Child Sexual Exploitation – what can we learn from Serious Case Reviews?

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Key Reviews to date

- Steady number of Serious Case Reviews in relation to CSE including:
  - Derby 2010
  - Rotherham (Child S) 2011
  - Torbay 2013
  - Rochdale 2013
  - Rotherham 2014 (Independent Inquiry)

Sian Griffiths 2015
What have SCRs told us about CSE so far?

- A valuable insight into the experience of young people who have been victimised.
- Detailed, complex analysis of the nature of the services provided, their strengths and weaknesses.
- Perspective from different parts of the country, different authorities – provides national insights.

**but**

- By its nature a very particular part of the story – important, but not the whole picture.

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What we have learnt? – is awareness of these symptoms in your collective DNA?

- Significantly missing from Education
- Frequently missing from home
- Early pregnancy and sexually transmitted infections
- Drug and alcohol misuse
- Self harm/overdoses
- Frequent A&E attendance
- Changes in behaviour/increasingly difficult behaviour
- Victims often targeted because they are vulnerable.

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Child Protection response to the young people in Rochdale

- Referrals to CSC predominantly led to NFA or referral to family support
- Ineffectiveness of CP plans – one young person on a plan for more than 4 years
- All of young people’s children were subject to Child Protection processes.
- Fundamental failings in safeguarding.
Rochdale (and others!): The Findings

- Lack of good strategic leadership
- Absence of multi-agency approach
- Decisions about prosecutions affected by view of witness credibility
- Health too often focused on clinical management not welfare
- Interventions often reactive – lack of review or clear practice framework.
The Findings: working with adolescents

- Capacity to work with adolescents with complex needs.
  - skills, training, organisational priorities, resources
- Attitudes towards the YPs the ‘lifestyle’ question.
- Failure to understand the impact of CSE and the capacity of young person to self protect.
- Focus predominantly on dealing with the young people’s ‘difficult behaviour’ not what was behind it.
- Failure to understand the needs of adolescents and the impact of adolescent neglect.

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The Findings – multi agency work

• Unresolved professional differences and conflicts
• Unwillingness to share information
• View of some professionals as ‘experts’ in CSE, deskills others.
• Not making links between the YPs – ‘bigger picture’
The Findings

Diversity: Race, Class, Gender, Culture

• Focus on ‘Asian’ men – what did this signify?
• No evidence of deliberate ‘political correctness’ …but …lack of discussion of race a concern.
• Also abused by white men and in family
• Impact of expectations & view of the YPs.

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Several other recent SCRS raise issues about the impact of race or culture in relation to perpetrators.

Complex issue – no easy answers, but must not be avoided.

History of polarised responses – racist generalisations / refusal to accept evidence of a problem

Low societal expectations and attitudes to class in relation to victims.

“it’s what they expected of our children”.

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What the victims of CSE need.....

- Respectful, non judgmental approach ‘*patience, empathy and perseverance*’.
- Time spent building and maintaining relationships.
- Support not only during, but after any prosecutions.
- Access to post abuse, specialist therapeutic services which can work with post traumatic stress.
- Long term intervention, not short term responses.

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Conclusions – where next?

- Lots of activity at strategic levels – specialist teams being developed. **But all professionals need to build confidence and knowledge.**
- Prevention/early help
- Sophisticated decision making re care pathways for young people, including the role of residential care.
- Good practice regarding transitions from care
- Importance of relationships between professionals and young people
- Urgent need for greater understanding of perpetrators
- Equipping parents and carers of young people to better understand and manage the risks
- Outreach and work with communities

....just for starters.....
Exercise: Health Check

What is the state of practice in Hertfordshire

1. Anything here familiar? – are these problems recognisable in Hertfordshire?
2. What would help to improve practice in Hertfordshire?
3. What can you do? what can the Board and senior leaders do?