

NICCY Event

17 September 2015

Child Sexual Exploitation

- My thanks to the Commissioner for the opportunity to provide an update on the progress being made in response to Professor Marshall's Inquiry report. 9 key recommendations and 26 supporting recommendations are for the health and social care family – made up of the Department (DHSSPS), the HSCB and the five HSCTS.
- The background to the Inquiry has been alluded to by Professor Marshall and Detective Chief Superintendent George Clarke, PSNI. I do not intend to elaborate any further on the background other than to say that it was initiated by the then Minister for Health, Social Services and Public Safety, Edwin Poots, with the full support of the Education and Justice Ministers. I think it is fair to say that all three departments have worked very closely from the outset on child sexual exploitation and I hope that we will be able to demonstrate today that we are continuing to work together on the issue.

Hierarchy of child abuse

- Before I deal with how the HSC has responded to date to Professor Marshall's recommendations, I want to say something briefly about child sexual exploitation in general terms.

- The first point that I think that it is important to convey is that there is no hierarchy of child abuse. Child sexual exploitation is one form of child abuse. It is a particularly insidious form of child sexual abuse where the perpetrator grooms, manipulates and controls the victim for his (or indeed her) own gratification and that of others. Unfortunately, the HSC system grapples everyday with child abuse and, based on child protection registration figures for 2014/15, physical abuse was the highest category for children on the register at 30%, followed by neglect at 28%.
- Of course we need to ensure that we have a thorough and robust approach to tackling child sexual exploitation coupled with purposeful and sensitive responses to those at risk, to victims and their families – that is beyond dispute.
- However, it is also important that our response is considered, measured, balanced and proportionate – in Professor Marshall’s own words - no sole focus on looked-after children, no panicked response, no lurching towards CSE as a stand-alone priority.
- An agreed definition of CSE is important. It unites us, gives us common purpose and a common understanding of exactly what we are dealing with. A working definition was previously agreed by the SBNI. A draft definition was included in the Department’s child safeguarding policy document, issued recently for consultation. In response to consultation, it has been suggested that we should adopt a definition of CSE agreed across the UK. As a result, it is our intention to further revise the

definition to do just that. The new definition, which will be included in the published revision of Co-operating to Safeguard Children will make it clear:

- that child sexual exploitation is a form of sexual abuse where children are sexually exploited for money, power or status;
 - that it can involve violent, humiliating and degrading sexual assaults and, in some cases, young people are persuaded or forced into exchanging sexual activity for money, drugs, gifts, affection or status;
 - that consent cannot be given, even where a child may believe they he or she is voluntarily engaging in sexual activity with the person who is exploiting them;
 - that it doesn't always involve physical contact and can happen online; and finally
 - that a significant number of children who are victims of sexual exploitation go missing from home, care and education at some point.
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- It is clear that CSE includes a wide range of activities, some are criminal, some are not. Understanding the abusiveness of these activities and how perpetrators manipulate and exploit children and young people for their own gratification is central to an effective response to CSE.
 - I particularly welcome Professor Marshall's emphasis on dealing with those who exploit – the perpetrators. It is of central importance that a

clear, unequivocal and consistent message is given that the responsibility for the sexual exploitation of a child or young person lies solely and squarely with the perpetrator. No inference should ever be made that a vulnerable child or young person has actively contributed to or is in any way responsible for her or his own abuse. This lesson has emerged forcibly from the harrowing accounts of the victims of the large-scale Child Sexual Exploitation scandals of Rotherham and Oxfordshire.

- This focus on the abuse and the abuser is how we think about other types of abuse in child protection terms. Take physical abuse, for example. Current definitions are unequivocal about who is responsible for that abuse, who is perpetrator and who is victim – they make no mention of the behaviour of the child or young person in relation to their abuse. That’s because it is totally irrelevant.
- Like any other victim, a child or young person who is the victim of CSE needs targeted help and support to deal with the aftermath of their sexual exploitation - that includes help and support to achieve justice for their ordeal. That support may also need to extend to traumatised parents, carers, and wider family. Other inquiries have taught us that many parents and carers have lived in fear, been threatened and intimidated and are victims of violence from perpetrators - some have had to move home and employment as a result of intimidation and publicity that has resulted from prosecutions and court action.

Recommendations

- It is a serious issue. It requires a serious response. I hope that by way of today's event we will be able to demonstrate just how seriously the HSC family has taken Professor Marshall's report and its recommendations, and the extent to which we have built on work undertaken by us to tackle CSE prior to the establishment of the Inquiry.
- Former Minister Wells, who took receipt of the Inquiry report, accepted all of the recommendations made for the HSC. We transferred ownership of a small number of recommendations because we were of the view that's where they belonged. For example, recommendations made for 'all agencies' were transferred to the SBNI as a partnership of safeguarding agencies - this was done with the agreement of the Interim Chair of the SBNI. 8 key recommendations and 24 supporting recommendations remain the responsibility of the HSC.

Analysis of HSC Recommendations

- In thematic terms, the recommendations for the HSC relate to legislation, strategy, policy, standards, guidance, training, awareness-raising and service provision. In many of the recommendations, Professor Marshall challenged us to assure ourselves that our existing systems and arrangements are sufficiently robust to deal with CSE. That has required us to examine our existing systems and arrangements and to strengthen them if necessary.

Oversight Structures

- From the outset we were determined to get the momentum going and to keep it going. For that reason, Bernie McNally was appointed to steer implementation of the HSC recommendations. Bernie is here today. She was appointed to add an element of independence to implementation. I'm sure Bernie won't mind me referring to her as being 'of' the HSC system – she is a former Director of Children's Services in the Belfast HSC Trust but, at the same time, she is sufficiently removed from the system to be able to provide a challenge function. Bernie is a member of the Marshall HSC Response Team, which is led by the Department's Chief Social Worker and Deputy Secretary, Seán Holland. The Response Team is also made up of senior officers, at Director level, in the HSCB, PHA and all five HSCTs. Bernie also leads a Marshall Implementation Group, the body responsible for taking forward individual recommendations, which accounts for its activities to the Response Team.
- A number of the recommendations are cross-departmental. For that reason, a cross-departmental Senior Officials Group, made up of Deputy Secretaries in the Departments of Health, Education and Justice, has been set up and is led by DHSSPS. It, too, is supported by an Implementation Group, which reports progress to it. I should note that DEL and DARD have recently joined the cross-departmental Implementation Group, specifically because of their responsibilities in the areas of further education, careers service and training.

- We are quickly moving towards the end of the first year of implementation and I can report that all groups have met quite a number of times in that period and that progress is being charted and monitored very closely. A HSC implementation plan was published in May of this year. Implementation of each recommendation is assigned to one of three phases with each phase running from November to October, starting in November 2014 (when the Inquiry report was published) through to November 2017. It is important to note that the published plan reflected the position at a snapshot in time. It will be supplemented by six monthly progress reports. The first HSC progress report is due in the coming weeks.
- We separately published a cross-departmental plan and the Departments of Education and Justice published their own plans. In response to a suggestion from the Children’s Commissioner, we are in the process of merging all four plans into a single composite plan. It is also intended to produce a single composite progress report. All plans and reports will be published on the DHSSPS website – a dedicated area on the website has been set up for the purpose.
- Implementation in the current circumstances, both political and financial, is not without challenge. Ongoing financial difficulties may require us to extend timescales or to moderate our original plans. Where this occurs, it will be reflected transparently in future progress reports.

- I am not proposing to take you through all of the HSC recommendations in detail. Time wouldn't allow me. I can report that work has started on all of them. Of the ten Phase 1 recommendations, nine are either complete or partially complete. Within Phase 2 (which is due to start in November 2015), one supporting recommendation is already complete, that is ahead of time, and one key recommendation and a further two supporting recommendations are partially complete. Also, two Phase 3 supporting recommendations are partially complete.
- We do not consider that all of the recommendations are equal either in terms of effort to deliver and/or potential impact - Professor Marshall's distinction between key and supporting recommendations reinforces the point. The higher-impact recommendations are of course the more challenging to deliver and will, consequently, take longer to deliver. They are also likely to be the more costly to deliver. Professor Marshall has given us the scope to create Northern Ireland solutions for Northern Ireland problems and to take account of Northern Ireland structures and existing best practice. For example, Supporting Recommendation 60 is written in exploratory terms - we have been tasked with considering the establishment of a model of Multi-agency Safeguarding Hub (a MASH), which takes into account the learning from Operation Owl, the co-located project at Willowfield, and the Regional CSE Group. The MASH is a GB creation designed to facilitate information sharing between key agencies and to improve access to early help. In responding to supporting recommendation 60, there were a number of factors which had to be considered - our integrated health and social care system; our established Gateway arrangements;

the Regional Emergency Social Work Service; Family Support Hub developments; the decision by the Chief Constable to make PSNI Public Protection Units co-terminous with HSC Trusts and to establish a Central Referral Unit. We consider that, combined, those factors enable us to successfully deliver a MASH-type model for Northern Ireland.

- Implementation of supporting recommendation 60 and a number of related recommendations is being progressed through a series of joint workshops involving PSNI and social services. CSE leads have been established in each HSC Trust and their co-location on a part-time basis in each of the 5 PPU is actively being pursued. Consideration is also being given to the potential to co-locate social work staff in the PSNI CRU, which as Detective Chief Superintendent Clarke has indicated has been operational since April of this year.
- In regular regional meetings which take place involving police and social services, data collected by the CRU is considered to identify trends in referrals. The data will also be used to assist in determining how best to maximise the co-location of social work staff within the CRU.
- Another recommendation, which I would like to mention is key recommendation 6, which relates to the creation of safe spaces for children and young people at risk of, subject to, or recovering from CSE, again taking account of models of best practice, international

human rights standards and, importantly, the views of young people. In response, we have engaged in a range of activities as follows:

- A literature review of national and international research into the concept of “Safe Spaces” has been undertaken to establish best practice in this area;
- A series of consultations and engagements with children and young people within the looked after system and with those who have subsequently left the system is being commissioned to help us understand, from young people’s perspectives, what actions could be undertaken to make them feel safer both within the care system and in the wider community;
- Local organisations, including VOYPIC, the Northern Ireland Commissioner for Children and Young People, Barnardo’s and NSPCC have all been consulted on how Safe Spaces could be operationalised in Northern Ireland;
- We have engaged with the Safeguarding Officers of the 11 new super councils to explore how community facilities, including parks and leisure services, can become safer places for young people;
- A number of recent developments are also relevant to implementation of key recommendation 6, including the Strategic Review of children’s residential care carried out by the

HSCB. As a result of that review, children's homes across Northern Ireland will accommodate smaller numbers of children; and specialist fostering services will provide a safe place where an assessment of need can be carried out when a child is at risk of or suspected to be subject to CSE. In addition, a specialist home for unaccompanied and trafficked young people has been established and is working well.

- **Other recommendations to note are:**

- Supporting **recommendation 15** which is being led by the HSCB - Regional guidance has been agreed and re-issued to both police and social workers on how to respond to children who go missing, both in terms of prevention and how to effectively capture information and evidence that might be used to disrupt or prosecute perpetrators. The guidance will be underpinned by joint training.
- In line with **supporting recommendation 18**, independent interviews for children, who return from a period of missing, are now standard practice and will be monitored through the monthly reports in children's homes and the LAC review process.
- In response to **Supporting recommendation 21** (ensuring adequate support for foster carers and foster children), a review of existing service provision is currently being undertaken by the HSCB and it will report in December 2015.

- **Key recommendation 11** recommends that we ensure that there are clear reporting pathways, 24 hours a day, seven days a week, for reporting concerns about children and young people, including CSE, with appropriate feedback provided to the individual or agency making the report. I can confirm that all 5 Trusts have a daytime single point of entry for all new referrals and arrangements for processing referrals; they acknowledge referrals through common template letters; and they have feedback mechanisms to those making referrals to HSC Trust gateway teams about children and young people, including those expressing concerns about CSE.
- Also, the Regional Emergency Social Work Service has an after-hours single point of entry for all referrals and has established clear feedback mechanisms to the relevant Trust on the next working day. The service is currently reviewing how they provide feedback to any individual who makes a referral out-of-hours. This will be subject to examination by the RQIA in the course of a planned child protection review.
- **Supporting recommendation 51** refers to ensuring that the availability of Recovery Orders under Article 69 of the Children Order is highlighted in guidance and training. Information on Recovery Orders and other legal remedies available to front-line practitioners has been developed by the HSCB and HSCTs and Trust CSE leads are involved in raising awareness of those remedies. In addition, the Department's child safeguarding policy, recently consulted on, makes specific reference to recovery orders.

- The challenges generated by technology are explored in the Marshall report and relatively recent events in Northern Ireland have demonstrated the devastating consequences of sexual exploitation facilitated by technology. We know that it can weaken parental control in the sense that it is more difficult for parents and carers to keep on top of the activities of their children. In response to the challenge, the Northern Ireland Executive has commissioned the SBNI to develop an e-safety strategy and action plan on its behalf. Work on development of the strategy is underway. It is intended to launch the strategy to coincide with Internet Safety Day in 2017. The development of the strategy has the full support, including financial support, of seven government departments.

Thematic review

- I want to say something briefly about the Thematic Review, which was undertaken by the SBNI in response to a direction from the DHSSPS Minister. Like the Marshall Inquiry, the Thematic Review was prompted by Operation Owl. However, unlike Marshall, it related to the cases of specific children in the care system, believed to have been the victims of sexual exploitation. The Department has received the final report from the Interim Chair of the SBNI and a process of engaging with the young people whose cases were reviewed is underway, managed by HSC Trusts as corporate parents. We want to ensure that all of the young people are made aware of the report, of what it contains, what it concludes and that they understand that it

will be published. By way of engagement, and in line with an agreement put in place with them, we also want to provide assurances to the young people that the report does not include information that would enable them to be identified.

- Subject to Ministerial approval, it is intended to publish the report when the process of engagement concludes.
- Finally, I want to pick up on a point raised with me by the Commissioner relating to some form of independent evaluation of how we are doing in terms of implementation of the Marshall recommendations. Clearly 3 inspectorates supported Professor Marshall in the conduct of her Inquiry. It is entirely within their gift, individually or jointly, to review how the 'system' in its widest sense has responded to the Inquiry recommendations. However, I think account needs to be taken of the Thematic Review and what it will potentially recommend, of review plans by the Policing Board relating to child sexual exploitation and the RQIA's intention to review implementation of the recommendations made in its 2011 child protection review. The HSC child protection and looked after systems in particular has been subject to a rolling programme of review over a number of years. It is important that we provide sufficient time to allow system improvements to become embedded before we subject the system to further review. In the interest of affording children and young people maximum protections, it is essential that we get the balance right.
- Thank you.