Practice review report: Rochdale child sexual exploitation

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularity around multi-agency working. They will help to contextualise risk factors and raise questions about prevention within situations of known abuse, neglect and harm. They have been summarised to assist in this process, but more information is available in the actual review reports.

Context and background of review

The serious case review looked at six girls who suffered sexual exploitation in Heywood, Rochdale between 2007 and 2010.

A second serious case review looked at a separate case involving a seventh girl.

Nine men from Rochdale and Oldham were sentenced for up to 19 years in prison in May 2012 after being convicted of offences including rape.

Sir Peter Fahy, chief constable of Greater Manchester, denied his officers had failed to investigate allegations of rape made by underage girls before a decision was taken not to prosecute in 2008.

The view he put forward was that in most of those cases, the girls themselves did not regard themselves as victims and were not willing to make complaints. The police position is that a number of girls in Rochdale that they believe were being abused would not talk to them and, even if they did, they would not tell them about what was happening, much less make a complaint because that would mean triggering the criminal justice system.

Five of the girls had "clearly" needed help and intervention by safeguarding agencies before the abuse began.

Circumstances of, and challenges faced by, the individual

Six of the seven young people considered in the reviews were, for several years prior to being sexually exploited, in need of help and, at times, more proactive intervention by safeguarding agencies to protect them from what are described as "highly damaging experiences such as neglect, domestic violence, parental mental health problems and substance misuse."

There was no evidence of co-ordinated responses that took account of these risks. Had this approach been taken the reports conclude that "it must have been possible that the vulnerability of these young people could have been assessed and responded to at a much earlier stage".

What happened?

Greater Manchester Police (GMP) – Failure to recognise child sexual exploitation in the early stages.

Rochdale Social Services – Lack of organisational priority over child sexual exploitation, an unstable duty and assessment team, and a "chaotic" duty system.

Health services – GPs had explicit information that some of the girls were at risk "that could have helped them identify the possibility of sexual exploitation at earlier points".

Crown Prosecution Service (CPS) – Recognition of child sexual exploitation in the early years "was very poor", resulting in missed prosecution opportunities in 2008.

Why it happened?

In seeking to answer the question as to why such problems developed and persisted for so long, the reports outline the following system-wide failures:

- longstanding difficulties in achieving effective multi-agency working – both at senior level and in operational practice
- failure by strategic managers to focus on routine safeguarding practice and to understand how it was delivered
- lack of an evaluative culture focused on the experience of young people, outcomes and effective interventions
- under-resourcing resulting in high workloads and decision making influenced significantly by budget to the detriment of practice that would meet children's needs.

Report recommendations

In reviewing the work of the agencies between 2003 and 2012, the reviews have identified a widespread pattern of weaknesses and failings across all agencies at an organisational level, but also in terms of some individual practice. The reports conclude that the repeated nature of these failures exposes fundamental problems and obstacles at a strategic level over a period of years and that this undermined the agencies' ability to protect and safeguard young people.

In addition, the reports identify inadequacies in the following key areas:

- policy and procedures either not available or poorly understood and implemented on the frontline
- absence of high quality supervision, challenge and line management oversight
- resource pressures and high workloads in key agencies contributing to disorganisation and at times a sense of helplessness
- policies, culture and attitudes within many of the agencies, which were actively unhelpful when working with adolescents; and performance frameworks focused on quantitative practice not on the quality of practice or understanding the child's journey through services and outcomes.

Citation Griffiths, S. (2013) *The overview report of the serious case review in respect of Young People 1,2,3,4,5 & 6*. Rochdale: Rochdale Borough Safeguarding Children Board.