of the practical, ethical, legal and data
8 protection implications of the use of data and
9 analytics.
10 In Tower Hamlets, the co-located child sexual
11 exploitation team has helped to improve the sharing of
12 data with Tower Hamlets children's social care.
13 However, the Metropolitan Police Service is now looking
14 at how data sharing with health, education and
15 third-sector organisations can be improved to identify
16 children at risk of, or suffering from, child sexual
17 exploitation. This is another area where the
18 Metropolitan Police would welcome recommendations from
19 the inquiry.
20 We recognise that officers and staff working in the
21 field of child sexual exploitation and their colleagues
22 in children's social care working in the same area
23 undertake a difficult and stressful job with a heavy
24 workload. That needs to be recognised and we would like
25 to extend our thanks to them.

1 However, the Metropolitan Police Service recognises
2 that, despite significant strides having been made in
3 this area in recent years, there does remain much more
4 to be done, and we await the publication of the report
5 with interest. Thank you.
6 THE CHAIR: Thank you, Mr Butterfield. Ms Perry?
7 Closing statement by MS PERRY
8 MS PERRY: Chair, panel, I represent the London Borough of
9 Tower Hamlets together with Mr Powell and Mr Langford,
10 instructed by Sarah Williams.
11 Tower Hamlets welcomes its continued involvement in
12 this inquiry and in this strand of the investigation.
13 As chair and panel will be aware, Tower Hamlets has
14 assisted this inquiry in other investigations since 2017
15 and has disclosed some thousands of pages of
16 documentation and eight rule 9 statements into this
17 investigation alone.
18 We are in the process of completing our written
19 submissions, and, as such, these oral submissions will
20 simply touch upon some key points that we would like to
21 highlight.
22 The task of combating CSE in Tower Hamlets is no
23 small one. In 2016, sitting in the Family Division,
24 Mr Justice Cobb observed in Rotherham Metropolitan
25 Borough Council v M and Others [2016] EWHC 2660 (Fam)

1 that, and I quote:
2 "Child sexual exploitation is an increasing
3 phenomenon affecting children and young people, male and
4 female, of all backgrounds and from all communities
5 right across the UK. It has been a particular concern
6 to local authorities in densely populated,
7 multicultural, urban areas of the country."
8 Which, of course, includes Tower Hamlets.
9 CTI, in her opening to this investigation,
10 highlighted the particular demographics of Tower Hamlets
11 that illustrate the difficulty of the task that
12 front-line workers face. Tower Hamlets has a population
13 of over 300,000 and is the second most densely populated
14 local authority in the UK. Whilst this presents as
15 a logistical difficulty, Tower Hamlets does not shy away
16 from its responsibilities.
17 As chair and panel are aware, Tower Hamlets has
18 embarked upon a significant improvement journey and,
19 therefore, we will make submissions on key points
20 arising from that journey with fuller written
21 submissions to follow.
22 First topic: key areas of improvement. What has
23 worked for Tower Hamlets?
24 Chair and panel have been provided with full
25 disclosure in respect of Tower Hamlets' improvement

1 journey. You have now heard oral evidence that augments
2 the written evidence provided to date. Most recently,
3 Ofsted acknowledged that leaders and managers in
4 Tower Hamlets demonstrated a relentless focus to improve
5 practice, to deliver good experiences and progress for
6 children and their families.
7 Tower Hamlets takes an holistic approach to all
8 child protection work, with contextual safeguarding
9 being an integral part of that process. Our child
10 exploitation team has shown that partnership working
11 must include as many relevant agencies as possible to
12 maximise positive outcomes for children and young
13 people. Therefore, one factor that has been
14 significantly enlarged is partnership working, in the
15 broadest sense.
16 Strong partnership working demands that local
17 authorities embrace the ethos of working together --
18 health, education, as well as the police, are critical
19 to the fight against CSE.
20 Tower Hamlets simply cannot respond to a social
21 threat as dynamic, complex and pervasive as CSE in
22 isolation. This criminal offence mutates and evolves.
23 Co-location. This has been a key element for
24 Tower Hamlets in tackling CSE and very much represents
25 the philosophy of Working Together. Our exploitation

1 team is co-located at present remotely, with the MPS,
2 and works closely with other teams, including the CSE,
3 the Edge of Care team, sexual health services, education
4 and community partners. The daily meeting brings
5 multi-disciplinary scrutiny.
6 RHIs are also important and provide a key disruption
7 point in some cases. They are the subject of detailed
8 audit and scrutiny and a key intelligence gathering
9 tool.
10 We will deal with data in respect of RHIs in our
11 written submissions.
12 Auditing. Auditing is a key part of the quality
13 assurance process at Tower Hamlets and is undertaken by
14 the Social Work Academy. It is a fantastically useful
15 tool that helps combat complacency and instils a culture
16 of transparency. It ensures that good practice is being
17 applied consistently. The Improvement Board and the
18 Tower Hamlets Safeguarding Children's Partnership also
19 have crucial roles in monitoring performance and
20 improvement.
21 Strong community links. Relationships with key
22 community members in organisations cannot be
23 understated. But, more importantly, cannot be
24 established where there is a high turnover of staff,
25 which brings me to our next point, staff retention and

relationship building.
Changes in management and accountability were acknowledged in the 2019 Ofsted report where they found that the corporate director for children and culture had transformed the culture in children's services to one of collective accountability for protecting vulnerable children. Our staff feel that the work they do is valued and this in turn means that a motivated workforce promotes the best possible care plans for our children and young people in the context of the resources available.
This improvement journey has, after all, taken place against a backdrop of austerity.
Screening and risk assessment. These Tower Hamlets tools take into account both past time and future risk and allow space for nuanced professional analysis. Each improvement tool is linked to the others. Together they provide a full picture around which the therapeutic plan for the child can be constructed. That's an important point because the focus here has not been on care planning, but that is what frames, of course, the experiences of the young person. It is the care plan. Although, of course, the tools that one uses to reach that care plan are crucial.
Second topic: how has that improvement been

embedded? Tower Hamlets has been able to measure, monitor and embed the fact of improvement in a number of ways, including by audit, quality assurance and through Ofsted. For example, as you know, every case with an element of CSE -- every case -- is audited. And every RHI is reviewed and quality assured.
Embedding change is an organic process that does not stop at the organisational or geographical border of Tower Hamlets. For example, following the successful delivery of training of social workers to counter the use of victim-blaming language, Tower Hamlets then extended this training to judges, court users and local practitioners at the East London Family Court.
Embedding change has also involved building and maintaining positive relationships against a backdrop of accountability. A key priority is creating management structures which work, which can be measured as working and which build positive relationships amongst employees, the community and with our children and young people.
My final topic: recommendations that would assist institutions responding to CSE. We have limited time, and therefore I make some key, non-exhaustive points which we will develop further in written submissions. Tower Hamlets has considered what the ideal model for

combating CSE might be. There are no silver bullets. However, we consider that specialist workers working in the broadest possible community partnership, coupled with significant resources that include a proximate specialist placement would go some way to meeting the relevant need. Bearing in mind a proximate placement will not always be in the best interests of the young person.
At the inception of this hearing, we made the point that CSEN is an extrafamilial risk. We said our entire child protection system is build around protecting from familial abuse and that's where the resources are focused nationally. Tower Hamlets is working hard to promote an alternative approach. However, effecting cultural change takes time and requires a coherent national approach.
We suggest that specialist CE teams go some way to embedding that cultural change, based on our experience.
When making recommendations, we suggest that a good starting point is to consider the child or young person's journey through any institutional response from the child's perspective. For example, ideally, a child at risk of CSE would be assisted by the Edge of Care team or the local equivalent at home with his or her parents. But what if that is not possible? This is all

about levels of risk.
The point is this: if it is not possible to keep a child safe at home, and not possible to find a foster placement that can contain and protect a child, then a specialist placement must be considered.
A critical point here is the statutory obligation on the part of the Secretary of State under section 82(5) of the Children Act. The local authority has a sufficiency duty pursuant to section 22G of the Children Act 1989. But there is a broader state obligation that is being missed. We asked a rule 10 question of the DfE on this point. This point has been a subject of repeated scrutiny within the High Court of the Family Division, the Court of Appeal and, this week alone, the issue arises in a case handed down by the High Court and is also before the Supreme Court today, being heard as I speak.
We have schedulised all the relevant authorities on this issue and we will attach them to our closing for chair and panel's consideration, because this is an issue that the Family Division of the High Court and the President of the Family Division -- both Presidents in that timeframe -- has been raising with the government since at least 2017.
So we say that it is vitally important that this

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1 inquiry is aware of that line of authority and we ask
2 that a recommendation is made that there is better
3 provision of, and funding for, specialist residential
4 and secure accommodation for our vulnerable children and
5 young people.
6 That provision is essential to enable adequate
7 institutional response to CSE.
8 We, Tower Hamlets, are doing all that we can to
9 upskill and improve the available placements in borough.
10 We are very clear that we haven't given up. We are
11 training the carers in borough and are actively
12 recruiting specialist carers.
13 We have been questioned about placing out of
14 borough, but remember that 80 per cent of our young
15 people are accommodated no further than 20 miles from
16 our town hall. If we were a rural county council, those
17 young people would still be in borough at that distance.
18 We urge caution when considering any bare data. It all
19 needs to be placed, of course, in context.
20 Focus on distance is a one-dimensional approach, and
21 in Tower Hamlets, owing to its size, it's relatively
22 small, and its population, which is relatively big,
23 means that it's not uncommon to have young people placed
24 out of borough.
25 We suggest there are five key questions of relevance

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1 when evaluating the possibility of an out-of-borough
2 placement. One, what is the plan for the child? Two,
3 what is the treatment, support or therapeutic support
4 package? Three, how well placed is the provision to
5 provide that level of support? Four, what are the risks
6 to the young person and how are they best managed?
7 Would that young person, for example, be safer if placed
8 for a period of time out of borough and, therefore, away
9 from abusers? And, five, therefore, where is the
10 child's welfare best met?
11 The case study for CS-A22 was indicative of this
12 approach, where they thrived in a placement that was out
13 of borough.
14 The question is not where the child is placed, and
15 the research is equivocal about the impact of placements
16 locally or at a distance. The question is how a child
17 is placed and what the support plan is. So, please,
18 look to the care plan.
19 We ask, chair and panel, when formulating
20 recommendations to look at the outcomes for each of
21 the young people in our case studies, particularly those
22 for whom Tower Hamlets share parental responsibility.
23 They have progressed and they are safe. We built
24 a bespoke therapeutic plan around each one, but it would
25 have been much easier with better resources. The

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1 knowledge and volition is there, but Tower Hamlets has
2 had to be really creative when formulating care plans.
3 Sufficient specialist resource, not just residential
4 units, but other types of placement need to be made
5 available at a state level. This would allow care plans
6 to be tailored to the individual young person with the
7 local provisional network providing long-term support.
8 Section 22G and section 82(5) of the 1989 Act are not
9 mutually exclusive but facilitate partnership here.
10 Such state provision as repeatedly requested by the
11 Family Division would obviate the need for local
12 authorities to have to create very expensive bespoke
13 care plans from scratch, and usually at a point of
14 crisis. By sharing resources and expertise nationally,
15 as well as sharing information and intelligence across
16 county and borough borders, we can secure better
17 outcomes for young people harmed by CSE and CSEN.
18 Unless I can assist you further, those are my
19 submissions.
20 THE CHAIR: Thank you, Ms Perry. Mr Gold?
21 Closing statement by MR GOLD
22 MR GOLD: Madam, the chief constable is grateful for having
23 had the opportunity to explain how his constabulary has
24 learned lessons, implemented recommendations and put in
25 place effective strategies to prevent future child

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1 exploitation or CSE.
2 With respect to the need for Topaz and to its
3 background, Topaz was developed from the learning and
4 recommendations of the Serious Case Review into
5 Operation Brooke, the 18-month police operation
6 in May 2013, following the recovery of a vulnerable
7 14-year-old girl missing from an arrest in Bristol.
8 The Operation Brooke Serious Case Review found that
9 in cases involving sexual exploitation, there was often
10 a pattern of focusing less on the initial prevention of
11 the abuse and disrupting and prosecuting perpetrators
12 than trying to stop victims from having further
13 involvement with such perpetrators. This meant victims
14 often continue to be at risk of ongoing abuse by those
15 same persons. The review also considered that the
16 constabulary's working methods and recording systems
17 failed to identify patterns in individual and group
18 behaviour, that this reduced the prospects of a timely
19 response in the detection of perpetrators and that it
20 led to a reactive rather than proactive approach.
21 In addition, the constabulary itself recognised that
22 a different approach was necessary on realising that its
23 core processes for safeguarding, reactive investigation
24 and organised crime investigation needed to be
25 supplemented to address the different dynamics and

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1 challenges that CSE presented. This included dealing
2 with victims who, without significant work and time to
3 build their trust and confidence, were unable to make
4 disclosures to the police.
5 The constabulary also just could not replicate the
6 resource-intensive investigation model of
7 Operation Brooke for the volume of CSE cases that
8 increased awareness and reporting had highlighted.
9 The consequence is that the Serious Case Review for
10 Operation Brooke reshaped the constabulary's whole
11 approach to CSE. Chief Superintendent White, in his
12 statement of 2 December 2019, at paragraphs 13 to 24,
13 describes the systematic identification of
14 the challenges to the constabulary's approach prior to
15 Topaz. He also demonstrates how Topaz achieves its
16 purpose in addressing those issues at paragraph 31.
17 Central to this, he explains, is the importance of
18 disruption, at paragraph 93, and the victim-focused
19 approach using engagement officers, at paragraphs 151 to
20 155.
21 With respect to CSE problem profiling, Parliament
22 has defined organised crime groups as those which have
23 as their purpose, or one of their purposes, the carrying
24 on of criminal activities and which consist of three or
25 more persons who act, or who agree to act, together to

1 further that purpose. In the Serious Crime Act 2015,
2 section 45(6).
3 This involves individuals planning, coordinating and
4 committing offences which are sufficiently serious to be
5 punishable on indictment with a term of imprisonment of
6 seven years or more. Insofar as such activities must be
7 with a view to obtaining gain or benefit, this will
8 include sexual gratification.
9 The constabulary's experience and holistic
10 understanding of CSE in Bristol indicate that such
11 structured, hierarchical and clearly defined groups that
12 comprise organised crime groups are, in this field,
13 rare. However, where they do exist, they can result in
14 very high harm.
15 Consequently, the constabulary continues to be
16 proactive and vigilant in identifying such groups.
17 The inquiry definition of organised crime networks,
18 characterised by two or more persons who are involved
19 in, or who facilitate, the sexual exploitation of
20 a child, is significantly more extensive. However, the
21 constabulary's experience of the majority of CSE being
22 peer on peer, dynamic, fluid and opportunistic means
23 that its systems are set up to be able to show large
24 groups of people flagged for CSE who are interrelated
25 for a wide range of incidents. The constabulary's 2019

1 problem profile concluded, at pages 16 to 17, that no
2 significant organised crime group involvement with CSE
3 within Avon and Somerset had been identified and that
4 incidents involved a loose collection of associates who
5 may be involved in other criminal activity.
6 The constabulary's data analytics provide it with
7 a detailed understanding of the cohorts who are at risk
8 from CSE and the cohorts who pose a risk of perpetrating
9 it. The use of data analytics allows the constabulary
10 to understand who may be vulnerable to the hidden harm
11 of CSE so it can support them proactively rather than
12 reactively when they come to the attention of
13 professionals. This allows the constabulary to
14 contribute to the provision of a tiered response from
15 early conversations with children and young people by
16 professionals already working with them so as to
17 understand if they are at risk and to raise their
18 awareness to multi-agency early intervention, structured
19 safeguarding processes, involvement by Topaz and
20 specialised commissioned services of Barnardo's.
21 As to the disruption of offenders, Topaz seeks to
22 prevent and reduce the prevalence of CSE through the
23 disruption of perpetrators. That requires creativity
24 and innovation, what the constabulary describes as
25 placing individual bricks of disruption that create

1 a wall between a perpetrator and someone who has been
2 victimised or who is at risk of being victimised to
3 prevent such offending. An important element of that is
4 the timely use of CSE warning letters and child
5 abduction warning notices, as well as more intensive
6 means of direct, indirect and locational disruption.
7 The case studies that the inquiry evidence has
8 highlighted demonstrate the effective use of such
9 disruption as follows. With respect to CS-A32, words of
10 advice were given to the manager at the business
11 premises and there was a modern-day slavery
12 investigation, together with a review by Topaz and the
13 offender management unit. With respect to CS-A59, an
14 engagement officer was aligned. There was positive
15 disruption with child abduction warning notices with
16 clear conditions and later related arrests. The
17 perpetrator was sentenced to a custodial term of 21
18 weeks, reduced to eight on appeal, for knowingly
19 inducing a child to run away or stay away.
20 With respect to CS-A302, there were two different
21 investigations dealt with by police in two other areas.
22 CS-A302 has provided two evidential disclosures but
23 expressed that they presently wish the police to take no
24 related action. Child abduction warning notices were
25 issued to two individuals prior to CS-A302 moving out of

1 the area.
2 With respect to CS-A62, child abduction warning
3 notices were issued and there was a positive response to
4 breaches, including out of force. CS-F57 was found to
5 be fit to plead, pleaded guilty to child abduction of
6 A62 and was sentenced to a custodial term of ten months,
7 a Criminal Behaviour Order for five years, preventing
8 him from being in company with any child under the age
9 of 16 unless present with a family member, and
10 restraining orders for five years, preventing his having
11 any contact with key individuals.
12 With respect to CS-A33, the perpetrator was charged
13 with three breaches of a Sexual Offences Prevention
14 Order, resulting in his being sentenced to a custodial
15 term of four years.
16 You will see the constabulary's 2019 problem profile
17 identified at page 6. The data released in July 2019
18 suggested that only 1.5 per cent of rape offences
19 received conviction. However, the data in that document
20 shows that CSE-linked rape offences within
21 Avon and Somerset received a positive outcome in
22 9.5 per cent of occurrences, and that, in general, the
23 CSE-linked sexual offences, those being offences other
24 than rape, the positive outcome rate was 9.2 per cent,
25 above the national average for all sexual offences.

1 With respect to empathy and concern for child
2 victims, the constabulary's use of engagement officers
3 has addressed feedback received from victims, from
4 Serious Case Reviews, commissioned services and
5 assurance work. It changes the focus of Topaz to victim
6 needs, including welfare and therapeutic support rather
7 than investigative needs. That separation has been
8 important. The child or young person will lose trust in
9 the police where an investigative officer takes steps
10 without their knowledge or permission, but their having
11 access to an engagement officer whose function is to
12 provide them with support separate from any
13 investigation enables the building of trust with victims
14 giving them confidence to make disclosures and then
15 further disclosures without their feeling as though they
16 are losing control.
17 The constabulary has seen that this change of
18 approach enables it to respond positively and
19 effectively to children and young people when they need
20 help and are ready to speak generally and in respect of
21 what they feel would improve their safety and situation.
22 The result of that sustained, long-term approach is
23 that as stated in the 2019 problem profile at page 11.
24 The conversion rate for video interviews and statements
25 for evidential purposes for the north Topaz team stands

1 at 52.7 per cent. That stands at a higher rate than
2 data previously quoted by the Lucy Faithfull Foundation,
3 disclosure rates of between 10 and 20 per cent.
4 The constabulary's problem profiles have informed
5 the force strategic threat assessment which prioritises
6 child sexual exploitation and child sexual abuse as the
7 highest threat. It has highlighted areas of strategic
8 intelligence requirement that are proactively addressed
9 primarily through its CSE prevention and co-ordination
10 officer. That officer has formed relationships with
11 residential children's homes, including those which
12 provide specialised CSE placement, schools, which
13 especially includes those providing services for
14 disabled children, BAME and religious communities,
15 which, historically, have not seen high levels of trust
16 and confidence in reporting CSE, and key businesses,
17 such as hotels, taxis and nightclubs.
18 In 2019, this officer provided awareness and
19 training sessions to over 21,000 schoolchildren,
20 professionals, police staff, business employees and
21 parents. The constabulary has also produced training
22 and resources for these businesses and organisations,
23 highlighting the importance and need for engaging with
24 young people and children using respect, empathy, the
25 children's own voices and an awareness of their

1 potential vulnerability. This has reinforced the need
2 to avoid victim-blaming language.
3 There never can be permanent solutions or full
4 achievement and the constabulary accepts that there is
5 a need for continued and ongoing reinforcement of
6 avoiding victim-blaming language.
7 The nature of front-line policing is highly
8 demanding and therefore, regrettably, attritional. But
9 the constabulary recognises that constant education,
10 support and leadership is required to maintain a culture
11 of empathy and understanding.
12 In relation to missing children and Return Home
13 Interviews, the constabulary has clear roles,
14 responsibilities and processes for identifying and
15 problem solving those who are repeat missing children.
16 It no longer permits children to be classified as
17 absent. The distinction between absent and missing now
18 applying only to adults.
19 There is a growing evidence base that shows
20 increasing links between episodes of children being
21 missing to their risk of being harmed. In consequence,
22 Chief Superintendent Wright wrote in February of this
23 year to the constabulary area's five directors of
24 children's services and through local safeguarding
25 arrangement lead chairs to highlight the need to improve

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both the prevention of repeat missing episodes and the understanding of its relevance as an indicator of victimisation and need.

Improvement work in Bristol has been progressed as a result and the constabulary expects that this should support ongoing reductions in missing episodes for children and young people.

Finally, in relation to audit, review and performance improvement, the constabulary has regularly completed detailed and thorough single-agency assurance work in addition to that provided for multi-agency safeguarding requirements through local arrangements and formal inspections. The assurance work has maintained high levels of focus on the voice and experience of victims. It has provided a clear understanding of the current position, where improvement work needs to be focused and how the response to CSE needs to develop and evolve.

The constabulary's experience is that this honest self-awareness and reflection and the learning that that has produced over the past five years, has been both rapid and significant and the process of continual improvement should maintain that pace.

In conclusion, the constabulary can speak only of its own development, the lessons it has learned and how

it has sought to improve its responses and processes to the policing of CSE. The chief constable very much hopes that this can inform the inquiry's constructive examination of what more might be done in the future.

Those are my submissions.

THE CHAIR: Thank you, Mr Gold. We will now take the afternoon break and return at 3.05 pm.

(2.50 pm)

(A short break)

(3.05 pm)

THE CHAIR: Ms Rayson?

Closing statement by MS RAYSON

MS RAYSON: Thank you, chair. Bristol's opening statement outlined the work going on in Bristol which we believe offers areas of strength which we can contribute to the inquiry's work. Our longstanding services operate at all levels. We take a holistic view of the child, we implement relationship-based practice and we benefit from mature partnerships.

The partnership focus on disruption is showing evidence of its impact on organised abuse. The use of data analytics supports prevention and identification. Bristol's closing statement has at its heart what we have learnt from our young people and what we are currently endeavouring to learn and is informed by

experts in the field, such as Drs Hallett and Beckett, as well as relevant national and local information.

Dr Benneyworth, in her evidence, echoed the views of Bristol City Council when observing how important it is that we empower young people, involve them in discussions, coproduce information and hear their voices strongly in local and national systems.

Empowering children necessitates discussions around agency. How they enact agency through relationships with significant others, such as family, social workers, peers and teachers, is becoming the subject of much-needed research.

A search for agency was a central motif in the experiences of vulnerable young people who were the subject of a recent longitudinal study. A child-centred approach also requires a reconsideration of the definition of child sexual exploitation, one which is less complex, less likely to cause professional differences of opinion as to whether harm falls into the category or not, but, most importantly, a definition that reflects the lived experiences of young people.

Dr Hallett's work in that regard is both informative and persuasive.

In preparing for the inquiry and responding to requests for information, Bristol has been open,

transparent and co-operative. We have been fully supportive of the inquiry's aims and objectives and remain so. The themes chosen by the inquiry have caused us to scrutinise and reflect on BCC's practice and policies. Change has been implemented as a result of the information-gathering exercise, good examples being the introduction of a specialist CSE worker and the reinstatement of fortnightly missing oversight meetings that ensure senior management oversight and effective multi-agency review of individual children's plans aimed at reducing missing episodes.

CSE creates complex safeguarding challenges. Through our use of data analytics, mature partnership arrangements and relationship-based practice methodology, we continue to look for hidden harm; to be committed to prevention of harm at all levels and to be determined to support in a timely and effective way those who have been harmed. We are consistently reviewing and developing our approach, perhaps most significantly through our work with the University of Bedford and the contextual safeguarding scaleup project.

We wanted to highlight a number of areas which Bristol submit are of profound importance to any debate about CSE.

Supporting families. Bristol has made a conscious

1 decision to invest in and reconfigure services to give
2 added support to the objective of reducing family
3 breakdown arising from extrafamilial abuse. We have
4 prioritised work with families and tried in particular
5 to reduce the stigma experienced by victims and their
6 family members. Our multi-disciplinary Strengthening
7 Families teams work intensively with Bristol families,
8 with social work support where needed, to ensure there
9 is full exploration of all options which can support
10 a child remaining safely at home in their familiar
11 community.
12 Our approach to working with individuals is enhanced
13 by the implementation of contextual safeguarding, with
14 its focus on approaches to groups and specific
15 locations.
16 Chair, you have heard powerful witness evidence from
17 PACE, from the mother of CS-A2, about the
18 marginalisation of parents in many cases, moving through
19 shades of criticism to being blamed for the abuse at
20 worst. That approach ignores the invaluable
21 contributions many parents can make to their child's
22 protection. It must surely be a priority for abused
23 children not to be punished by being taken away from
24 their home and their relationships if those can be
25 supported by professionals working with, not against,

1 parents.
2 Hidden harm. As stated, an important characteristic
3 of CSE is it involves hidden harm. The national and
4 local efforts to understand and, therefore, be better
5 able to protect from sexual exploitation will be
6 assisted by the ONS study into adult reports of
7 childhood experiences, adding to the understanding of
8 characteristics and prevalence of abuse.
9 In her written and oral evidence, Ann James
10 reflected that Bristol's Think Family database and the
11 predictive analytics raise ethical issues about data
12 sharing, there being no existing ethical framework for
13 big data/predictive analytics. The algorithms may be
14 affected by bias which allows less easy identifiable
15 groups to be overlooked. But we continue to make
16 significant contributions to academic and professional
17 research and have made the decision to be as transparent
18 as possible about data collection with those who live in
19 Bristol.
20 The point, however, is that the
21 information-gathering exercise represents Bristol's best
22 efforts to identify risk before, rather than after,
23 a child is harmed; to give children and families the
24 opportunity to work together with children's services to
25 prevent harm. A single view of an individual across

1 agencies helps to shape an early and timely
2 understanding of the needs of the family and who is best
3 placed to support the child and family.
4 By flagging up the involvement of other
5 professionals, multi-agency working can start when risks
6 are emerging rather than once they have crystallised.
7 As we have explained, one of the predictive risk
8 models does look exclusively at the identification of
9 vulnerability to CSE. It identifies the characteristics
10 of an individual in comparison with those of the target
11 cohort. Whilst it cannot replace professional judgment
12 and must adapt in response to our developing
13 understanding and the changing nature of offending, we
14 believe the use of algorithms can make a significant
15 contribution to child protection and there is potential
16 for further development. The database also has the
17 benefit of allowing us to target resources.
18 Accommodation and resources. The sufficiency of
19 accommodation and resources is identified by most
20 participants as a significant challenge to the provision
21 of a dynamic service for young people who are, or are at
22 risk of, being exploited and who cannot remain within
23 their family. From the complexities of identifying risk
24 through the provision of appropriate and safe
25 accommodation to offering good-quality therapeutic

1 support in a timely fashion, resources are limited at
2 a time when local authorities face significant financial
3 challenges.
4 The sufficiency of care placements and particularly
5 specialist care placements is a national issue, and, as
6 mentioned by my learned friend Ms Perry, as recently as
7 Monday of this week, Mr Justice MacDonald in the Family
8 Division was forced to approve an unregulated placement
9 for a young woman of 16 with multifaceted difficulties
10 who was at high risk of serious self-harm or suicide.
11 Bristol's reprofiling of its children's homes to
12 deliver smaller homes and a therapeutic approach is
13 contributing to the provision of local, suitable and
14 safe accommodation options for young people,
15 particularly older teenagers. Without a safe and secure
16 placement, the exposure to risk and actual harm simply
17 continues.
18 The inquiry will recall the oral evidence of
19 Ms James about the benefits of specialist trauma
20 recovery model training which would allow the delivery
21 of trauma-informed practice to support vulnerable
22 individuals and families. The approach puts
23 relationship building and therapeutic interaction first
24 to mediate the impact of trauma. Investment in this
25 field would, in the view of Bristol, be amply repaid as

it's probably the only proven way of breaking the cycles of abuse which perpetuate exploitation.

Transition into adult services. Our young people do not cease to require support and safeguarding when they reach the age of 18. We would welcome national guidance and the provision of resources to enable properly supported transition into adulthood. Bristol is able to draw on best practice which has been developed locally, including maintaining relationships with young people we've already created. Bristol will continue to support young people by ensuring the provision of a wrap-around package of care and support.

Seldom-heard groups. The panel heard from the Angelou Centre and Apna Haq about the need to develop culturally competent services. Bristol recognises this and has taken action to ensure that seldom-heard groups are supported to access services, monitoring performance and acting on its findings and the feedback from young people. For example, the panel heard that boys in Bristol have a specific offer and access to CSE services in the city. Bristol presented good examples of children with disabilities who were safeguarded through effective partnership working by specialist disability and CSE services. We highlighted the importance of health services making an accessible and flexible offer,

something that Bristol has achieved through co-location and the integration of these services within its specialist CSE-commissioned arrangements. What is abundantly clear is that much more needs to be done on both a local and a national basis.

Return Home Interviews. The evidence given by the local authorities and police forces about Return Home Interviews serve to reinforce our views that the strict statutory framework comprises a set of static processes that do not necessarily meet their objectives. RHIs need to be reframed as conversations. The timing should reflect the particular needs of the child. As recognised by Mr Heaney, there may be more immediate needs when a child returns, such as the need for medical attention.

To achieve its objectives, the Return Home Interview procedure needs to be flexible. Ann James spoke to the lived experience of children in receipt of a missing response and the potential impact of implementing statutory processes from multiple agencies rather than taking a nuanced and relationship-based approach.

The voice of young people. Bristol is committed to developing its services in conjunction with young people. In conclusion, we relate the words of one of the young people who has asked that their views be

shared and whose views speak to themes being considered by the inquiry. She is known to the inquiry by a cipher. When we spoke to her recently and asked whether she wanted us to pass on anything to the panel, we also asked her to choose a pseudonym. So this is what "Amelia" wanted to say. She wanted the inquiry to know that, in her view, out-of-area placements are necessary for children who have been sexually exploited by a group of perpetrators. She talked of how unsafe she now realises she was when she was moved out of area. She said:

"Moving away saved my life" and felt that being out of Bristol helped her to feel safe enough to talk about the perpetrators who'd offended against her. However, Amelia felt that there should be more provision closer to Bristol to help continue contact with family and friends.

"Amelia" spoke to us about the importance of the quality of care children receive in specialist placements. She shared that it felt like home and that the staff team were skilled at building nurturing relationships while maintaining good boundaries which made her feel confident that she was safe with them. She explained that there was no way she could go missing due to the level of monitoring.

Amelia was aware the inquiry was also considering the statutory response to perpetrators of sexual exploitation. She talked of preventative work being needed to protect children from being groomed, but also support and resources for children who are at increased risk of exploiting children when they become adults in order to break the cycle of harm. Amelia said she wanted the inquiry to hear that "Groomers shouldn't just be locked up. Give them help too".

Amelia's final message to the inquiry was about how to be realistic in supporting children and survivors to cope and recover. She said this:

"So many people have said to me, 'One day, you'll wake up and you'll be fine'. No-one can promise that. You've got to tell kids, 'You will learn to live with it', rather than, 'You'll get over it'. I still wake up each morning thinking about it, but I've learnt ways of living with it, and that's what other kids need to know."

Thank you, chair.

THE CHAIR: Thank you, Ms Rayson. Finally, Mr Berry?

Closing statement by MR BERRY

MR BERRY: Good afternoon, chair and panel. The NPCC thanks the chair and panel for the opportunity to participate in the CSEN investigation. We hope that the evidence

that we have supplied and these short closing submissions will be of assistance.

The inquiry heard evidence from a senior police officer in each of the geographical areas under consideration. The inquiry will understand that each chief officer of police is operationally independent and does not take direction from the NPCC. The NPCC is a coordinating body that seeks to agree common national approaches to improve policing in a number of different portfolio areas. The NPCC portfolio relevant to this investigation is the violence and public protection portfolio led by Chief Constable Simon Bailey. Sitting under that portfolio are two NPCC working groups: child protection and abuse investigation, led by Chief Constable Bailey; and group-based child sexual abuse, led by Chief Constable Mark Collins. The inquiry has received statements from both chief constables, which I know it will consider carefully.

I will focus these submissions on six themes: action plans; audit and performance management; data; guidance; the future; and a response to some of the points that have been raised.

Action plans. The NPCC and its predecessor ACPO published a national CSE action plan in 2012, a CSE problem profile in 2013 and further CSE action plans in

2014 and 2016. Each successive version took account of reports from CSE-related enquiries, academic research, the improved intelligence picture and the increased understanding of CSAE.

When the 2016 national CSE action plan ended in 2018, it was replaced on two different levels.

First, on a regional level, by bespoke regional action plans, based on the findings from regional problem profiles created by a network of regional CSA analysts put in place by funding obtained from the Home Office by the NPCC.

Second, on a national level, by the National Vulnerability Action Plan, which was issued by the NPCC and the College of Policing in 2018 and refreshed this year. That plan covers not just CSAE, but 14 strands of vulnerability. The intention in creating the NVAP, as it is known, was both to avoid duplication across 14 different thematic action plans and also to recognise the increasing evidence of crossovers between different strands of vulnerability. For instance, a case involving group-based CSAE may also involve missing children or modern slavery and human trafficking, or, indeed, all three. A single national plan covering the whole terrain of vulnerability reduces the scope for a siloed approach.

Forces also continue to have local action plans in place to ensure compliance with the national and regional action plans I've just mentioned.

Audit and performance improvement. Having an action plan is one thing, but ensuring that it is implemented is the crucial part. That is the responsibility of local forces. They are, however, assisted by the NPCC.

Through the Vulnerability, Knowledge and Practice Programme, the NPCC co-ordinates force-level and regional responses to the National Vulnerability Action Plan, and whilst the NPCC cannot direct individual forces, its Vulnerability, Knowledge and Practice Programme conducted a benchmarking exercise in 2019. Data was provided to the NPCC by every force in the country; that data was analysed by specialists in the NPCC, and each force was then provided with a bespoke response which highlighted good practice and areas for improvement within the force and also shared good practice from other forces. The next NPCC benchmarking exercise is planned for 2021.

The NPCC's Operation Hydrant also offers all police forces the opportunity to receive support through a peer review or peer support process. A team of experienced investigators and specialists can support a local investigation at any stage. Where

Operation Hydrant is called upon, its input ensures that nationally recognised best practice is embedded within an investigation.

Data. The creation of problem profiles and action plans at a regional, national or local level requires consistently accurate data. The need for accurate data has been emphasised by the NPCC. All forces have been directed in successive action plans to ensure that crimes are correctly tagged as CSAE to provide opportunities for auditing and analysis.

The National Vulnerability Action Plan has specific actions relating to data and analytical capability. With respect to data, the headline action is: data collected in support of local responses to vulnerability is of high quality, supported by policy, training and accountability, and that should include multi-agency data. With respect to analytical capability, the headline action is: to develop analytical capability and capacity to identify high-risk areas of vulnerability in order to target intervention/prevention activity, including identification of emerging threats.

The quality of data was improved by the network of regional CSAE coordinators and analysts put in place via funding obtained by the NPCC between 2016 and 2018. Those coordinators and analysts were able to gather

regular intelligence submissions from forces and partner organisations and to help overcome the issues created by the lack of uniformity and data recording across 43 different police forces and also as between the police service and external bodies. Since 2018, Home Office funding has been limited to the equivalent of half a CSAE analyst in each of the ten regions.

Guidance. It is the College of Policing, rather than the NPCC, that produces formal, professional guidance to the police service. The NPCC has supported the development of the College of Policing's authorised professional practice content on CSAE. In partnership with the College of Policing, the NPCC's Operation Hydrant has developed a senior investigating officer advice for investigations into allegations of non-recent institutional child sexual abuse. A revised version of that guidance, some 80 pages long, was published this year.

In partnership with the Children's Society and victim support, the NPCC has published a suite of guidance and toolkits for practitioners which are available on the csepoliceandprevention.org.uk website, which I invite the inquiry to consider. These guide guidance on appropriate language, that the inquiry has already considered, and toolkits on specific groups of

young people experiencing CSE, including black and minority ethnic young people, LGBTQ+ young people, boys and young men and young people with physical disabilities.

The future: Chief Constable Bailey has given evidence that he is working on a long-term tackling organised exploitation project. Subject to government funding, this project would involve a new approach to tackling organised exploitation. Organised exploitation, for these purposes, includes group-based and organised CSAE, county lines and modern slavery. It is policing's experience that organised exploitation increasingly operates over traditional county borders, online and offline, and across multiple different types of offending.

The proposal is for a national exploitation hub that would be the nerve centre of the police's fight against organised exploitation. The hub would be able to harvest and assess intelligence and data from a number of police and multi-agency sources; to analyse and understand patterns of offending; to threat assess and prioritise actions; to task local, regional and national law enforcement responses to this type of criminality.

Whether this project is funded by the Home Office remains to be seen. The project was submitted as

a representation to the government's comprehensive spending review, which was delayed and has now been cancelled due to the COVID-19 pandemic. The NPCC will now seek other vehicles to pitch this important project to government.

Response to points raised. I would like to respond to two points that have been raised: one is whistleblowing; and the other is on the concept of risk.

As to whistleblowing, in his opening on behalf of Ms Oliver and Mr Wedger, Mr Jacobs said that police officers cannot speak out on failures to investigate child exploitation. In fact, not only are police officers able to speak out, and not only are they encouraged to speak out, but they are required to speak out.

The police conduct regulations 2020 and the College of Policing's Code of Ethics require officers to challenge and report improper conduct. Each police force has a whistleblowing policy which provides a variety of ways in which wrongdoing can be reported, including anonymous reporting.

If a police officer feels uncomfortable in raising wrongdoing directly within their own force, there is also the option of reporting the matter directly to the IOPC, using the IOPC report line. Details are on its

website.

Mr Jacobs suggested that police officers do not enjoy the same employment rights as other workers. That is incorrect, insofar as the protection of whistleblowers is concerned -- see section 43KA of the Employment Rights Act 1996.

Mr Jacobs also called for the creation of an independent ombudsman to investigate concerns raised by police officers. This submission overlooks the existence of the IOPC, whose independence has been strengthened yet further this year by new statutory powers to investigate matters of its own initiative.

Second, the concept of risk. The NPCC certainly supports the point that risk assessments should not overlook the fact that a victim has already suffered or is currently suffering from harm. The NPCC would, however, caution against a recommendation that the concept of risk is abandoned. The police service does need a tool to assess the likelihood of a threat occurring in the future for a whole host of reasons, including prioritising resources. It is not obvious what the alternative tool to a risk assessment would be.

Moreover, the concept of risk is very well established in police training and practice, across a suite of College of Policing guidance on risk, and,

1 indeed, in legislation, an obvious example being Sexual
2 Risk Orders under section 122A of the Sexual Offences
3 Act 2003.
4 In conclusion, chair and panel, the NPCC is acutely
5 aware that the police service's response to group-based
6 CSAE was not adequate in 2014, when the chair's
7 independent report shone a light on the disgraceful CSAE
8 in Rotherham.
9 Policing has come a long way since then.
10 Significant work has been done to understand the nature
11 of the threat, to come to terms with the scale of
12 the threat, and to work out how best to tackle that
13 threat.
14 It has been recognised, for instance, that
15 group-based CSAE is not only perpetrated by British
16 males of Pakistani origin. It is a much broader and
17 more complex problem than that.
18 Senior officers have done their best to educate
19 front-line officers on the threat and how to respond to
20 it. There has been a move away from a victim-blaming
21 culture to a point where, in the vast majority of cases,
22 the response is different to what it would have been
23 six years ago.
24 There has been a move towards a culture of
25 professional curiosity, where CSAE is everyone's

1 problem, not something that should be left for
2 specialist officers to deal with. There has also been
3 a move towards identifying the threat at an earlier
4 stage and actively targeting individuals and groups who
5 want to abuse children.
6 Policing in this area is not perfect. The inquiry
7 has heard evidence and relatively recent examples of
8 victims and their families not being satisfied with the
9 police response in their cases. The NPCC does not shy
10 away from that criticism. On the contrary, it is
11 reflective. It wants to learn and to help the police
12 service learn. That is not an empty expression or
13 soundbite. It is backed up by action. The NPCC's
14 Vulnerability, Knowledge and Practice Programme is doing
15 work to analyse learning from individual investigation,
16 enquiry and review reports and ensure that the learning
17 is captured, cascaded and used in support of practice
18 development in police forces, and I hope it goes without
19 saying that the inquiry's report on this investigation
20 will be given the most careful consideration by the
21 NPCC.
22 Chair and panel, those are my submissions.
23 THE CHAIR: Thank you very much, Mr Berry. That concludes
24 the closing statements. Ms Hill, is there anything you
25 would like to say in response?

1 MS HILL: Chair, yes, thank you. As I indicated at the
2 outset of this hearing today, there are a few issues
3 I would like to address.
4 Closing statement by MS HILL
5 MS HILL: As you're aware, chair, there has been some media
6 reporting since the last day of these hearings, and we
7 would wish, please, just to simply put on record some
8 views on these issues that we are concerned perhaps
9 misrepresent the position.
10 Firstly, as far as the selection of areas is
11 concerned, chair, as you know, there has been criticism
12 of the inquiry for focusing on certain geographical
13 areas that are not those where there have been
14 high-profile cases of child sexual exploitation by
15 networks. With respect, we would suggest that that is
16 to miss the point entirely of what this investigation
17 was aiming to do.
18 Chair, the inquiry announced its selection of these
19 six geographical areas in March 2019, at the same time
20 as inviting applications for core participant status.
21 I set out the reasoning and methodology for that
22 selection during the two preliminary hearings, and again
23 in opening this public hearing. To reiterate, chair,
24 the inquiry considered publicly available material,
25 including the number of children on child protection

1 plans, the deprivation index, policing arrangements,
2 absence from school data, et cetera, and chose a sample
3 of 13 local authority areas.
4 From those areas, evidence was provided by
5 institutions which enabled the inquiry to select
6 six particular areas providing a range of features,
7 including size, demography, geography and social
8 characteristics, as well as being likely to illustrate
9 contrasting practice and performance on the selected
10 themes.
11 The inquiry carefully considered the extent to
12 which, if at all, it should focus on areas such as
13 Rochdale, Rotherham and Oxford, all of which had
14 attracted public attention and high-profile
15 prosecutions. The inquiry considered that it was more
16 appropriate to focus on different areas for three main
17 reasons.
18 First, this was always intended to be
19 a forward-looking investigation, building on analysis
20 that had already been done and assessing current and
21 very recent practice, including the extent to which
22 institutions have learned lessons from high-profile
23 reports and inquiries. As such, the evidence you have
24 heard was largely related to the last three years.
25 Looking at practice in particular areas several years

before that would have given a radically different focus and would not have enabled a comparison between different areas and their current practice.

Second, the high-profile areas mentioned have all been the subject of investigations, Serious Case Reviews or inquiries which looked at past mistakes. Recommendations have been made in those areas, some of which were intended to have national application. If the inquiry had decided to select these areas, it would inevitably have involved considerable duplication of work and evidence. For example, as you're aware, Ms Oliver provided evidence to the assurance review into Greater Manchester published in December 2019, and Ms Champion MP was a leading figure in work following on from the Rotherham inquiry which you conducted. But had this investigation chosen to focus on those areas over those periods, that work would have been duplicated.

Thirdly, chair, all of the available evidence makes it clear that the sexual exploitation of children by networks is not a rare problem faced by a small number of areas where there have been high-profile criminal cases. The selection of areas which have already been the subject of such high-profile investigations may have given a false impression that sexual exploitation of children by networks was limited to or concentrated in

towns and cities in the north and Midlands. You may conclude, chair, on the basis of the investigation evidence and the timelines read out, that CSEN is far more widespread than that.

The advantages of selecting areas which have not previously been the subject of reports or inquiries or prosecutions was perhaps highlighted today by Ms Harrison on behalf of CS-A2, who said this morning that, until this inquiry decided to include Warwickshire in this investigation, her client felt that there was no real accountability for the failings of both the local authority and the police in her daughter's case.

In our submission, chair, far from shying away from exploring difficult issues in this investigation, you have conducted a full and appropriate inquiry examining the practices of a significant number of institutions in granular detail. After considerable thought and preparation, the methodology and scope of this investigation was devised to ensure that you, chair and panel, received contemporaneous evidence about the institutional response to child sexual exploitation by networks, including good and bad practice across a range of geographical areas, and it was specifically devised so that it did not just focus upon those areas where child sexual exploitation by networks is already known

to be or has been a significant problem.

Chair, you have maintained that approach, despite some core participants seeking to deflect you from examining current practice into revisiting older cases that have already been the subject of much analysis and comment.

Second, the selection of themes by this investigation. There has been a suggestion made that the inquiry is not seeking to learn the lessons from these previous high-profile investigations, and is avoiding the issue of the ethnicity of perpetrators of CSEN. With respect, chair, we would suggest that neither of these propositions is correct.

In March 2019, the inquiry announced its selection of its eight themes for this investigation, and I have already explained the reasoning and methodology for that selection, but I reiterate that these themes were selected based on a review of recommendations made by national reports, reviews and inquiries, building on the work done by the National Working Group in 2015.

The list of published reports taken into consideration by the inquiry has been provided to core participants. Far from ignoring what has happened in the past and the work produced by these inquiries and reports, this investigation seeks to build on that work

that has already been done, both in choosing its themes and assessing the extent to which lessons have been learnt.

As to the suggestion that the inquiry took these decisions to avoid examining the ethnicity of perpetrators of CSEN issue, again, with respect, that's also not correct. On the contrary, the very first theme for this investigation, chair, that of problem profiling, was intended to consider the extent to which police forces and local authorities are aware of the ethnicity and gender of both perpetrators and victims of CSEN in their areas.

The inquiry specifically sought evidence on this topic in relation to all six areas and the appropriate witnesses were asked questions about this issue during the hearing.

More generally, evidence provided by core participants, including Ms Oliver and Ms Champion, on the ethnicity issue has been adduced before you. You have also been provided with witness evidence submitted by academics, such as Dr Ella Cockbain, which test whether it is, in fact, correct to assert that there is an overrepresentation of ethnic minority perpetrators in CSEN.

You will, of course, be aware, chair, that the

1 experiences and treatment of victims of CSEN from
2 minority groups was not a specific theme chosen by the
3 investigation in the way that children with disabilities
4 and male children were. However, the issue was covered
5 in some detail under the wider theme of empathy and
6 concern for child victims. You heard evidence about the
7 extent to which support is provided to ethnic minority
8 victims of CSEN. You heard oral evidence from
9 Zlakha Ahmed and Rosie Lewis, and this issue was also
10 explored with several institutional witnesses.
11 I reminded you in my opening, chair, of the separate
12 work done by the inquiry's research project on this
13 issue, which led to the publication in May 2020 of
14 research into the motives and behaviours of perpetrators
15 of child sexual exploitation who were convicted
16 alongside other perpetrators. This specifically
17 addressed the question of the ethnicity of CSEN
18 perpetrators, noting that the diversity of ethnicity of
19 perpetrators is unclear, largely due to poor recording,
20 but that available data did challenge the view that
21 perpetrators, especially those operating in a network or
22 gang, are solely or predominantly of one ethnicity.
23 Also, in May of this year, the inquiry published
24 research on child sexual abuse in ethnic minority
25 communities. This cited research suggesting that

1 unhelpful stereotypes which assume that CSE is
2 perpetrated by Asian men against white girls have led
3 some professionals to believe that children from ethnic
4 minorities are unlikely to be the victims of CSE and
5 that, on balance, a lack of awareness of the risk to
6 these children and especially boys has led to failings.
7 Most core participants in this investigation were
8 designated as such in May 2019, and therefore had the
9 opportunity, chair, to make submissions on the selection
10 of geographical areas and the selection of themes, at
11 least from that point. They first did so in January of
12 this year, around three months before the public hearing
13 was due to take place. By that stage, lengthy witness
14 statements and documentary evidence had been provided,
15 focusing on those six chosen areas and those eight
16 chosen themes.
17 Finally, chair, the issue of the balance of
18 the evidence has been raised. You will recall that this
19 was an issue dealt with in submissions on day 4 of
20 the hearing. I set out the inquiry's position at that
21 point, and, in response, you decided that an additional
22 day of hearing should be listed, which allowed for three
23 additional non-institutional witnesses to be called; as
24 I have already mentioned, Ms Ahmed of Apna Haq, Ms Lewis
25 of the Angelou Centre and Ms Gibbons from PACE. You

1 also directed that the timelines in relation to the
2 particular children should be read out.
3 We also invite you, chair, in considering the
4 institutional evidence in writing your report, to
5 properly scrutinise that evidence, including by testing
6 it with reference to the child-specific evidence.
7 Chair, thank you. Those are all the observations
8 I wish to make.
9 THE CHAIR: Thank you, Ms Hill.
10 Closing remarks from THE CHAIR
11 THE CHAIR: In conclusion, the panel and I are grateful to
12 those who have provided evidence to the inquiry for the
13 purposes of this investigation, and to all core
14 participants for their assistance. We appreciate your
15 efforts in bringing information and issues to the
16 inquiry's attention for us to consider, and in
17 particular would like to thank the victims and survivors
18 from whom we heard.
19 This investigation has proceeded against the
20 backdrop of a pandemic and national emergency which has
21 impacted everyone in ways we could not have imagined.
22 We recognise the pressures that this has placed on each
23 of you, both personally and professionally, and we are
24 grateful for the flexibility and patience you have all
25 shown when we were required to postpone the hearing due

1 to take place in April and reconvene the hearing in the
2 form of virtual public hearings in September
3 and October.
4 We will now consider all of the evidence and
5 submissions we have heard and produce our investigation
6 report. We expect to be able to publish this report in
7 late summer next year. Thank you, all, and I now draw
8 this hearing to an end. Thank you.
9 (3.48 pm)
10 (The hearing concluded)
11
12
13 I N D E X
14

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15 CS-A50 (read)
16 Summary of timeline of WITNESS 7
CS-A29 (read)
17
Summary of timeline of WITNESS 13
18 CS-A114 (read)
19 Summary of timeline of WITNESS 16
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21 CS-A51 (read)
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