

# Independent assurance review of the effectiveness of multi-agency responses to child sexual exploitation in Greater Manchester

## Part Three

The review into Operation Span  
and the investigation of non-recent  
child sexual exploitation in Rochdale

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# Chapter 1. Introduction and context

## Introduction

- 1.1. In July 2017, the BBC broadcast *The Betrayed Girls*, a documentary about child sexual exploitation (CSE) in Greater Manchester. The documentary featured Sara Rowbotham, the coordinator of an NHS sexual health service in Rochdale known as the Crisis Intervention Team, part of Pennine Care NHS Foundation Trust. It also included Maggie Oliver<sup>1</sup>, a former Greater Manchester Police (GMP) detective. The documentary laid out the following concerns:
- The Crisis Intervention Team had notified GMP<sup>2</sup> and Rochdale Borough Council children's social care of “dozens” of cases of CSE prior to 2008, but both agencies failed to protect these children.
  - Lessons were not learned from the failure of GMP's Operation Augusta CSE investigation, and the same mistakes were repeated in its Operation Span.
  - While GMP hailed Operation Span as “*a fantastic result for British justice*”, GMP had been aware of the ‘on-street’ grooming of vulnerable children and the profile of offenders since 2004 but had failed to address these crimes.
  - During Operation Span, GMP chose not to record the numerous crimes committed against one child victim, even though she had provided significant evidence over a six-month period and identified many of her abusers in several identification parades. These perpetrators were potentially left to continue their abuse of other children.
- 1.2. In response to these allegations, in September 2017 Andy Burnham, the Mayor of Greater Manchester, commissioned the review team to undertake an independent assurance exercise into these matters. Our work has entailed four streams of work.
- As part of the first workstream, we considered Operation Augusta, a major police and social care investigation into CSE in the inner-city areas of Manchester. Our review also considered the premature death of 15-year-old Victoria Agoglia, a child in the care of Manchester City Council, who was seriously exploited and died of a drug overdose. In January 2020, Greater Manchester Combined Authority (GMCA) published our independent report,

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<sup>1</sup> Both Sara Rowbotham, the former co-ordinator of the Crisis Intervention Team, and Maggie Oliver, formerly Detective Constable Oliver, have asked to be referred to by name throughout this report.

<sup>2</sup> We refer to Greater Manchester Police throughout the remainder of this report as GMP.

*Part One: An assurance review of Operation Augusta.* This concluded that Operation Augusta was poorly resourced and closed prematurely, failing to protect the many children it had identified as victims and failing to address the criminal activities of the perpetrators.

- Our second workstream covered historic CSE in Oldham. In November 2019, the then Leader of Oldham Council and the Chair of Oldham Safeguarding Partnership wrote jointly to the Mayor and the Greater Manchester Safeguarding Standards Board's independent chair, requesting that a review into safeguarding practices in the borough of Oldham be included in the independent review team's assurance work. Our findings were published in our second report, *Part Two: The review into historic safeguarding practices in the borough of Oldham*, in June 2022.
- This is our third report, and it will focus on the sexual exploitation of children in Rochdale between 2004 and 2012, and specifically consider the allegations set out by both Sara Rowbotham and Maggie Oliver in 2017.
- Our fourth workstream will consider the current arrangements across Greater Manchester for reporting on the quality of multi-agency practice to address the risk of CSE. We had initially anticipated, as set out in the terms of reference, that we would undertake our own 'deep dive' review of practice. However, after consideration, the agencies elected towards the end of 2019 to put in place their own quality assurance processes. Our review will therefore focus on:
  - an analysis of the current peer review processes in place under the umbrella of the Greater Manchester complex safeguarding hub
  - an analysis of the criminal justice and broader outcomes for 74 children where we have concluded in this report that there is substantial evidence, they were being sexually exploited between 2002 and 2012
  - a consideration of the following GMP CSE operations:
    - Operation Green Jacket, which was launched in response to our first report
    - The second investigation into the exploitation and death of Victoria Agoglia
    - Operation Sherwood, which was launched after our second report
    - Operation Exmoor, which includes the offences against some of the children previously not included in Operation Span.

We also plan to interview those survivors who have approached the review team to reflect on their experiences with these recent operations in our final report.

## Context and background

- 1.3. Operation Span began in December 2010 and concluded with the conviction of nine men in May 2012 for serious sexual offences against children. These offences had been initially investigated between August 2008 and August 2009, but the Crown Prosecution Service (CPS) made the decision not to proceed with a prosecution on the basis that it viewed the main victim as “*unreliable*”. The case attracted significant media interest. Following the trial, GMP, Rochdale Borough Council and the CPS all made a public apology for the multiple failures that allowed the abuse of the children to continue for almost two years after it was first reported.
- 1.4. Assistant Chief Constable B, from GMP, said the force had already learned lessons since its failed investigation of 2008. They apologised for the quality of that work and for failing to challenge the CPS decision not to proceed with charges against the men in 2009. They said:
- “We could have dealt with issues around the 2008 investigation better than we did and we apologise to any victims that have suffered because of any failings about that investigation. At the time we did what we thought was best. Hindsight being wonderful we will probably look back and think we could have done some things better. We have learned lessons since 2008 and that has come out during the trial. If there is any light at the end of the tunnel in relation to 2008, it's that we are now in a much better place as a wider partnership of agencies dealing with some of these issues.”*
- 1.5. However, at the same time as the apology, a police source was reported as saying to the media:
- “Rochdale's Crisis Intervention Team<sup>3</sup>, set up to reduce teenage pregnancies, came across 'innumerable' vulnerable girls but did not always communicate with police and social services.”*
- 1.6. In June 2012, the Home Affairs Select Committee began its own investigation, publishing the findings in its report, *Child sexual exploitation and the response to localised grooming*. On 12 June 2012, the then Leader and the then Chief Executive of Rochdale Council (Chief Executive B) gave evidence to the

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<sup>3</sup> From 2002, the Heywood, Middleton and Rochdale Primary Care Trust commissioned sexual health services that specialised in the mobilisation of resources to meet the needs of vulnerable young people. This Crisis Intervention Team (CIT) was recommended in *Safeguarding Children Involved in Prostitution* (Department of Health, Home Office, Department for Education and Employment, 2000).



committee. Chief Executive B explained that they believed that there were 47 children who were either witnesses or victims, five of whom had been cited during the recent trial. They committed to reviewing all these 47 children but not to limit the review to just those 47.

- 1.7. In September 2012, the Rochdale Local Safeguarding Children Board (LSCB) published its *Review of Multi-agency Responses to the Sexual Exploitation of Children* report. This considered a child known as 'Suzie', one of the victims cited in the Operation Span trial. The report noted that the Crisis Intervention Team had made several referrals to children's social care services about Suzie, but these were not generally acted on by children's social care. The report made the following judgement:

*"The review found, therefore, that, while some organisations were consistently supportive in their response to Suzie, overall, child welfare organisations missed opportunities to provide a comprehensive, co-ordinated and timely response to her as a child in need and, in addition, the criminal justice system missed opportunities to bring the perpetrators to justice and so to protect Suzie and other young people from their criminal behaviours. It was not until 2011, that a comprehensive assessment of Suzie's needs was carried out and a support plan put in place; and it was 2012 before the alleged offenders were brought to trial."*

- 1.8. On 6 November 2012, Sara Rowbotham, the coordinator of the Crisis Intervention Team, gave evidence to the Home Affairs Select Committee. The Crisis Intervention Team was set up in 2002 to provide outreach advice and support to young people who required contraception and sexual health advice and support. In response to questioning, she explained that she had been making referrals to both police and children's social care since 2004:

*"We were making referrals from 2004, very explicit referrals, which absolutely highlighted for protective services that young people were incredibly vulnerable. I tried to be as articulate as I possibly could to make Children's Social Care aware of the level of concern."*

- 1.9. Sara Rowbotham went on to state that she had recently collated some figures from 2005 to 2011 and identified that her service had made 103 referrals. She also explained that as her referrals were not being responded to, she began to make the council's safeguarding children unit aware of the referrals she was making. She went on to refute any suggestion that the Crisis Intervention Team had not appropriately communicated its concerns to children's services.

1.10. In January 2013, two serious case review overview reports<sup>4</sup> into seven children sexually exploited in Rochdale were published by Rochdale LSCB. Within the report, there are several criticisms that the Crisis Intervention Team failed to communicate appropriately with the statutory agencies. We will consider the validity of these criticisms in Chapter 12.

1.11. We interviewed Maggie Oliver at the beginning of our review. She is now the founder and chair of the Maggie Oliver Foundation and is a former GMP detective with 16 years' service. Her strong view was that Operation Span was inappropriately curtailed and serious allegations presented by a key witness were never appropriately investigated. She had been reported in *The Guardian* (May 2017) as saying:

*"I'm speaking to kids who are telling me that even to this day they are seeing offenders that they've named, walking around Rochdale ... Somebody saw one in London; another person told me that one has moved around the corner from her ... That's why I'm saying things haven't changed, because those men have been named by those girls [to the police ...] and I know that they're still out there walking around."*

1.12. Maggie Oliver also alleged that several suspects were identified by victims and not subsequently apprehended. In our interview with Maggie Oliver, she made the following allegations:

- One victim, Child 44, was identified as being raped by many men but only one suspect was subsequently charged, and this was only for sexual activity with a child even though she was 12 years old at the time the rapes began. In fact, she was made pregnant when she was just 13 by one of her abusers. The allegation made by Maggie Oliver was that many of these men have still never been questioned for these offences and remain without any indication on their police records of the crimes they have been accused of. Similarly, this victim's nominal record only refers to the incident of having sex and not the multiple rapes she experienced. Maggie Oliver informed the review team that this victim, who is now an adult with three children and is in receipt of Disability Living Allowance, was allegedly chased down the street by relatives of her abuser just a few years previously. It was also alleged that the police failed to respond when it was reported to them.
- Another victim, Child 3, was identified as a victim at the start of Operation Span and pursued by police and asked to come on board as a key witness.

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<sup>4</sup> *The Overview Report of the Serious Case Review in respect of Young People 1, 2, 3, 4, 5 & 6 and The Overview Report of the Serious Case Review in respect of Young Person 7* (Rochdale LSCB, 2013).

However, her history of abuse had never been appropriately investigated, and she had subsequently been charged with an aggravated public order offence when she got into an altercation with one of her many abusers. Detective Constable Oliver alleged that this man spat in Child 3's face.

- Another victim, 'Amber'<sup>5</sup>, allegedly identified 20–30 men who had abused her and positively identified eight out of ten of her abusers in the first of three planned identification parades. Maggie Oliver stated that at this point GMP was reluctant to extend the operation and a decision was taken not to use this victim's evidence. Allegedly, none of Amber's interviews were put on the system, no crimes were recorded, and nothing was recorded in respect of the suspects. Subsequently, this victim was included in the indictment, without being informed, although she had never been arrested, charged, or interviewed under caution, and was completely unaware of this until she was told by Maggie Oliver after she had resigned from GMP, six months after the trial had ended. This victim had allegedly been identified through social media and been confronted by one of her abusers, who threatened to post her address online and firebomb the house in which she lived with her young children. When she reported this to the police, there was nothing on the system in respect of the abuse she had reported other than her being named on the indictment as a 'co-conspirator'. It was also alleged that the indictment led to children's social care starting care proceedings in relation to her two children, which were subsequently dismissed by the family court judge.

1.13. It has been put to us that the failure to tackle the offenders identified in Operation Augusta gave the perpetrators confidence that they were above the law. This was reinforced by the abortive investigation into sexual exploitation at two Rochdale restaurants and further reinforced by the limited scope of the main phase of the investigation. In short, there remained many men who had been accused of raping children who had never been arrested or questioned.

1.14. Furthermore, both Sara Rowbotham and Maggie Oliver asserted that in Operation Doublet, a follow-up operation to Operation Span, survivors were only given three opportunities to make a statement and if they refused, they were asked to sign a disclaimer stating they would not make an allegation in the future. Their view was that this was poor practice, contrary to a victim-centred approach, and reduced the opportunity to safeguard future victims of exploitation.

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<sup>5</sup> On receiving draft sections of our review report, 'Amber' requested that she be referred to throughout the remainder of the report by this pseudonym.

## Our methodology

- 1.15. We commenced our review by considering two databases created by the Crisis Intervention Team in early 2013. These were drawn to our attention by two of our interviewees who were formerly employed at the Crisis Intervention Team. One database was in respect of young people believed to be subject to, or at risk of, CSE. The other was in respect of those children linked to suspected perpetrators. From these databases, we selected a sample of 59 children to review in depth using the available records from GMP, Rochdale Council and the Crisis Intervention Team.
  
- 1.16. We undertook a full analysis of contemporary documentation relating to Operation Span. A complete list of the documentation we considered, and the interviews we held, is set out in Appendix D. It includes a review of the Operation Span HOLMES<sup>6</sup> account with respect to 30 children within our sample, audits completed by Rochdale Council on our sample of 59 children, the Operation Span senior investigating officer (SIO)'s policy book, and relevant minutes and reports. We had access to all the individual independent management reviews (IMRs) produced by GMP, Rochdale Council and Pennine Care NHS Foundation Trust. We asked Rochdale Council in May 2023 for a copy of the unredacted serious case reviews (relating to Young People 1–6 and Young Person 7). On 11 September 2023, we received notification from the current chair of the Rochdale Borough Safeguarding Children Partnership that they would not release to the review team the unredacted serious case reviews for legal reasons. We interviewed 12 individuals, including three survivors, two workers from the Crisis Intervention Team, the chair of the Rochdale LSCB at the time of the publication of the serious case review overview reports, the head of the Crown Prosecution Service North West complex case unit and former officers of GMP. We invited a further ten individuals for an interview. Two provided a joint written response and eight did not respond to our invitation.
  
- 1.17. We undertook a detailed documentary review of the major operations that preceded and followed Operation Span. This included the first investigation into exploitation at two restaurants in Rochdale between 2008 and 2009 and the investigation into CSE in Rochdale conducted in 2007. A full list of the documentation we considered is set out in Appendix D. It included the investigating officer's case book for the 2008/09 investigation, the GMP records in respect of three significant suspects, the log records kept by the

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<sup>6</sup> The Home Office Large Major Enquiry System (HOLMES) is computer system used by the police to manage serious and complex crime investigations.

investigating officer of the 2007 investigation and the SIO's policy book for Operation Doublet.

We interviewed one additional former GMP officer. We also invited a further five former GMP officers, but they did not respond to our invitation. One former Rochdale Council officer could not be traced.

- 1.18. The review team would like to formally record their appreciation to all those individuals who gave their own personal time and effort to contribute to the review process.

## **Timescales for completing this report**

- 1.19. We commenced our work in October 2017 with separate interviews of both Maggie Oliver and Sara Rowbotham. In the early days of our review, it was put to the review team on many occasions by senior officers of both GMP and Rochdale Council that, as mistakes had been publicly acknowledged, apologies provided and standards of practice improved, there was little merit in a further review of these well-documented events. Notwithstanding these concerns, it was clear to the steering group that oversaw the work of the review team, and was led by the Deputy Mayor of Greater Manchester, that assurance was required on the fundamental concerns set out in the BBC documentary *The Betrayed Girls* and the public statements of Maggie Oliver and Sara Rowbotham.
- 1.20. Our access to personal and sensitive relevant information to support this review had to be negotiated to ensure that the law regarding access to information was being followed and survivors' rights respected. In this respect, the legal advice given to Rochdale Council, GMP and the GMCA all differed. However, with the support of legal advice provided by GMCA's counsel, an agreement was reached that the information we requested could lawfully and appropriately be shared with the review team. We have set out detailed timescales in Appendix C. We first formally requested access to Rochdale Council's records in March 2018 and the council agreed to the arrangements for sharing this information with the review team in February 2021.
- 1.21. Following the publication of the Operation Augusta report in January 2020, GMP agreed to allow the review team access to the records it held on the 59 cases. At the point Rochdale Council gave its agreement, GMP became reluctant to allow the review team access to the records we required on our sample children. Both GMCA and GMP took individual advice from their

counsels in December 2020 and despite a meeting of the two counsels in May 2021, a way forward could not be agreed.

- 1.22. In June 2021, following the appointment of the force's new Chief Constable, GMP shared the legal advice it had originally received in December 2020. This explicitly stated that there was a legal basis for disclosure by GMP to the review team and that there was no limitation on the extent of the material requested, provided that the disclosure was done in an appropriate manner and with appropriate safeguards. In November 2021, GMP agreed to a data-sharing agreement with the review team. We therefore commenced our review of the data held by GMP in December 2021. In August 2022, GMP agreed to allow the review team to view information on individuals it deemed to be subject to a 'live investigation'.
- 1.23. Following our detailed review of the HOLMES account and a substantial amount of supporting information, we commenced our review of the audits on the 59 cases prepared by Rochdale Council. In 2023, we completed a due diligence 'deep dive', reviewing original case notes, meeting records and reports as required. This exercise demonstrated that the audits had been undertaken to a high standard and we were confident that we had been given access to all the information we needed to see to form a judgement on these children.
- 1.24. In the second half of 2022, we also negotiated a data-sharing agreement with the Pennine Care Trust, which released all the information we requested in March 2023. We completed our final interviews over the remaining months and presented our finished report to GMCA at the beginning of September 2023. Following a factual accuracy test and fair process review our report was released for publication in January 2024.
- 1.25. The next chapter is an executive summary in which we set out our main findings. The remainder of our report lays out the detailed evidence to support our conclusions. For clarity, we have also provided a summary at the beginning of each chapter. Throughout this report, we have quoted from the letters, reports and official records that were produced at the time. The terms 'prostitute', 'prostitution', 'soliciting' and 'escort' are sometimes used in these documents. This terminology was in common usage at the time, and we make no intended criticism of the authors who used this language. 'Child prostitution' was the term commonly used in legislation until 2015. Following a campaign by Ann Coffey MP, the Serious Crime Act 2015 replaced the term with 'child sexual exploitation'.

## Chapter 2. Executive summary

- 2.1. In July 2017, the BBC broadcast *The Betrayed Girls*, a documentary about child sexual exploitation (CSE) in Greater Manchester. The documentary featured Sara Rowbotham, the coordinator of a sexual health service in Rochdale known as the Crisis Intervention Team. It also included Maggie Oliver, formerly a detective with GMP. The documentary laid out the following concerns:
- The Crisis Intervention Team had notified GMP and Rochdale children’s social care of “dozens” of cases of child sexual exploitation prior to 2008 but these agencies failed to protect those children.
  - Lessons were not learned from the failure of Operation Augusta and the same mistakes were repeated in Operation Span.
  - While GMP hailed Operation Span as “*a fantastic result for British justice*”, since 2004 GMP had been aware of the ‘on-street’ grooming of vulnerable children and the profile of offenders but had failed to address these crimes.
  - During Operation Span, GMP chose not to record the numerous crimes committed against a child victim even though she had provided significant evidence over a six-month period and identified many of her abusers in several identification parades. These perpetrators were potentially left to continue their abuse of other children.
- 2.2. In response to these allegations, in September 2017, Andy Burnham, the Mayor of Greater Manchester, commissioned the review team to undertake an independent assurance exercise into these matters. Our first report covered Operation Augusta and was published in January 2020. Our second report covered Oldham Council and was published in June 2022.
- 2.3. This is our third report, and it focuses on the sexual exploitation of children in Rochdale between 2004 and 2012 and specifically the allegations set out in 2017 by both Sara Rowbotham, the former coordinator of the Crisis Intervention Team and Maggie Oliver, a former GMP detective. This chapter provides an executive summary of our main findings. Detailed evidence for our conclusions is set out in the subsequent chapters.
- 2.4. **2004–06: Evidence of widespread CSE in Rochdale.** We have found compelling evidence that there was widespread organised sexual exploitation of children within Rochdale from 2004 onwards. In December 2013, the Rochdale Local Safeguarding Children Board (LSCB) published two serious case review overview reports. These reviews covered seven children in total. Only three of the children were cited as victims in the 2012 Operation Span trials in respect

of exploitation by the gang linked to two takeaway restaurants in Rochdale in 2008. We have considered the histories of three children who were not part of Operation Span and had suffered sexual exploitation many years earlier. Their abuse was known to both GMP and Rochdale Council, but no meaningful action was taken to protect the children, disrupt the activities of their abusers or bring their abusers to justice.

- 2.5. We have established that Sara Rowbotham and her colleagues at the Crisis Intervention Team repeatedly shared their significant concerns during this period with the police and children's social care. They had begun to build up a wealth of information to suggest these and many other children were being sexually exploited by an organised crime gang led by two professional criminals, but the statutory agencies failed to respond appropriately to these numerous concerns.
- 2.6. Regrettably, we have found that the lessons to be learned from the tragic death of Victoria Agoglia in 2003 were not followed through by the actions of GMP. We have found many examples of children who disclosed exploitation not being protected from significant harm. The child's unwillingness to make a formal complaint was repeatedly used as an explanation for not pursuing these investigations. No disruptive or investigative action was taken to tackle these very dangerous individuals and children were left to be abused by them and subsequently by their associates. Additionally, no meaningful activity was taken to assess the risks these individuals posed to their own or other children they had contact with. Frustrated by the lack of action by both the police and children's social care, Sara Rowbotham and her colleagues began to map out the considerable information on the sexual exploitation provided by many children who used their service.
- 2.7. **The 2007 investigation.** In 2007, the Crisis Intervention Team alerted GMP and Rochdale Council to the presence of an organised crime group dealing in the sexual exploitation of many children in Rochdale. GMP identified the two leaders of this gang, Nominals 26 and 27, who were described by the investigating detective as "*prolific career criminals*". These men were believed to be using the children to also facilitate the gang's illicit dealing in Class A drugs. Some of these children had disclosed crimes not only to the Crisis Intervention Team but also to GMP.
- 2.8. Although there was a clear pattern of information encompassing several children that presented a potentially successful line of inquiry, GMP and its partners chose to not progress any investigation against these men as they were informed that the children were too frightened to assist any inquiry.



The information presented by the Crisis Intervention Team should have initiated a major police investigation, supported by partner agencies, into the detection and prosecution of the crimes committed against these children and the disruption of offending behaviour. The government guidance in place at the time<sup>7</sup> advised the police not to rely solely on victim testimony but to seek evidence to support charges such as grievous bodily harm, unlawful wounding, actual bodily harm, kidnapping, abduction, rape or indecent assault, racially motivated crime, drugs offences, tax evasion and, if the coercer was on benefits, social security fraud. The police also had at their disposal the issuing of risk of sexual harm orders and child abduction warning notices. Furthermore, a multi-agency approach was required to provide the ongoing protection of these children. Given the risk of significant harm, there was a clear statutory requirement to ensure that all these children, not just those currently known to children's social care, were appropriately assessed and protected from significant harm.

- 2.9. We conclude this was a serious failure to protect these children and agencies ignored the coercion and control these men were able to perpetrate on these children and their families. It was not for many years, and well after we had commenced our review, that any charges were brought against any of these men for the abuse they committed over this period.
- 2.10. A small-scale police investigation started in 2007, run by a single detective, but this did not focus on the criminal exploitation of children by the organised crime gang identified by the Crisis Intervention Team. This investigation resulted in no charges or convictions. GMP under-resourced the inquiry despite repeated requests for support by the officers involved. There is no evidence of a meaningful disruption strategy by GMP within this investigation and there is no evidence that GMP considered non-traditional covert policing opportunities. Furthermore, the statutory agencies did not consider the risk posed by the suspects to their own and other children they had contact with.
- 2.11. **August 2008 to July 2009: The first investigation into CSE at two restaurants in Rochdale.** On 6 August 2008, Child 41 was arrested on suspicion of causing criminal damage at a takeaway in Rochdale. Following her arrest, Child 41 disclosed that she had been raped and sexually assaulted by staff at a takeaway restaurant in Rochdale. Her disclosures led to a

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<sup>7</sup> *Safeguarding Children Involved in Prostitution: Supplementary Guidance to Working Together to Safeguard Children* (Department of Health, Home Office, Department for Education and Employment, 2000).

sequence of events culminating in the conviction of nine men almost two years later.

- 2.12. The story of Child 41, Child 44 and 'Amber' first entered the public domain during the trial of the Operation Span defendants in 2012. Amber has asked to be referred throughout the remainder of this report by her pseudonym 'Amber'. Child 41, Child 44 and Amber are all featured in *The Overview Report of the Serious Case Review in respect of Young People 1, 2, 3, 4, 5 & 6*, which set out many of the multi-agency failures in protecting these children.
- 2.13. We have looked in detail at the first unsuccessful investigation into CSE, concerning the gang centred around two takeaway restaurants in Rochdale. We have concluded that this investigation identified widespread sexual exploitation of many vulnerable children by at least 30 adult perpetrators. This was a complex inquiry and needed to be resourced accordingly.
- 2.14. Despite the investigating officer explicitly setting out the scale and complexity of the investigation, his superiors failed to support his request for additional resources. Consequently, the investigation only scraped the surface of what had occurred and ultimately the Crown Prosecution Service (CPS) determined that the main victim, Child 41, was an unreliable witness, and the available forensic evidence was problematic. Both the CPS and GMP apologised for this failure in 2012 after the conviction of the Operation Span defendants.
- 2.15. However, we have discovered that another child had also given evidence that she had been sexually exploited at the same venue. She had also provided a statement setting out how she had been a witness to the exploitation of other children by the same men who had raped Child 41. The detective responsible for investigating her crime failed to focus on her disclosure and as a result insufficient effort was put into identifying the man who raped her. It is our view that had this investigation been sufficiently resourced, and her complaints pursued with the rigour required, it may have strengthened the evidence to proceed with the prosecution.
- 2.16. In March 2009, Child 44, still only 13 years old, had a termination at Rochdale Hospital. GMP subsequently took possession of the foetus. The consent of neither Child 44 nor her mother was sought nor was either party informed of the retention of the foetus. The foetus was subsequently forensically examined but none of the DNA matches related to possible suspects in the investigation at the time. The Human Tissue Authority codes of practice came into force in July 2006, and stipulate that it is not an offence to retain human tissue for a DNA examination if it is for a criminal investigation. However, we regard it as highly

unacceptable that Child 44 and/or her parents were not informed of the retention and why GMP required it. Child 44 did not become aware of this information until 2011 when she was told by Detective Constable Oliver during Operation Span. The GMP independent management review (IMR) submitted to the Rochdale LSCB initially referred to this incident:

*“DS B faced an ethical and legal issue about an aborted foetus which had originated from Child 44, and which had been recovered by the police, who were exploring the option of extracting DNA from the foetus to support the criminal prosecution. The recovery of the foetus had taken place without Child 44’s knowledge or consent. This issue remained unresolved up to and after the point where the Crown Prosecution Service took the decision not to prosecute in these cases.”*

- 2.17. However, the final version of the IMR submitted to Rochdale LSCB serious case review panel was silent on this matter and the author explained to the review team that he had been asked to remove this. The IMR co-author informed the review team that this and other similar instructions had subsequently caused him and his colleague to stand down from their role as IMR authors. Nonetheless, the LSCB’s serious case review overview report did refer to this incident, but it falls short in openly criticising the actions of GMP for what we regard as a deplorable disregard for the victim's wishes and feelings.
- 2.18. Throughout this period Sara Rowbotham and her colleagues at the Crisis Intervention Team were informing both the police and children’s social care of the prevalence of CSE within the community, but both agencies failed to respond to these concerns with the rigour and immediacy the team’s concerns required. The multi-agency processes in place to identify and respond to complex child sexual abuse were weak and continued to be overly reliant on child victims making disclosures to law enforcement agencies as a way of keeping them safe. There is no evidence that meaningful multi-agency assessments were put in place for individuals who posed a risk to children.
- 2.19. We found only one record of an attempt at disruption based on liaison with Rochdale Council’s licensing department taxi enforcement team (presumably to seek to revoke an individual’s licence) and no evidence that covert tactics were considered. It has been suggested to the review team that in GMP, at that time, there was an unofficial understanding that covert resources would only be used for major and serious crime investigations such as murder, firearms offences and drug supply, and that this was the case across all police forces in England and Wales. While there may be some truth in this, it is also a fact that

the SIO<sup>8</sup> for Operation Augusta identified the need to explore covert opportunities in 2004, as did Detective Constable A in 2007. The failure to identify this investigation as one requiring an enhanced response with a suitably experienced and qualified SIO was a missed opportunity that would almost certainly have increased the opportunities for a successful criminal justice outcome.

2.20. All the evidence we have seen conclusively confirms that the police investigation came to an end after the CPS decided not to proceed with one victim, Child 41. This was despite GMP being aware of the names of many other victims and many other perpetrators. We conclude that GMP had put insufficient resources into the investigation and closed it down prematurely. As a result, many perpetrators were left to continue to abuse children and many more children were left vulnerable to exploitation during the following months and years.

2.21. **January 2010 to December 2010: The Sunrise Team at Rochdale.**

The Sunrise Team, a specialist multi-agency CSE team, had first been approved by Rochdale LSCB in 2008. Despite the urgency, funding was not agreed to commence until April 2009, and then for only two years. The team members did not start to assemble until the latter half of the year. A social worker was not assigned to the team until the end of 2009 and, even then, was given a substantial caseload by children's social care, diverting the social worker's full attention away from the team. It had originally been agreed that two experienced child protection police officers would be placed within the team, but the division was reluctant to release staff of this calibre. In early 2010, in the absence of suitably qualified and experienced individuals, Police Constable A<sup>9</sup> was placed within the team. Through research into past cases, Police Constable A identified a complex network of CSE within Rochdale. This coincided with the significant disclosures made by Child 44, initially to the Sunrise Team social worker, of the widescale abuse of children by up to 60 men.

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<sup>8</sup> Senior investigating officer.

<sup>9</sup> Police Constable A later progressed to being a detective. We refer in later sections to the same individual as Detective Constable F.

2.22. Following support from a GMP analyst and a tier five specialist interview advisor<sup>10</sup>, the responsible detective inspector submitted a compelling picture to their senior command team within the Rochdale division:

*“What is clearly emerging is an organised industry where vulnerable young children are being targeted for sexual abuse by processes including grooming with the use of money and gifts, threats of injury and/or death if non-compliant, and that is not just an issue within the Rochdale area.”*

2.23. Although the detective inspector requested additional staffing to support this complex operation, these resources were not made available. Once more, children were left at the mercy of their abusers because of an inadequate response by GMP and children’s social care to the serious exploitation of vulnerable children.

2.24. **December 2011 to May 2012: Operation Span.** It was not until December 2010, almost 12 months after Child 41’s disclosures, that GMP finally put in place a major incident team to tackle the exploitation centred around the two takeaway restaurants, first brought to its attention in August 2008. Operation Span, which led to the conviction in May 2012 of nine men, was described at the time by GMP as *“comprehensive and effective, mitigating threat risk and harm”*. However, we have found that Operation Span was a relatively limited offender-focused investigation that mainly addressed a small number of perpetrators who had not been prosecuted following the earlier disclosures in 2008.

2.25. Despite its apparent strategic importance, following the first Operation Span gold<sup>11</sup> group meeting, no further gold group meetings were held other than to coordinate the arrangements for the trial. The senior command at GMP appeared to have little ongoing oversight of progress. The operation suffered because of successive changes in leadership. The first SIO (SIO 1), an experienced detective superintendent, was intent on leading a victim-centred investigation and set out a commendable and comprehensive strategy.

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<sup>10</sup> A tier five interview advisor’s role encompasses three primary areas: (i) being a tactical interview adviser to act as a consultant to senior investigating officers in charge of the most serious investigations; (ii) coordinating interviews in complex cases across all interview specialisms; and (iii) developing interview strategies and tactics in particular cases or operations.

<sup>11</sup> The gold commander assumes and retains overall command for the operation or incident. They have overall responsibility and authority for the gold strategy and any tactical parameters that silver or bronze commanders should follow. The gold commander, however, should not make tactical decisions. They are responsible for ensuring that any tactics deployed are proportionate to the risks identified, meet the objectives of the strategy and are legally compliant, particularly in terms of the Human Rights Act 1998. The gold commander chairs the gold group or the strategic coordinating group (SCG).

However, SIO 1 was quickly replaced in February 2011 by a detective chief inspector (SIO 2) with no previous experience in managing a major operation. This officer was subsequently given responsibility for overseeing the public protection units as well as Operation Span, and was, a few months later, in August 2011, replaced by a detective inspector (SIO 3). These changes suggest the operation was not considered a priority by the GMP senior command team.

- 2.26. Operation Span's terms of reference were comprehensive. We have seen evidence that SIO 1 put in place a plan to identify all victims, implement a disruption strategy and use non-traditional covert policing tactics. However, within a short period, the investigation began to focus on a limited number of victims and witnesses who could support the prosecution of a small number of men identified as suspects from the beginning.
- 2.27. We have heard evidence that many victims gave interviews identifying numerous men who had exploited them in the belief these men would be charged with offences against them. We have found that many of these crimes were not formally recorded or investigated by GMP. Furthermore, promises to support the victims during and after the trial were not forthcoming and these young people were left to be harassed and intimidated by the men who had previously abused them. Although GMP required the engagement of these individuals to achieve a successful prosecution, it is not surprising, given the lack of support our interviewees described, that so many survivors declined to engage in subsequent investigations. We will describe this in more detail in Chapter 9 on Operation Doublet.
- 2.28. In summary, we conclude that while Operation Span successfully convicted nine men, it failed to address the numerous crimes and instances of exploitation brought to the notice of GMP and children's social care at the time. We conclude that during Operation Span, as alleged by both Maggie Oliver and Sara Rowbotham, many children's testimonies were ignored, and their abusers were not brought to justice. We conclude that in our judgement these allegations are credible.
- 2.29. In 2012, Operation Span was presented as having resolved the matter of CSE in Rochdale. However, the commendable and comprehensive investigative strategy set out by SIO 1 was not followed through after their departure. Nowhere in the public statements GMP and Rochdale Council made at the conclusion of the trial did they indicate that Operation Span had only scraped the surface of the problem and that many men who had serially abused children

had not been apprehended, including the organised crime gang first drawn to their attention in 2007.

- 2.30. **The indictment of Amber and the role of the CPS.** In January 2011, Amber was considered by SIO 1 as a critical witness to the successful outcome of Operation Span. It was known to the SIO that Amber had previously been arrested in 2009 on suspicion of procuring children on behalf of the men who were abusing her. We have established that this arrest was made, even though GMP and Rochdale children's social care were aware that she had been a victim of sexual exploitation and abuse for several years. Amber denied any role in procuring children when interviewed by the police.
- 2.31. In February 2011, the head of the complex case unit at CPS formally agreed that Amber would be designated as a victim, and she should never have been arrested in 2009. Following that decision, Detective Constable Oliver was officially tasked by SIO 1 to befriend Amber and her family and win her confidence to give evidence to the inquiry. Amber gave many hours of interviews, over many months, and identified a significant number of men who had abused her and other children.
- 2.32. In our interview with Detective Constable Oliver, she asserted that at some point in 2011 GMP became concerned that Amber's evidence was likely to expand the investigation beyond that which the dedicated resources would allow. Given the evidence we have seen, we believe, on the balance of probabilities, that this was the case. We note that GMP has since acknowledged that none of Amber's evidence was entered as crimes against her on the police system and did not form part of the forthcoming Operation Span trial.
- 2.33. In September 2011, it became apparent that the evidence that Amber held was critical to the successful prosecution of Operation Span. The CPS, in consultation with GMP, decided to name Amber as a co-conspirator in the sexual exploitation of other children and included her name on the indictment for the trial. We understand this was a legal tactical decision by the lead barrister for the prosecution to ensure the jury heard Amber's critical evidence to the case. This decision was made despite the previous commitments provided to Amber and in the full knowledge that she had been coerced by her abusers. We regard the lack of concern by GMP and the CPS for the impact on a vulnerable survivor as unacceptable. Amber was not informed that she would be named on the court indictment and was unable at any stage of the procedure to defend herself against these allegations. We can find no evidence to indicate that any consideration was given to how the decision would affect Amber

personally or what the repercussions of the decision might be for her family. By naming her as a co-conspirator, in our judgement, there was a foreseeable risk to her and her family's personal safety that was either ignored or not considered. We regard this as deplorable further abuse of a CSE survivor<sup>12</sup>.

- 2.34. Amber's exposure through the court process had a long-term damaging impact on her welfare. It is disappointing that, although the GMP and Rochdale individual management reviews and the serious case review overview report covered the period up to and including the Operation Span trial, none of these reports mentioned the treatment of Amber and the deleterious consequences of her designation as an offender rather than as a victim.
- 2.35. It was not until 12 April 2022 that the Chief Constable of GMP issued Amber with a public apology for failing to investigate the crimes against her and failing to recognise her as a child victim.
- 2.36. **2012–13: Operation Doublet.** Operation Doublet, initiated in May 2012, was triggered by growing concerns in the media that a significant number of perpetrators remained at large following Operation Span. As a follow-up investigation to Operation Span, we have reviewed the first phase of Operation Doublet during the period from May 2012 to December 2013.
- 2.37. The scope of Operation Doublet initially included some existing small-scale investigations and identified in total ten children as potential victims. It is concerning that Child 3, Child 44, and Amber were never included in this operation, given the significant evidence they had shared with GMP during the previous Operation Span investigation. Furthermore, detectives had committed to Child 3, during Operation Span, that she would at first be used as a witness and subsequently they would investigate the crimes committed against her. We regard this failure as particularly deplorable as Child 3 had disclosed significant abuse by the organised crime gang abusing children from 2004.
- 2.38. By November 2012, the SIO, Detective Chief Inspector D (SIO 4) had included 42 children in total in Operation Doublet. However, we have discovered that by

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<sup>12</sup> In response to our draft report the Chief Prosecutor for North West England at the time informed the review team that regardless of the merits of the decision there was no excuse for not informing Amber and he was not aware that she had not been.



October 2012 the multi-agency Child Sexual Exploitation Strategic Group chaired by the Rochdale divisional commander, Chief Superintendent C, had identified approximately 127 referrals of potential victims that had been made by the Crisis Intervention Team to children's social care but had not been acted on. This figure later grew to 260 potential victims, of which only 90 had been approached as part of Operation Doublet and its related operations. Despite the public outrage in respect of failed children in Rochdale, senior managers in both GMP and Rochdale Council decided to take no positive action in respect of the remaining 170 potential victims unless they formally came forward. SIO 4, to his credit, made several representations to Rochdale Council and his divisional commander expressing concern about the impact of this policy and setting out the risk of further reputational damage<sup>13</sup>.

- 2.39. This policy decision was not reversed until February 2013, after the media received a report that 34 children believed to have been sexually exploited had not been included in the Operation Doublet investigation. SIO 4 noted in the policy book that he believed the source of this story was the staff at the Crisis Intervention Team, who had become very concerned about the decision by the Child Sexual Exploitation Strategic Group to take no positive action on the large number of potential victims.
- 2.40. The media report led to the Pennine Care NHS Foundation Trust sending the list<sup>14</sup> of 54 children the Crisis Intervention Team believed had been victims of CSE to GMP. Operation Doublet had already considered 20 of these children, leaving 34 not being investigated. The decision was therefore taken by Chief Superintendent C that these 34 children would fall under the auspices of the Child Sexual Exploitation Strategic Group but that, in the first instance, they would be reviewed by Operation Doublet to ensure there were no overlaps in offenders. By March 2013, the number of potential victims not originally included in Operation Doublet and requiring further investigation had grown to 55.
- 2.41. Operation Doublet experienced a very high victim drop-out rate. We believe this was primarily because the operation did not have sufficient resources to work at the pace survivors felt comfortable with and to provide sufficient support and ongoing contact to sustain their commitment. Two of our interviewees

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<sup>13</sup> Detective Chief Superintendent C was not interviewed by the review team. Following receipt of the 'fair process' letter, Detective Chief Superintendent C informed the review team that they disagreed with this account but provided no detail in support of their view.

<sup>14</sup> It is this list that we have used as the basis of our sample (See Chapter 11. The children).

stated that they believe the survivors were given only three opportunities to make a formal statement to the investigation, and if they did not provide a statement after three approaches, they were required to sign a disclaimer to that effect. We can find no record of that policy being instigated in the SIO's policy book, but it would go some way to explain the high number of survivors who disengaged from the investigation. By June 2013, only five victims were still engaged with Operation Doublet and only four of these had made a formal complaint. The number of perpetrators identified at this point stood at 52. A further 34 potential victims still needed to be approached.

- 2.42. While the public face of GMP was reassuring the public that the investigation of the past exploitation of children in Rochdale was a priority, it is clear from our research that this was far from the case on the ground. As we have seen with earlier operations, the SIO for Operation Doublet repeatedly struggled to sustain sufficient resources to meet the demands of a complex investigation, and on many occasions, lost staff to support investigations that were viewed as a higher priority by his superiors. In April 2013, to meet the increase in the number of potential victims SIO 4 put in a request for 12 additional detectives. But the SIO was only granted permission to appoint eight agency staff for six months, a far from ideal situation when detectives were expected to be building relationships with survivors. In 2013, the MIT<sup>15</sup>, SOI 4's core team of detectives, was taken away on two separate occasions to assist with murder inquiries, and progress was also hindered by staff absences through sickness and holidays. At the end of September 2013, the SIO was informed they would be required to take responsibility for the serious sexual offences unit in addition to existing responsibilities with Operation Doublet. The SIO noted that they were highly concerned that this would affect their ability to manage Operation Doublet, and in November 2013 Assistant Chief Constable C, recognising this workload was unrealistic, replaced SIO 4 with another detective chief inspector.
- 2.43. Our terms of reference did not extend beyond December 2013. However, in November 2023, GMP provided the review team with a schedule of convictions resulting from the three major operations that have occurred following the conclusion of Operation Span. These were Operation Routh, Operation Doublet, and Operation Lytton. We have only included data concerning convictions and nothing in respect of future criminal trials to avoid publishing material that may inadvertently jeopardise a criminal prosecution. In summary, this information demonstrated that in total 30 men had been convicted and most had received lengthy prison sentences. While this is a significant number of

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<sup>15</sup> Major incident team.

successful convictions, we have noted that these trials only included 13 children in total, of whom only six had previously been known to the Crisis Intervention Team and are included in our cohort of 74 children. These findings are set out in the table in Chapter 9.

- 2.44. We do acknowledge the considerable amount of effort that was dedicated to achieving these successful convictions. Nonetheless, the number of children included in these trials was a very small proportion of the children who were known to be sexually exploited in Rochdale over the period we have covered. We will therefore return to this matter in our final report, when we will review the criminal justice outcomes and wider outcomes for the remaining 68 children where we have concluded in this report that there is substantial evidence, they were being sexually exploited between 2002 and 2012.
- 2.45. **Individuals who potentially pose a risk to children.** In our research we have identified at least 96 individuals who potentially pose a risk to children. We note there may be an element of duplication as some of the individuals we identified are recorded by only one name or a nickname. We believe this is only a proportion of the individuals engaged in CSE over this period.
- 2.46. We conclude that the successive operations we have considered failed to tackle the widespread exploitation of children by these men. The three major operations were consistently under-resourced in providing the necessary support to enable victims to disclose their abuse and for them to remain engaged with the investigation.
- 2.47. GMP and Rochdale Council failed throughout the period to consistently use disruption tactics to break up the activities of these men. There is only very limited evidence of GMP using child abduction warning notices and risk of sexual harm orders and very few examples of GMP liaising with the council's licensing and environmental health departments to tackle the sexual exploitation of children within the taxi and restaurant industries. This was even though the prevalence of CSE in these industries was well known to GMP and Rochdale Council.
- 2.48. There is little evidence, other than the individuals formally charged as part of Operation Span, that GMP and Rochdale children's social care conducted the necessary risk assessments in respect of the risk posed by the suspects to their own and other children they had contact with. The SIO recorded that a strategy meeting had concluded that:

*“None of the suspect’s children are in danger and case conferences will not be held about them.”*

- 2.49. We have not seen the assessments that were undertaken to support this conclusion, but we are aware that no assessment was undertaken on Nominal 6 by Oldham Council, and given his background and offences, this should have been addressed.
- 2.50. In conclusion, the statutory agencies made insufficient progress in Rochdale to identify and respond effectively to those who posed a risk to children, and we are not able to provide assurance that sufficient was done to bring those individuals to justice or protect other children whom they may have had contact with.
- 2.51. **The children.** Our review considered the effectiveness of responses to safeguarding children at risk of CSE from 2004 to the conclusion of Operation Span, including its overlap with the first phase of Operation Doublet. We therefore set the following tests to consider in relation to the records held by GMP and Rochdale Council.
- Was there a significant probability from the information on the files that the child was being sexually exploited?
  - Could we provide assurance that this abuse was appropriately addressed by either Greater Manchester Police or Rochdale Council? In this regard, we judged the response in line with the procedures that were in place at the time.
- 2.52. In our formal sample of 59 children, we concluded that there was a significant probability that 45 children had been sexually exploited. Of these 45, we found that we could only provide assurance that three children were appropriately protected by the statutory agencies. There were serious failures to protect the children in 37 cases.
- 2.53. We also considered an additional 52 children mentioned in the GMP and Rochdale Council files we reviewed, bringing the total number of children to 111. We believe there was a significant probability that 74 of the children we considered were being sexually exploited. Of these 74, we found that we could only provide assurance that three of them were appropriately protected by the protective agencies. There were serious failures to protect the children in 48 cases.

- 2.54. On 1 August 2023, we asked GMP to provide the review team with a list of all the criminal justice outcomes and a summary of the engagement with successive operations achieved on behalf of these 74 children. We will include an analysis of our findings in our fourth report.
- 2.55. We have judged the quality of practice by the policies and procedures in place at the time. While we accept that professional awareness of CSE has since improved, we have concluded that there was, at the time, a clear understanding of the prevalence of CSE within the borough. This knowledge was held by senior and middle managers in both GMP and children's social care. The legislative and procedural obligations to protect children from significant harm caused by CSE were clear and police and local authorities had a range of powers to intervene, protect children and disrupt offenders.
- 2.56. GMP failed to learn the lessons from the tragic death of Victoria Agoglia and the failure of Operation Augusta. The detection, disruption and prosecution of sexual offences against children were not given sufficient priority during the period covered by this review. Despite the clear evidence that organised crime gangs had been sexually exploiting children in Rochdale for many years, and the evidence of the prolific serial rape of countless children in Rochdale, it was not until January 2011 that GMP and Rochdale Council finally established a multi-agency CSE team in Rochdale and then it was only initially staffed by one inexperienced police constable and a social worker with a large caseload.
- 2.57. We regard this as a lamentable strategic failure by senior leaders in GMP and Rochdale Council. While so many of the failures have been put down to the individual approaches of frontline detectives, we have seen that investigations into CSE were, repeatedly, insufficiently resourced and supported given the scale of the offending within the Rochdale area. The missed opportunities to learn from the death of Victoria Agoglia and to prioritise an effective strategic response to the detection, disruption, and prosecution of organised CSE should firmly be laid at the door of the senior officers in GMP throughout this period.
- 2.58. **The allegation that the Crisis Intervention Team failed to appropriately refer its concerns to the statutory agencies.** On the conviction of the nine Operation Span defendants, a police source was quoted in the media as saying that the Crisis Intervention Team had come across innumerable vulnerable girls but did not always communicate this to the police and social services. In 2012, Sara Rowbotham, the coordinator of the Crisis Intervention Team, refuted this and informed the Home Affairs Select Committee that since 2004 her team had made 103 referrals of CSE to either GMP or Rochdale Council. She also stated these were not responded to appropriately.

- 2.59. However, the two serious case review overview reports published in 2013 explicitly criticised the Crisis Intervention Team for not following child protection procedures and for not communicating appropriately with other agencies, and the reports also disputed the contention that the Crisis Intervention Team had made the number of referrals suggested. However, we have established that by October 2012, the multi-agency CSE strategy group chaired by Chief Superintendent C<sup>16</sup> was aware of approximately 127 potential victims who had been referred by the Crisis Intervention Team to children's social care and that these referrals had not been acted on. This figure later grew to 260 potential victims. This information was clear to all the partners three months before the publication of the serious case review overview reports in December 2013. We find this level of misrepresentation quite disturbing. We would have liked to have put our concerns to both the author of the overview reports and the chair of the serious case review panel. These individuals provided a joint written statement that did not directly address these concerns and they declined to be interviewed by the review team.
- 2.60. In contrast, our review has found compelling evidence to support the view that the Crisis Intervention Team was sharing explicit information with the authorities on the exploitation of multiple children. We also have evidence that, despite these explicit concerns, GMP and Rochdale Council failed to take appropriate action.
- 2.61. For several years, Sara Rowbotham and her colleagues were lone voices in raising concerns about the sexual exploitation and abuse of these children. Both GMP and Rochdale Council failed to respond appropriately to their concerns, and it has been a gross misrepresentation to suggest that the Crisis Intervention Team in some way was complicit with this failure and to tarnish the reputation of this small group of professionals.

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<sup>16</sup> Chief Superintendent C was not interviewed by the review team. Following receipt of the 'fair process' letter, Chief Superintendent C informed the review team that they disagreed with this account but provided no detail in support of their view.

# Chapter 3. 2004–06: Evidence of widespread child sexual exploitation in Rochdale

## Summary and conclusions

- 3.1. We have found compelling evidence that there was widespread organised sexual exploitation of children in Rochdale from 2004 onwards. In December 2013, the Rochdale Local Safeguarding Children Board (LSCB) published two serious case review overview reports. These reviews covered seven children in total. Only three of these children were cited as victims during the 2012 Operation Span trial, in respect of exploitation linked to two takeaway restaurants in Rochdale in 2008. We will cover the investigation that led to that trial in Chapter 7. However, this chapter will focus on three children who suffered sexual exploitation many years earlier. Their abuse was known to both GMP and Rochdale Council, but no meaningful action was taken to disrupt or prosecute their abusers or assess the risk posed by their abusers to their own or other children.
- 3.2. We have established that Sara Rowbotham, and her colleagues repeatedly shared their significant concerns about this child sexual exploitation (CSE) to the police and children's social care. They had begun to build up a wealth of information to suggest these and many other children were being sexually exploited by an organised crime gang led by two professional criminals, but the statutory agencies failed to respond appropriately to these numerous concerns.
- 3.3. Regrettably, we have found that the lessons to be learned from the tragic death of Victoria Agoglia in 2003 were not followed through by the actions of GMP. We have found many examples of children who disclosed exploitation not being protected from significant harm. The child's unwillingness to make a formal complaint was repeatedly used as an explanation for not pursuing these investigations. No disruptive or investigative action was taken to tackle these very dangerous individuals and children were left to be abused by them and subsequently by their associates.

## Detailed findings: 2004–06: Evidence of widespread child sexual exploitation in Rochdale

- 3.4. In our first report on Operation Augusta<sup>17</sup>, we looked at the severe exploitation and death of Victoria Agoglia in 2003. In summary, in the two years before her death, while in the care of Manchester City Council, Victoria Agoglia was *“repeatedly threatened, assaulted, returned intoxicated and in distress, gave information that she was involved in sexual exploitation, alleged rape, and sexual assault requiring medical attention, became involved in the criminal justice system and had several pregnancy scares”*<sup>18</sup>. In our report we noted there was evidence of some multi-agency meetings, but not one of these occasions resulted in a Section 47<sup>19</sup> child protection investigation to protect Victoria from significant harm.
- 3.5. A Part 8<sup>20</sup> review report was commissioned following Victoria’s death and was completed in September 2004. It made two specific recommendations relevant to our work in Rochdale:
- Recommendation 4.10: *“In line with recommendations (71–72) from the Bichard Inquiry relating to the reporting of sexual offences against children and subsequent action and recommendation 98 of Lord Laming’s inquiry, the police should be informed of each and every occasion where a criminal offence is alleged to have been committed against a child.”*
  - Recommendation 4.11: *“Joint police and social services investigation should take place where there is evidence that a child is involved in commercial sexual exploitation, this should occur in all circumstances, including those when a child refuses to make a complaint. There should never be an expectation that vulnerable children/young people can provide protection for themselves.”*

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<sup>17</sup> *Part One: An assurance review of Operation Augusta* (Malcolm Newsam CBE and Gary Ridgway, December 2019).

<sup>18</sup> *The report of the Part 8 review panel in respect of Victoria Byrne* (City of Manchester Area Child Protection Committee, September 2004).

<sup>19</sup> When a child is suspected to be suffering, or likely to suffer, significant harm, the local authority is required by Section 47 of the Children Act 1989 to make enquiries to enable it to decide whether it should take any action to safeguard and promote the welfare of the child.

<sup>20</sup> *Working together to safeguard children* (1991) followed the Children Act 1989 and introduced ‘Part 8’, setting out the following duty: *“Whenever a case involves an incident leading to the death of a child where child abuse is confirmed or suspected, or a child protection issue likely to be of major public concern arises, there should be an individual review by each agency and a composite review by the ACPC [area child protection committee].”*



- 3.6. Regrettably, we have found that the lessons to be learned from the tragic death of Victoria Agoglia in 2003 were not followed through by the actions of GMP. We have found many examples in the case studies we considered of children who disclosed exploitation continuing not to be protected from significant harm and the child's unwillingness to make a formal complaint being repeatedly used as an explanation for not pursuing these investigations and tackling their abusers.
- 3.7. In December 2013, the Rochdale LSCB published two serious case review overview reports<sup>21</sup>. These covered seven children in total. Only three of the children were cited as victims in the 2012 Operation Span trials in respect of exploitation linked to two takeaway restaurants in Rochdale in 2008. We will cover the investigation that led to that trial in Chapter 7. However, four of the children were also the victims of CSE many years earlier. Their abuse was known to both GMP and Rochdale Council, but no meaningful action was taken to disrupt or prosecute their abusers. In this chapter, we will set out the experience of Child 1 and Child 8 prior to 2007 alongside the experiences of other children. The two remaining children included in the serious case reviews, Child 9 and Child 34 will feature in our later chapters.
- 3.8. As early as 2005, the Crisis Intervention Team was drawing the attention of the protective agencies to the widespread sexual exploitation of children in Rochdale. The following cases are illustrative of the nature of this abuse.

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<sup>21</sup> *Working together to safeguard children* (2010), the statutory guidance in place at the time, states that a serious case review must:

- establish what lessons are to be learned from the case about the way in which local practitioners and organisations work individually and together to safeguard and promote the welfare of children
- identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- improve intra and inter-agency working and better safeguard and promote the welfare of children.

## Child 1

- 3.9. Child 1 was one of the seven children considered by the serious case reviews following the conclusion of Operation Span. She was not included as a victim or witness in Operation Span. There are striking similarities between the circumstances surrounding Victoria Agoglia and Child 1. They were both identified at an early age as being vulnerable to sexual exploitation. They were both in the care of the local authority and both followed a similar pattern of regular absconding alongside evidence of substance misuse and sexual exploitation by older men. The Crisis Intervention Team began working with Child 1 in respect of sexual health in December 2004 following a referral to a health practitioner in another NHS service.
- 3.10. At the start of 2005, a health provider reported concerns to Rochdale children's social care that Child 1 had disclosed having unprotected anal sex with an Asian<sup>22</sup> man the previous week.
- 3.11. In April 2005, Child 1 was reported to be meeting "Asian men" and "having sexual intercourse with them". Child 1 was still only 14 at the time.
- 3.12. At a further professional meeting in April 2005, Sara Rowbotham, the Crisis Intervention Team coordinator, set out major concerns about Child 1's vulnerability concerning the number of abusive partners she had.
- In May 2005, Sara Rowbotham, clearly still concerned, faxed a chronology to Child 1's social worker. This chronology set out recent incidents:  
*"Child 1 also admitted to having had loads of sexual partners and had engaged in [explicit description of profound sexual abuse]. She also stated that sometimes this was against her will and that if she didn't do what some men asked for, they would hit her and therefore she had to do what they wanted."*
  - In June 2005, a worker from the Crisis Intervention Team spoke directly to Child 1's social worker, noting:  
*"Spoke to [social worker] and shared concerns re XXX. i.e. XXX is married and has a property. XXX is often talked about by Child 5 as a man who*

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<sup>22</sup> We have throughout much of this report used the term 'Asian' as this was how the ethnic origin of the suspected perpetrators was most commonly described in the contemporaneous records we have considered. Where the ethnic origin has been more accurately described we use the specific description.

*organises parties, invites teenage girls, and encourages them to have sex with his friends. He also drives a taxi (XXXXXXXXX). Child 1 recently gave XXX [money] because he told her she had [damaged his possessions]. He also asked her to give him £10. [Two Crisis Intervention Team workers] have done a home visit this morning and suggested that Child 1 should be placed into a secure unit.”*

- 3.13. In summary, we have found substantial evidence that the Crisis Intervention Team shared concerns about Child 1 with Rochdale children’s services on many other occasions. The team believed that Child 1 was only one of many children being sexually exploited by an organised network in Rochdale. When Child 1 was 14 she told the team that Nominal 26 was her boyfriend. Nominal 27 had recently introduced her to several of his friends and the Crisis Intervention Team believed she had been forced to engage in sexual activity with all of them.

Neither GMP nor Rochdale Council addressed this threat to children nor was there any attempt to disrupt or remove the threat presented by these men or their associates.

### **Child 3**

- Child 3 was included as a witness in Operation Span but none of the offences against her have ever been brought to court. Child 3 is one of the adult survivors we interviewed as part of our research.
- In the middle of 2006, when she was 15 years old, the Crisis Intervention Team flagged up concerns about Child 3, believing she was being exploited by the same network of men. Child 3 had named Nominal 26 as one of her boyfriends, saying that he loved her and had bought her presents.
- At a ‘child in need’ meeting convened by Child 3’s school, Sara Rowbotham reported:

*“Indications are that she is associating with two or more older men who at present have a great deal of power over her ... She is seen to be in a very vulnerable position in which she is being subtly manipulated to feel she is being loved and cared for whilst she is being distanced from her family and those who are trying to support her. [The coordinator] feels that this is a classic situation where she is being groomed for prostitution.”*
- On 3 August 2006, Child 3 was referred to Rochdale children’s social care by the headteacher at her school. The duty social worker who took the referral noted:

*“School is concerned that [Child 3] (14) is very vulnerable at present and believes Child 3 may be at risk of being sexually abused and exploited as a result of social activities and relationships with 2 or more adult men.”*

- On 10 November 2006, a strategy meeting was held to discuss concerns about Child 3. The notes of the meeting record the child coming to school with expensive gifts such as a £500 phone and a £400 necklace given to her by “Asian” men. The Crisis Intervention Team worker recalled having concerns in June 2006 that the child was being groomed for prostitution. The social worker concluded that there was no role for children’s social care, given the number of professionals already working with Child 3. The other agencies did not agree with that decision and, as a result, a strategy meeting was held on 7 December 2006. Nonetheless, the case was closed in December 2006. The file noted that childcare services had undertaken an assessment and there would be no further involvement from them because the concerns could not be evidenced.

- 3.14. This was an unsatisfactory response given the level of concern about Child 3, which should have led to a formal child protection investigation by police and children’s social care, given the risk of significant harm to Child 3.

## **Child 8**

- 3.15. Child 8 was considered by the Rochdale LSCB serious case review. She was not included as a witness or a victim in Operation Span. The Crisis Intervention Team had good reason to believe she was being sexually exploited by the same men who were abusing other children the team had also raised concerns about to the statutory agencies. Child 8 had disclosed her involvement in carrying packages for Nominal 26 across to a town in Yorkshire. The Crisis Intervention Team believed that Child 8 was also regularly used for sexual services by Nominal 26 and his associates. She was too scared to share this information with the police.
- 3.16. Between 2004 and 2006 the Crisis Intervention Team had the following concerns:
- In the second half of 2004, Child 8 was reported to the police as missing from her home on numerous occasions. She would be absent for several hours and over time the reports became more concerning. On 2 July her mother reported she believed Child 8 was “*in the company of Asian males*” ,
  - The Crisis Intervention Team coordinator included Child 8 in a letter to Rochdale Council’s safeguarding children’s unit on 15 March 2005 indicating young people who were vulnerable to sexual exploitation. She copied in the Pennine Care NHS Foundation Trust’s named nurse for child protection.

- In the second half of 2005, one of Child 8's relatives contacted the police to report that another relative had told him Child 8 had been to a named hotel with an Asian man. The police went to speak to Child 8 but she denied being at a hotel with an Asian man. No further action was taken by the police. This response was inadequate and should have included further investigation at the hotel to identify any possible witnesses and possible evidence from CCTV, financial records, or forensic recovery.
- In October 2005, Child 8 disclosed that while missing from home she had got in a car with two Asian men. She said they bought vodka and then drove her to a remote location where, she alleged, she was physically assaulted and raped by both men. The police investigation into her allegation took 17 months to conclude. Regrettably, the Crown Prosecution Service (CPS) decided that no further action would be taken even though the detective inspector leading the investigation appealed this decision.
- In February 2006, the Crisis Intervention Team again raised concerns with both children's social care and the safeguarding children's unit, noting:
 

*"Child 8 contacted crisis intervention ... yesterday complaining about pains, she was covered in love bites and bruises and said she had spent the night with four Asian men in a hotel but can't remember what happened."*

Although a social worker visited the family, Sara Rowbotham was informed that children's social care was unable to intervene *"as Child 8 was now 16 years of age"*. We consider this response as inadequate. Child 8 was still a child at the time and the circumstances required an assessment given the allegation of non-censual sexual exploitation.

- 3.17. While we have focused in this chapter on the exploitation before 2007 of Child 1, Child 3 and Child 8, this was very much just the tip of the iceberg. During our research we have identified numerous other children who were being exploited at the same time and who were drawn to the attention of the authorities by Sara Rowbotham.

### **Child 37**

- When Child 37 was still only 13, she went to the local police station to report that she had been in the park with another child and met four Asian men. She explained that she had consented to sexual intercourse with one of the men in the park but was then raped by another man. Child 37 was subsequently placed into police protection in the same month. However, as Child 37 did not consent to a medical or video interview, GMP recorded the crime as requiring no further action as there was insufficient evidence to proceed.

- A few weeks later Child 37 was located outside of Rochdale, where she had been staying with an Asian man, Nominal 43, who she had been having sex with. Child 37 was placed under a police protection order but refused to make a complaint or be interviewed. A social worker recorded:

*“Child 37’s choices and actions have ultimately led to her being involved in situations and having experiences that have exploited her level of immaturity and relative vulnerability.”*

- Significant incidents of exploitation continued to be reported by Child 37 for the rest of 2004 and 2005. but no further action was taken based on her refusal to make any formal statement to the police. Child 37 later gave birth to a child and the father was an adult male who was referred to as her ‘pimp’ but no action appears to have been taken against this man even though Child 37 was still just 15 years old.

## **Child 92**

- In early 2005, Child 92 (aged 16) was said to be in a relationship with a 19-year-old Asian man. Her parents were concerned that she had come home with bruising and bleeding. She was taken to hospital with severe injuries and the doctor said she was badly bruised and injured, consistent with signs of a sexual assault. Child 92 denied any assault and continued to see the Asian man.

## **Child 6**

- Child 6 reported being raped by two men, Nominal 26 and Nominal 39, in summer 2005. She told the police that she was given vodka, and when she woke in a house her clothes were dishevelled. She later withdrew her complaint. We were unable to locate the crime report on GMP records.

## **Child 2**

- On 19 December 2005, Sara Rowbotham reported to a multi-agency meeting concerns about Child 2 and her association with another child. It was noted at the meeting:

*“Child 2’s mother said that Child 2 had been ‘a different child since meeting [the other child]’. Child 2 was said to have made an allegation of rape against an Asian man. The coordinator of the CIT said that she had known Child 2 for 2 years. [The other child] was also known to CIT and ‘has been involved in sexual exploitation’.”*

## Child 4 and Child 5

- On 12 September 2006, Sara Rowbotham sent a referral letter to the duty assessment team at Rochdale social services in respect of Child 4 and Child 5:

*“I write to refer Child 5 with concerns she is actively working as a street prostitute. Child 5 was returned to her parent's address by the police who had caught her soliciting [Child 4]. Child 5 informed us that mum told her to leave following this incident and she is now staying with an older man ‘Nominal 31’ ... although Child 5 is over the age of consent she is very vulnerable to sexual exploitation. Please advise.”*

- 3.18. There was, therefore, by the end of 2006, compelling information that a significant number of children were being exploited within the Rochdale area, and this was regularly being drawn to the attention of both Rochdale Council and GMP by Crisis Intervention Team staff. We also conclude that more should have been done by both GMP and Rochdale Council to protect these children and investigate the crimes perpetrated against them. National guidance has progressed since that time, but there was still a clear expectation that children should be protected from significant harm and sexual exploitation.
- 3.19. The lessons to be learned from the tragic death of Victoria Agoglia in 2003 were not followed through in the actions of GMP. Children who disclosed exploitation were not protected from significant harm and the child's unwillingness to make a formal complaint was repeatedly used as an explanation for not pursuing these investigations and tackling their abusers.
- 3.20. Frustrated by the lack of action by both the police and children's social care, Sara Rowbotham and her colleagues began to map out the considerable evidence of sexual exploitation involving many children who used their service. We shall cover the details of this evidence and the response of both GMP and Rochdale children's services to these concerns in the next chapter.

# Chapter 4. The 2007 investigation into child sexual exploitation in Rochdale

## Summary and conclusions

- 4.1. In this chapter, we consider how the agencies charged with protecting children responded to the growing concerns flagged up by the Crisis Intervention Team coordinator and her co-workers in 2007.

We conclude that the Crisis Intervention Team and GMP believed they had identified an organised crime group dealing in the sexual exploitation of children. They also believed they had identified the two leaders of this gang, Nominals 26 and 27, who were described by the investigating detective as “*prolific career criminals*”. The Crisis Intervention Team had identified at least 11 children they believed had been sexually exploited by this gang. These men were believed to be also using the children to facilitate the gang’s illicit dealing in Class A drugs. Some of these children had disclosed crimes not only to the Crisis Intervention Team but also to GMP. Although there was a clear pattern of information encompassing several children that presented a potentially successful line of inquiry, GMP and Rochdale Council chose not to progress any investigation against these men as they were informed that the children were too frightened to assist any inquiry.

- 4.2. This should have initiated a major police investigation supported by Rochdale Council into the detection and prosecution of the crimes committed against these children, the disruption of offending behaviour and the mitigation of risk posed by potential perpetrators to other children they had access to. The government guidance in place at the time<sup>23</sup> advised the police not to rely solely on victim testimony but to seek evidence to support charges such as grievous bodily harm, unlawful wounding, actual bodily harm, kidnapping, abduction, rape or indecent assault, racially motivated crime, drugs offences, tax evasion and, if the coercer was on benefit, social security fraud. The police also had at their disposal the issuing of risk of sexual harm orders and child abduction warning notices. Furthermore, a multi-agency approach was required to provide the ongoing protection of these children. Given the risk of significant harm, there was a clear statutory requirement to ensure that all these children, not just

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<sup>23</sup> *Safeguarding Children Involved in Prostitution Supplementary Guidance to Working Together to Safeguard Children* (Department of Health, Home Office, Department for Education and Employment, 2000).



those currently known to children's social care, were appropriately assessed, and protected from significant harm.

- 4.3. We conclude this was a serious failure to protect these children. and agencies ignored the coercion and control these men were able to perpetrate on the children and their families. It was not for many years, and well after we had commenced our review, that charges were brought against any of these men for the abuse they committed over this period.
- 4.4. A small-scale police investigation began in 2007, run by a single detective (Detective Constable A), but did not focus on the criminal exploitation of children by the organised crime gang identified by the Crisis Intervention Team. This investigation resulted in no charges or convictions. GMP under-resourced the inquiry despite repeated requests for support by the officers involved.
- 4.5. There is no evidence of a meaningful disruption strategy by the GMP within this investigation and there is no evidence that GMP considered non-traditional covert policing opportunities. Furthermore, Rochdale Council did not consider the risk posed by the suspects to their own and other children they had contact with.

### **Detailed findings: The 2007 investigation into child sexual exploitation in Rochdale**

- 4.6. On 24 January 2007, the coordinator of the Crisis Intervention Team sent a letter, addressed to 'Safeguarding Children', to Rochdale Council's safeguarding children unit. This letter highlighted the team's concerns about manipulation, violence and sexual exploitation Child 1 had disclosed in 2005. Following Child 1's return to Rochdale in 2006, the Crisis Intervention Team was concerned about her continued vulnerability, and the letter noted:  
*"Child 1 remains very scared of the men she was previously assaulted by and it would appear that she is exposed to their threats /abuse again. Some of these men present themselves as boyfriends and will buy her alcohol to have sex with them. Others are not as subtle and from recent conversations we believe she has been forced to engage in sexual activity ... I believe she does not have the skills required to protect herself from the unwanted advances of predatory men and is very vulnerable to sexual manipulation/exploitation. In her current circumstances Crisis Intervention team believes she is at risk of significant harm."*

- 4.7. This letter prompted a strategy meeting about Child 1 on 29 January 2007. The police were represented by Detective Constable A. The minutes record that Sara Rowbotham told the meeting that:

*“There are lots of concerns, but Child 1 does not divulge information as she is afraid of triggering an investigation by professionals. However, it is known that there is a group of men who are violent and threatening towards Child 1 and they give her anything to make her have sex with them or their friends. She is significantly sexually abused by these men on a regular basis.”*

The meeting concluded:

*“Rochdale Childcare Services have had one referral in regard to the current situation. Childcare Services will not stay involved as the Young People’s Support Team will take the lead in this case. The role for childcare services is to gather information. The legal aspect is such that unless an interim care order was applied for there is no role. If there is a need for a section 47 it would return to childcare services.*

*“The police representative will talk to his superior officer about Child 1 and her situation and also about other young girls in similar circumstances as evidence is poor and is unlikely that any complaints will be made. Advice will be sought on how best to deal with the issue.”*

The minutes go on to record the following:

*“A discussion was also held amongst the professionals present at this meeting in relation to the issue of young English females who are seriously exploited by Asian males in this area. The chair queried whether a further meeting about sexual exploitation of girls should be arranged.”*

- 4.8. This was a wholly inadequate response to the significant risks set out before the strategy meeting. The meeting had heard compelling information that Child 1 was at risk of significant harm, but no Section 47 investigation had been commissioned or any plans put in place to prevent the serious harm that Child 1 was suffering.

- 4.9. On 29 January 2007, Sara Rowbotham wrote a further letter to the council. This letter focused on the exploitation of at least 11 children and their involvement with the two professional criminals we referred to in Chapter 3. These were Nominals 26 and 27. The letter said:

*“Crisis Intervention Team – Primary Sexual Health Services believe the young women named below have been exploited in a variety of forms by 2 Asian men [redacted] both named [Nominal 26 and 27]. The [redacted] is currently incarcerated, the [redacted]. Both men drove a [colour and make] car with the number plate [redacted].”*

- *Child 1 described both Nominal 26 and Nominal 27 as her boyfriend. (Nominal 26 when she was 14 years) Nominal 27 has recently introduced her to a number of his friends and we believe she has been forced to engage in sexual activity with all of them. She has stated that she is frightened of Nominal 27.*
- *Child 3 has named Nominal 26 as one of her boyfriends he loves her and has bought her presents.*
- *Child 4 Recently picked up by the Police soliciting ... and also entertained men at sex parties for Nominal 26.*
- *Child 5 Recently picked up by the police soliciting. Child 5 has long association with Nominal 26 whom she describes as her mate. She has stated that she has worked for Nominal 26 ... and having sex/drug parties there with his friends. Child 5 has also disclosed significant involvement with his drug dealing business.”*

The letter goes on to set out details in respect of children who the Crisis Intervention Team believed had been involved with the men over the past three years:

- *“Child 2 was accommodated for a short period by the Local Authority. Child 2’s life has moved on however during a difficult time Child 2 was associating with [two other children] and exposed to the same situations and experiences. Child 2 however was now [staying with a variety of men].*
- *Child 6 reported a serious sexual assault and violent attack by [Nominal 26] to G.M. Police during July 2005. She later withdrew her statement following threats of violence towards her family.*
- *Child 7 has disclosed a high number of sexual assaults by boyfriends including [Nominal 26] whom she described as her regular boyfriend for a number of months in 2005. During this time she disclosed a number of violent assaults against her by him.*
- *Child 8 has disclosed her involvement in carrying packages for [Nominal 26] across [name of town]. She is too scared to share this information with the Police. Crisis Intervention Team have great concerns that Child 8 is regularly used for sexual services by Nominal 26 and his associates.*
- *Child 9 was related to Child 8 and the report states ‘as above’.*
- *Child 10 was working as a prostitute/escort whilst [Nominal 26] was her boyfriend.*
- *Child 11. [Nominal 26] was named by Child 11 as her boyfriend however Crisis Intervention Team believe Child 11 was driven to [name of town] by him on a number of occasions and also used for sexual favours by his associates. Child 11 informed us that she was given drugs free of charge*

*for a period of time by [Nominal 26] then he started to insist she have sex with his mates for the drugs she had taken.”*

- 4.10. In this letter, Sara Rowbotham was very clear that in several of the cases the children were the subject of violent coercion and control by the two men and fearful of repercussions should they make any disclosures to the police.

The letter triggered a multi-agency strategy meeting held on 8 February 2007. The GMP's notes from that meeting recorded *“sexual exploitation of subject by Asian males in the red-light district of [area] Rochdale”*.

A further meeting was arranged for August 2008 *“for consideration of investigation/operation into the activities of Asian men using this subject and others for criminal sexual purposes”*.

- 4.11. The investigation was allocated to Detective Constable A and Detective Sergeant A. The second strategy meeting on 8 February 2007 was attended by Detective Inspector A and Detective Constable A. At this meeting, the Crisis Intervention Team coordinator set out further details that were known to her service. In her report to the meeting, she identified the two men by their full names and said:

*“There are a number of properties to which the girls go to entertain men. The girls have been given alcohol and drugs eg amphetamines cocaine ecstasy and have had sex with some men there. The girls have been taken to parties by car. The car registration is known but there are believed to be a group of men using it. Many of the girls are reluctant to make a complaint because they feel these men are the only ones who care for them. There have been reports of girls being forced to have sex with men, serious sexual assaults and Physical assaults. Threats were made to one girl and her family. This girl was left on the moors in a state of undress and did not know how she got there.”*

She also reported to the meeting:

*“Girls were taking packages to [name of town] for Suspect 26. One girl was left behind in [name of town] and staff from the Crisis Intervention Team had to collect her. Some of the girls are holding money and jewellery for Suspect 26.”*

- 4.12. The notes of the 8 February meeting record that Detective Inspector A advised that there had not been any complaints that had been followed through and the evidence available was not substantial enough to take forward to prosecution in isolation. However, this officer did acknowledge that other areas, such as Manchester and Oldham, had dealt with similar situations by getting information from all the children and putting the information forward in combination, particularly where the offenders were the same. The strategy meeting concluded that all agencies would feed into the police what they knew about

individual children in relation to Nominals 26 and 27. It was agreed this information would be passed to the Rochdale Council's safeguarding children unit, which would then forward it to the police. Although the meeting was attended by a team manager from children's social care, there were no actions for that service. This meeting agreed that a dedicated operation would be set up to address the serious issues raised and recorded that:

*"... the exact staffing/funding to be addressed by Detective Inspector A. At this stage, there was enough information for key agencies to be aware that there was systematic sexual exploitation of a number of young people".*

- 4.13. On 26 February 2007, another strategy meeting was held about Child 1. Detective Inspector A represented GMP and the coordinator from the Crisis Intervention Team attended. This strategy meeting heard evidence that Child 1 was regularly visiting a workplace where it was known her abusers worked, she was staying out until the early hours of the morning, had been seen in cars with a number of Asian men and had been taken to [name of town] by Asian men. The meeting concluded that an alternative placement should be sought for Child 1. Detective Constable A commented that more information was required on Nominals 26 and 27 and informed the meeting that:

*"The surveillance team may be willing to become involved to monitor the situation".*

- 4.14. There were no other recommendations about how to disrupt or apprehend the men who were believed to be exploiting Child 1 and the suggestion of surveillance was never followed through. There is no record of any consideration being given to assess the risk the men might pose to their own or other children they had contact with. Following the meeting, the chair of the strategy meeting sent a letter to all attendees, stating:

*"As agreed at the above meeting (8.02.07) I am writing to ask if your service/agency has any information regarding allegations that Nominal 26 and Nominal 27 have been sexually exploiting young people. Their names are [full name] (known as [nickname]) and his younger brother [full name] (known as [nicknames])."*

*The letter listed the 11 children who had spoken about their involvement with the two men over a number of years and added:*

*"[Detective Inspector A] from the Public Protection Investigation Unit has asked that agencies provide written information in chronological order about who has told them what and/or what they have observed. Please send any information to the Safeguarding Children Unit at the above address."*

- 4.15. The recommendations and actions from these strategy meetings for both Child 1 and the other 10 children believed to be at risk of sexual exploitation from this organised criminal gang were wholly inadequate. The Crisis Intervention Team had put forward substantive concerns that all 11 children might have been at risk of significant harm from these men. The unwillingness of the children to make formal complaints to the police was no reason not to progress a robust investigation into the risks these men, and the men who had superseded them, presented to these children. The statutory guidance in place at the time was explicit in this respect and the Part 8 review into the death of Victoria Agoglia had made the same point in 2004. Although Sara Rowbotham had brought forward evidence of multiple instances of CSE in the community, and these concerns were not disputed by any of the parties who attended the strategy meetings, we have found no evidence that the concerns in respect of Nominal 26 and Nominal 27 were ever followed through, primarily, we believe, because it was known the two men were currently in prison.
- 4.16. The police investigation made little progress during the first few months. A note indicates that Detective Constable A was initially on annual leave followed by a period of convalescence. Detective Sergeant A was on a course until 19 March 2007.
- 4.17. A further strategy meeting was held on 23 April 2007. Apologies were sent by Detective Inspector A. The minutes of the strategy meeting record that Detective Constable A advised that Nominals 26 and 27 were presently in custody:
- “It is believed that since [REDACTED] have been in custody other Asian males have taken over from them (new victims and new offenders). Information has been provided to the police. Further information can be collected but DC A believes this will not be sufficient. Direct evidence from the girls i.e. a complaint from them will be needed to prosecute. Anything less than this would present a weak case to court.”*
- 4.18. The meeting debated this position, and the chair noted that at an earlier meeting it was questioned why there needed to be a complaint made as in other areas of child protection this was not needed. The chair went on to refer to the minutes of the previous meeting on 8 February, which had been recorded:
- “At the last meeting, it was thought that DI A was saying that there may be a possible way forward but at this meeting, DC A is saying that this is not possible.”*

4.19. The meeting agreed that more information was needed from Detective Inspector A as it appeared that their views were being contradicted by Detective Constable A. However, the meeting disappointingly concluded:

*“In terms of the historical information provided this will not be going anywhere because the girls are not going to make complaints.”*

4.20. Given the level of concern about the children, and the full knowledge that new offenders had potentially moved in to continue the exploitation with new victims, the conclusions of the strategy meeting are far from satisfactory. These included:

- *“Information to be taken to the LSCB development officer who will be asked to pull together a group including police and Crown Prosecution Service to consider a way forward.*
- *The information that the Crisis Intervention Team has provided for the police and SCU about the girls (given it was provided by health for different reasons) to be returned. This was agreed at the meeting*
- *If anyone becomes aware of a young person being sexually exploited in the community, please make a note of details and pass to the SCU particularly if the child is under 13 years old. Details should also be emailed to the police.”*

The minutes record that no further meeting would be arranged.

4.21. These three recommendations give a revealing insight into the thinking at the time. There were significant concerns around the table for the welfare of the children and all the information before them was that these children were repeatedly being raped by a network of Asian men. No solutions were brought forward either by the police or children’s social care in the absence of statements from the victims, even though it was equally evident that the children feared retribution if they spoke to the protective agencies. The final recommendation supports the view of Sara Rowbotham and her colleagues that the appropriate route for notifying agencies of cases of CSE was through the safeguarding children unit and police, a practice that they were later criticised for in the Rochdale LSCB serious case review overview reports in 2013. Finally, the comment *“particularly if the child is under 13”* ignores the evidence of coercion and violence and portrays a significant lack of understanding regarding consent. Irrespective of their age, these children were disclosing that they were being raped and no child, whatever their age, could consent to this abuse.

4.22. Detective Constable A made their own record of the 23 April meeting:

*“The Manager Crisis Intervention Team/sexual health clinic has provided information from a number of the named victims of the sexual exploitation by the [REDACTED] named [name]. This information has been provided by*

*sexual health workers who have interviewed the child victims, the information has only been provided to the police on the provision that the victims remain anonymous because the health workers believe the victims would be placed at further serious risk of physical assault and intimidation.*

*“The information supplements the police intelligence but there is little if any direct evidence to assist police prosecutions. It is agreed by all professionals at the meeting that the named victims will not make any formal complaints to the police, they do not even wish to speak to Nightingale-trained officers. This is due to a number of reasons but the main two are they are scared of the suspects, or they see them as their boyfriends.*

*“I explain to the meeting that the police will consider any other available evidence to support a prosecution without the victim’s evidence when this is practicable and the fact that the child/young person is unwilling to give information/evidence that would not prevent an investigation and positive action being taken.*

*“I explain that, without a direct complaint or other corroborative evidence any police investigation into these matters would be inherently weak if based on hearsay evidence or second-hand information. Both the [Nominals] are prolific career criminals and are in custody serving lengthy sentences ... which are drug dealing linked.*

*“I explain there are two separate investigations required.*

- 1. Historic investigation into the sexual exploitation/abduction of numerous child victims by the [Nominals].*
- 2. A current and on-going dedicated multi-agency investigation into local Asian males who sexually exploit and facilitate sexual abuse of vulnerable female MFH (missing from homes), who are unlikely to complain due to a climate of fear/grooming etc.*

*“I explain that the police would attempt to prosecute suspects under Section 2 of the Child Abduction Act.*

*“Some of the agencies at the meeting failed to appreciate the difficulties encountered by the police in attempting to investigate these matters and felt that Asian males were untouchable, despite the main two being in custody. It was raised that if other divisions had dedicated sexual exploitation units to address these problems, why Rochdale could not have one.”*



4.23. The serious case review into Child 1 published by Rochdale LSCB in December 2013<sup>24</sup> stated:

*“In 2007, there was explicit recognition that Child 1 was one of a number of young women experiencing exploitation by a linked group of offenders. This led to three strategy meetings instigated by CSC [children’s social care] in 2007 specifically in relation to the multiple abuse of vulnerable young people. These meetings have been described as representing the first step leading to the recognition of the need for a joint approach to CSE and the development of the Sunrise Team in Rochdale. Whilst this is undoubtedly the case, progress in 2007 faltered quite quickly. Although a police investigation was initiated, Child 1’s case was not ultimately one of the young people subject to the investigation. The reason for this is recorded by the IMR [independent management review] as being due to Child 1’s unwillingness to co-operate. After the three initial meetings, no further strategy meetings were put in place and there was no other structured means for sharing the information.”*

4.24. We believe this gives an over-optimistic and inaccurate view of the situation at the time. We will show later that Operation Sunrise, a dedicated CSE team, was not set up in Rochdale until 2010 and remained under-resourced for some time thereafter. The main conclusion we draw from the strategy meetings in 2007 is as follows:

- The Crisis Intervention Team and GMP believed they had identified an organised crime group dealing in the sexual exploitation of children. They also believed they had identified the two leaders of this gang, Nominals 26 and 27, who were described by Detective Constable A as *“prolific career criminals”*. The Crisis Intervention Team had identified at least 11 children they believed had been sexually exploited by this gang and some of these children had disclosed crimes not only to the Crisis Intervention Team but also to GMP. Furthermore, it was clear that both the Crisis Intervention Team and GMP believed they had accurately identified the abusers as Nominals 26 and Nominal 27 and their associates. This should have initiated a full investigation into their activities as they were known to be dangerous professional criminals and were linked to the exploitation of several young children. Such an investigation was never undertaken and when Operation Doublet officer began their research many years later, they were unable to satisfactorily confirm that the men mentioned by these children were in fact Nominals 26 and 27. This was a serious failure by GMP in 2007, having been alerted in very specific terms to the nature of the abuse and provided with

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<sup>24</sup> *The Overview Report of the Serious Case Review in respect of Young Person 7.*

information that would have confirmed the men's identities beyond any reasonable doubt at the time.

- A major police investigation should have been launched, supported by Rochdale Council and other partner agencies, into the detection and prosecution of the crimes committed against these children and the disruption of offending behaviour, as well as the assessment of risk these men posed to their own and other children. The government guidance in place at the time<sup>25</sup> advised the police not to rely solely on victim testimony but to seek evidence to support charges such as grievous bodily harm, unlawful wounding, actual bodily harm, kidnapping, abduction, rape or indecent assault, racially motivated crime, drugs offences, tax evasion and, if the coercer was on benefit, social security fraud. The police also had at their disposal the issuing of risk of sexual harm orders and child abduction warning notices. Furthermore, a multi-agency approach was required to provide ongoing protection for these children. Given the risk of significant harm, there was a clear statutory requirement to ensure that all these children, not just those currently known to children's social care, were appropriately assessed and protected from significant harm.

4.25. The GMP independent management review (IMR) stated:

*“What the case of Child 1 clearly illustrates is that the widespread problem of CSE affecting the borough of Rochdale was known by the police and those statutory partner agencies which comprised the Local Safeguarding Children Board from January 2007. The failures to properly address and resource this sensitive issue with a structured partnership approach enabled the cycle of abuse to continue unchecked in Rochdale for a further four years. As partners of the Rochdale Safeguarding Children Board, Greater Manchester Police must accept its share of the responsibility for these serious failures and learn from the mistakes which were made.”*

The GMP IMR, written five years later in 2012, failed to mention that the police had still not initiated any investigation into Nominals 26 and 27 and the children they sexually exploited. We have seen evidence that suggests Operation Doublet started some preliminary enquiries but concluded there was insufficient information to corroborate the identity of the two suspects given the passage of time and their use of similar nicknames. An investigation into the historical activities of this gang did not begin until much later.

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<sup>25</sup> *Safeguarding Children Involved in Prostitution: Supplementary Guidance to Working Together to Safeguard Children* (Department of Health, Home Office, Department for Education and Employment, 2000).

4.26. On 26 April 2007, Detective Constable A asked Detective Sergeant A to get some clarity on the police response to this ongoing sensitive problem and look into the likelihood of a dedicated specialist unit being established.

4.27. On the same day, Detective Sergeant A sent a message to Detective Inspector A: *“Please can you consider the way forward with this investigation and how you wish it to progress?”*

1. *Technically it is not within our remit.*

2. *It is too much for [DC A] to deal with in isolation. Is there to be an incident set up or small unit as per other divisions?*

3. *The protocol launch for sexual exploitation is to be launched next week and I am sure we will be questioned on how the police are to progress this and other investigations of sexual exploitation we are carrying.*

4. *Can we have some guidance from senior management as to the divisional stance?”*

This message was also sent to another superior officer, identified by their number only, with the covering note:

*“Sir, could you look at this FSI [family support investigation] and my request for guidance above on the journal? Thanks.”*

There is no record of either Detective Inspector A or the other officer replying to this formal request.

4.28. The GMP IMR states:

*“Detective Constable A’s recollection of events surrounding these e-mails is that he was left to continue the investigation whilst Detective Inspector A, as head of the PPIU, made approaches to senior management regarding resourcing a multi-agency team to address the burgeoning sexual exploitation allegations.”*

4.29. However, it is clear from this correspondence that both Detective Constable A and Detective Sergeant A did not believe the very serious allegations raised at the strategy meeting in April 2007 could be satisfactorily investigated within their existing resources. The review team agrees with their judgement. There was at this point sufficient information to conclude that they were dealing with serious allegations of both historical and current sexual exploitation of multiple child victims by several suspects, some already known to the police. In our view, this should have triggered a divisional investigative assessment for consideration of a major incident team staffed through force-wide resources allocated by the force tasking group.

- 4.30. The investigation undertaken by Detective Constable A considered the following children:
- Two of the children the Crisis Intervention Team had linked to Nominals 26 and 27. These were included in the letter to the strategy meeting by Sara Rowbotham in January 2007.
  - A further five potential victims, two of whom were also known to the Crisis Intervention Team as being at risk of exploitation.<sup>26</sup> One of these five children was believed to be linked to Nominals 26 and 27.
- 4.31. However, it is clear from the records of the investigation that Detective Constable A did not consider the historical offences alleged to have been committed by Nominals 26 and 27 within their investigation. This was even the case when complaints were received by Child 4, who had been explicitly linked by the Crisis Intervention Team to Nominal 26. As Detective Constable A did not make herself available for an interview, we were unable to clarify the reasons for this exclusion.
- 4.32. In June 2007, Child 2 made it known to her Early Break adolescent services support worker that she wished to speak to the police. After two abortive attempts, she was interviewed but did not disclose sexual abuse or exploitation. She did, however, allege that her mobile phone had been taken off her by an Asian drug dealer to cover a cannabis debt.
- 4.33. In August 2007, Child 2 disclosed that while she was out with another child, (who she stated was working as a prostitute) they met several Asian men she referred to as that child's customers. One of these men, Nominal 1, asked Child 2 to perform a sexual act, and when she refused he threatened her with violence. In a video interview on 9 August 2007, she claimed that Nominal 2 'pimps' the other child out to his friends. Child 2 denied that she was being exploited by any Asian men other than the incident referred to. On the same day, a manager at Rochdale Council correctly advised the police that a strategy discussion was required to consider these allegations.
- 4.34. On 10 August 2007, Child 4 made it known that she wished to give information regarding sexual exploitation by Asian men. She was interviewed on 15 August and disclosed being groomed and sexually abused from the age of 15 by Nominal 2 and his friends. Child 4 also disclosed that she was paid to have

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<sup>26</sup> Child 8 and Child 9 were subjects of the serious case review published by Rochdale LSCB in December 2013.

sex with these men and that another child was also “*an active prostitute*”. She further disclosed that she had been sexually abused by another man, Nominal 3, when she was 14 years old. Child 2 was interviewed on the same day but denied being involved in any form of prostitution or exploitation.

4.35. On 24 August 2007, Sara Rowbotham sent the following letter:

*“To whom it may concern in respect of Child 2. Crisis intervention team believes that Child 2 has led and continues to lead a dangerous and risky lifestyle. Child 2’s vulnerability is exacerbated because of her close relationship with another child. During the time we have known her Child 2 has made numerous allegations of sexual assault /abuse and we believe she has been exposed to sexual manipulation by older men and has previously engaged in selling sex for goods and favours ... All information has been shared with police childcare services and Safeguarding Unit in particular our concerns relating to three men Nominal 2, Nominal 3, and Nominal 26.”*

4.36. A multi-agency strategy meeting was held on both children on 28 August 2007.

4.37. On 31 August 2007, a relative of one of the children notified the police that Child 2 had forewarned the men believed to be exploiting her about the investigation. However, the police did not arrest Nominal 2 until 18 September 2007. He admitted having had sex with Child 4, but only after she reached 16. Nominal 1 was arrested nine days later, on 27 September 2007, and admitted having sex with Child 4, but not until she was 16.

4.38. On 28 September 2007, the Crisis Intervention Team coordinator referred concerns about another child, Child 29, to Rochdale children’s social care. Her mother had explained that Child 29’s phone rang constantly and her phone book was full of male Asian names. Sara Rowbotham also referred to an incident known to social care that Child 29 had been in a locked room with two Asian men while she was under the influence of drugs and alcohol. Child 29 was only 13 at the time.

4.39. On 10 October 2007, Child 2 and Child 4 visited the police station to retract their allegations.

4.40. On 12 October 2007, Nominal 3 was arrested for the offence disclosed by Child 4 two months earlier. He admitted to allowing Child 4 to stay overnight at his house but denied the allegation.

4.41. On 15 November 2007, the police arrested Nominal 4. It is unclear from the record of the investigation what the allegations against him were. The investigatory record states:

*“The 4th suspect [Nominal 4] arrested 15/11/07, he denies the allegations totally despite being named by the victim and one of his co-accused.”* He was, however, picked out of an identity parade by Child 4 a few days later.

4.42. Child 4 subsequently provided the mobile number of a fifth suspect, who she alleged she had had consensual sex with while aged 15. It is unclear when she made this disclosure, but an interview was arranged to progress the matter. Child 4 failed to attend this interview and the investigator noted:

*“The investigation has again been delayed due to Child 4 failing to keep pre-arranged appointments, colluding with suspects, wishing to retract, etc. Child 4 is a very unreliable victim/witness.”*

4.43. On 2 April 2008, the investigating officer, Detective Constable A, wrote a summary of the investigation:

*“Despite the difficulties encountered by both victims, positive action has been taken against 5 suspects, I have not consulted with the Crown Prosecution Service as I do not believe we have sufficient evidence to convict the suspects. The two victims have been unreliable, suspected of colluding with the suspects, attempting to retract the complaints. 12 months on from my initial request for a dedicated unit being developed on this division (as Oldham and Manchester have) no decision has been made. The difficulty with this investigation is that Child 4 alleges consensual sexual activity for money after a period of grooming by one suspect. Child 4 maintains she was 15 when this started but cannot be sure of the exact dates. The suspects all claim she was over 16 and thought she looked older. Once over 16 Child 4 has developed this activity and continued to seek out these men for paid sex, in which she had a significant degree of control.”*

4.44. The final summary of the investigation concluded:

*“Police decision not to proceed, numerous difficulties presented by victims, conflicting evidence, suspected of assisting offenders to dispose of possible evidence, unreliable, wanting to retract complaints, suspected of attempting to demand money from offenders to drop charges, etc. All offenders deny USI [unlawful sexual intercourse].”*

4.45. The review team has several concerns in respect of the investigation and the way it was concluded.

- Originally the investigation had identified at least 11 children who were vulnerable to sexual exploitation; this grew to 15 during the life of the investigation. The investigation report only records that three of these children were interviewed.
- Little progress was made on the investigation until Child 2 came forward to speak to the police in August 2007.
- The investigation then quickly focused on Child 4, who made significant disclosures to the police in a video interview on 21 August 2007. The police were informed by the mother of Child 4 on 31 August that Child 2 had contacted Nominals 2 and 3 and informed them of the police investigation into their activities. Despite this, Nominal 2 was not arrested until 18 September 2007, and by then he had the time to dispose of any evidence.
- The strategy meeting held in April 2007 identified a credible threat presented by the organised crime gang to several young people. There is no record in this investigation of any police action in respect of this threat despite its evident seriousness.
- There was an unacceptable delay from disclosure to arresting the suspects despite the police being warned by the complainant's mother that they had been tipped off by another child. This delay allowed the suspects an opportunity to dispose of critical evidence and to potentially interfere with or intimidate witnesses.
- We believe this delay also contributed to what the investigating officer defined as collusion between the victims and the suspects. This seriously underestimated the potential for the suspects to intimidate and control the children. Without robust and rapid police action alongside proactive victim support, it is no surprise that given these delays Child 4 began to withdraw from the investigation.
- Detective Constable A increasingly viewed Child 4 as unreliable and collusive, and without any corroboration, put forward the view of the suspects that Child 4 was attempting to extract money from them to drop the charges. This attitude seriously underestimated the degree of coercion and control that were exercised by the very dangerous individuals she came into contact with.

4.46. The decision to close the investigation appears from the record to have been taken independently by the police and without reference to either the Crown Prosecution Service (CPS) or the multi-agency partnership. There is no evidence of any police activity with the remaining children who had been identified as being at risk. This is even more concerning as we are also aware that sometime in 2007 a scoping exercise was conducted by Rochdale LSCB.

This identified a total of 36 children believed to be victims of CSE, and 13 of these were included in the 2007 investigation. However, the other 23 children were not. By the time the 2007 investigation had been concluded both GMP and Rochdale Council were aware of at least 40<sup>27</sup> children vulnerable to CSE. None of these children was protected and none of the men suspected of exploiting them was charged with any offence.

- 4.47. The inadequate resourcing of the investigation contributed to these failings. It was not sufficiently resourced to undertake what soon became recognised by the investigating officers as a major investigation into multiple victims and multiple suspects. Both the responsible detective constable (Detective Constable A) and detective sergeant (Detective Sergeant A) recognised this. A clear request for additional resources was made to their superiors at the start of the investigation but senior officers did not formally respond to this request. We therefore place the responsibility for the failure to protect these victims on the senior leadership team of GMP and Rochdale Council at the time.
- 4.48. Towards the end of 2007 the Crisis Intervention Team became concerned about another set of children they believed were being sexually assaulted by a group of Asian men. On 12 November 2007, the team coordinator wrote a letter to the Rochdale Council safeguarding children unit in respect of Child 16. The letter contained explicit details of the exploitation that Child 16 was subject to. This letter explained that on 18 June 2007 Child 16 had disclosed she had consenting sex with a 20-year-old man, Nominal 5, in a kebab shop on [name of road]. He initially gave Child 16 free food and she disclosed she had sex with him on several occasions above the shop.
- 4.49. A staff member at the Crisis Intervention Team had interviewed Child 16 on 7 November and she disclosed sex with another man she believed was aged 19; she had suffered significant bruising on her back. She refused to speak to the police. The Crisis Intervention Team member recorded that:
- “Child 16 went on to talk about the “Dangerous man, Nominal 47 There’re some girls they’ve got who they put in a cage and make them bark like a dog or dress like a baby ... they are perverts. I had to burn my sim card They (residential staff) made me do it so that they (the men) couldn’t get in touch with me, they witnessed it.”*

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<sup>27</sup> The 40 children comprise the 16 children involved in the 2007 family support investigation (FSI) plus an additional 24 children covered in the scoping exercise conducted by Rochdale LSCB.



4.50. A strategy meeting was held on 21 November 2007 to discuss both Child 16 and Child 19. Sara Rowbotham attended but Child 16's social worker (from a local authority outside of Greater Manchester) did not. The record of the meeting makes the following observation:

*"[Sara Rowbotham] informed that when Child 16 made the disclosures she had changed her mind and felt she had been abused. [Sara Rowbotham] thought she [Child 16] may be persuaded to disclose further information that Child 16 was picked up by [name of taxi company]."*

*"[Detective Constable A] was asked if Child 16 did return to Rochdale she is persuaded to go and identify exactly which kebab shop she visited as the man there had been giving her kebabs for sex. He said that he could not take things further without an actual complaint, disclosures video interviews or signed statements. He also needed people to engage with the police if or when there is an opportunity for forensic evidence."*

4.51. The meeting concluded that both Child 16 and Child 19 were victims of exploitation and needed protection in the short and medium term. A second strategy meeting was held on 20 December 2007, by which time Child 16 was no longer in Rochdale. Although we were unable to locate the minutes of the meeting, its recommendations have been recorded as follows:

- Crisis Intervention Team to liaise with safeguarding children unit regarding disclosure or complaints from the girls
- Crisis Intervention Team to remain involved with both girls.

Child 16's social worker recorded against the original referral: *"Appropriate safety measures in place, No role for Rochdale CCS"*. While the child was not the responsibility of Rochdale children's social care, we believe the continued presence of a group of serious sex offenders within the borough should not have been so easily dismissed.

4.52. By 2008, the prevalence of CSE was well known by all agencies in the Rochdale area. On 11 February 2008, Sara Rowbotham produced a further summary of 23 children she believed were at risk of sexual exploitation. Her report linked these children with several named perpetrators she had already alerted the authorities to. This report was fed into the CSE scoping exercise commissioned by Rochdale LSCB.

4.53. In June 2008, a further report was submitted to Rochdale LSCB by the head of children's social care. We requested an interview with the author of this report, but neither we nor Rochdale Council were able to trace their whereabouts. This report said 50 children had been victims of CSE in Rochdale during 2007<sup>28</sup>.

The report was critical of the current position regarding both the safeguarding of children and the detection, disruption and prosecution of the perpetrators:

*"The current service provision does not appear to be safeguarding children who are being exploited/abused. On consideration of the data, it is apparent that:*

- *The level of safeguarding/intervention currently being used does not appear to be protecting these vulnerable children.*
- *Vulnerable children appear to be very quickly identified by perpetrators.*
- *It illustrates a single agency approach to the problem as opposed to a multi-agency perspective (lack of joined up working).*
- *Thresholds for intervention have not stabilised.*
- *Information gathering, sharing & referral processes are not standardised or showing evidence of following RSCB CPP; and*
- *Prosecution of perpetrators and/or disruption of activities does not appear to be coordinated (single agency threshold).*

*"The following plan was proposed and accepted by the Board:*

*"It is proposed that a similar dedicated team is established, as a matter of some urgency, in Rochdale to address the child sexual exploitation that is occurring in the Borough.*

- *Funded by RBSCB partners (cash & in-kind contributions);*
- *Time limited to 2 years initially.*
- *Staffed by 2 police officers, 1 social worker, and 1 health professional. (seconded posts); and*
- *Steering group to support and line manage on behalf of the Board.*
- *RBSCB officers to support team with protocol development etc."*

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<sup>28</sup> Update on Review of Sexual Exploitation Across the Borough. Head of Children's Services: A report to RSCB (dated 16 June 2008).

4.54. There is no doubt in our minds, therefore, that by the middle of 2008 senior managers within GMP, Rochdale Council and the NHS understood the serious level of exploitation in the borough and the inadequate response to protecting vulnerable children. Although this very modest plan was approved by Rochdale LSCB in June 2008, it was not until 2010 that it became functional and, even then, only by virtue of the secondment of temporary staff.

# Chapter 5. August 2008 to July 2009: The first investigation into child sexual exploitation at two restaurants in Rochdale

## Summary and conclusions

- 5.1. On 6 August 2008, Child 41 was arrested on suspicion of causing criminal damage at a takeaway in Rochdale. Following her arrest Child 41 disclosed that she had been raped and sexually assaulted by staff at a takeaway restaurant in Rochdale. Her disclosures led to a sequence of events culminating in the conviction of nine men almost two years later.
- 5.2. The story of Child 41, Child 44 and 'Amber' first entered the public domain during the trial of the Operation Span defendants in 2012. Child 41, Child 44, and Amber are all featured in Rochdale LSCB's 2013 *Overview Report of the Serious Case Review in respect of Young People 1, 2, 3, 4, 5 and 6*, which set out many of the multi-agency failures in protecting these children.
- 5.3. In this chapter, we consider the first unsuccessful investigation into child sexual exploitation (CSE) centred around two takeaway restaurants in Rochdale. We conclude that this investigation identified widespread sexual exploitation of many vulnerable children by at least 30 adult perpetrators. This was a complex inquiry and needed to be resourced accordingly.
- 5.4. Despite the investigating officer (Detective Sergeant B) explicitly setting out the scale and complexity of the investigation, their superiors failed to support the officer's request for additional resources. Consequently, the investigation only scraped the surface of what had occurred and ultimately the Crown Prosecution Service (CPS) determined that the main victim, Child 41, was an unreliable witness and the available forensic evidence was problematic. Both the CPS and GMP apologised for this failure in 2012, after the conviction of the Operation Span defendants.
- 5.5. However, we have discovered that another child had also given evidence that she had been sexually exploited at the same venues. She had also provided a statement setting out how she had been a witness to the exploitation of other children by the same men who had raped Child 41. The detective responsible

for investigating her crime failed to focus on her disclosure and as a result insufficient effort was put into identifying the man who raped her. It is our view that had this investigation been sufficiently resourced and her complaints pursued with the rigour required it may have strengthened the evidence to proceed with the prosecution.

- 5.6. In March 2009, Child 44, still only 13 years old, had a termination at Rochdale Hospital. GMP subsequently took possession of the foetus. The consent of neither Child 44 nor her mother was sought nor was either party informed of the retention of the foetus. The foetus was subsequently forensically examined but none of the DNA matches related to possible suspects in the investigation at the time. The Human Tissue Authority codes of practice came into force in July 2006, and these stipulate that it is not an offence to retain human tissue for a DNA examination if it is for a criminal investigation. However, we regard it as highly unacceptable that neither Child 44 nor her parents were informed of the retention and why GMP required it. Child 44 did not become aware of this information until 2011, when she was told by Detective Constable Oliver during Operation Span. The GMP independent management review (IMR) submitted to Rochdale LSCB initially referred to this incident:

*“DS B faced an ethical and legal issue about an aborted foetus which had originated from Child 44, and which had been recovered by the police, who were exploring the option of extracting DNA from the foetus to support the criminal prosecution. The recovery of the foetus had taken place without Child 44’s knowledge or consent. This issue remained unresolved up to and after the point where the Crown Prosecution Service took the decision not to prosecute in these cases.”*

However, the final version submitted to the serious case review panel was silent on this matter and the IMR author explained to the review team that he had been asked to remove this. The IMR co-author informed the review team that this and other similar instructions had subsequently caused him and his colleague to stand down from their role as IMR authors. Nonetheless, the overview report did refer to this incident, but it falls short in openly criticising the actions of GMP for what we regard as a deplorable disregard for the victim's wishes and feelings.

- 5.7. Throughout this period, from August 2008 Sara Rowbotham and her colleagues at the Crisis Intervention Team were informing the police and children’s social care of the prevalence of CSE within the community. But both agencies failed to respond to these concerns with the rigour and immediacy they required. The multi-agency processes in place to identify and respond to complex child sexual abuse were weak and continued to be overly reliant on child victims to make disclosures to law enforcement agencies as a way of keeping them safe. There

is no evidence that meaningful multi-agency assessments were put in place for individuals who posed a risk to children.

- 5.8. We found only one record of an attempt at disruption based on liaison with the taxi enforcement team (presumably to seek to revoke an individual's licence) and no evidence that covert tactics were considered. It has been suggested to the review team that in GMP, at that time, there was an unofficial understanding that covert resources would only be used for major and serious crime investigations such as murder, firearms offences, and drug supply, and that was the case across all forces in England and Wales. While there may be some truth in this, it is also a fact that the senior investigating officer (SIO) for Operation Augusta identified the need to explore covert opportunities in 2004, as did Detective Constable A in 2007. The failure to identify this investigation as one requiring an enhanced response with a suitably experienced and qualified SIO was a missed opportunity that would almost certainly have increased the opportunities for a successful criminal justice outcome.
- 5.9. All the evidence we have seen conclusively confirms that the police investigation came to an end after the CPS decided to not proceed with one victim, Child 41. This was despite GMP being aware of the names of many other victims and many other perpetrators. The reality was that GMP had put insufficient resources into the investigation and closed it down prematurely, and as a result many perpetrators were left to continue to abuse children and many more children were left vulnerable to exploitation during the following months and years.

## **Detailed findings: The 2008–09 investigation**

### **Child 44 and Amber**

- 5.10. Staff at the Crisis Intervention Team first met Child 44 when she was 13 and attended a drop-in on 11 July 2008. She made several concerning disclosures about older Asian 'boyfriends' giving her vodka and sexually abusing her. Sara Rowbotham wrote a letter to the named nurse for child protection on 11 August 2008 with regards to Child 44 and Amber, raising concerns about CSE, taxi firms and kebab shops. This information was shared at a strategy meeting on 12 August 2008 by the named nurse, although no one from the Crisis Intervention Team was in attendance. Children's social care completed a child protection assessment and, in October, both Child 44 and Amber were placed on child protection plans under the categories of neglect and sexual abuse.

- 5.11. On 3 August 2008, the mother of another child, Child 46, reported her daughter as a missing person. The mother found her daughter with Child 41, Child 44, and Amber. The daughter later disclosed to her mother that she and numerous other local children, including Child 41, Child 44, and Amber, had been regularly engaging in sexual activity with members of staff from two nearby restaurants in return for food and alcohol. This was an established practice by August 2008 and involved numerous local children and restaurant staff members and their associates, some of whom were taxi drivers. We cover the exploitation of Child 44 and Amber later in this chapter.
- 5.12. A police investigation was initiated into the allegations made by Child 46, who had disclosed being sexually abused by Nominal 18. Consequently, on 4 August 2008, the investigating officer, Detective Sergeant B, submitted a 'report of crime' stating:
- "Sir - Please return for a full update. This appears to be part of a larger scale sexual exploitation case with other potential victims."*
- 5.13. A few days later, on 6 August 2008, Child 41 was arrested on suspicion of causing criminal damage at a takeaway in Rochdale. Following her arrest Child 41 disclosed that she had been raped and sexually assaulted by staff at the same restaurants.
- 5.14. This information was passed to children's social care and a multi-agency strategy meeting was held on 12 August 2008. This identified that Child 41 was one of several children involved in sexual exploitation where the suspected perpetrators were Asian men associated with taxi firms and takeaways in the Rochdale and Oldham areas.
- 5.15. The meeting agreed that the police would continue with a video interview with Child 41, the duty social worker would undertake a home visit and request information from Child 41's school and additional information would be sought on the other children.
- 5.16. A Section 47 inquiry was completed nearly two months later. Considering the protective stance of Child 41's parents and the referrals to other support agencies, the social care manager decided that no further action was required from children's social care at that time. As a result, the case was closed to children's social care and there is no record of the agreed follow-up strategy meeting being held. The investigation appeared to stall at this point, despite the corroborative evidence from Child 46.

5.17. On 30 October 2008, a worker from the Crisis Intervention Team spoke to a Rochdale social worker and shared concerns that Child 41 had been a victim of sexual exploitation due to disclosures made in August 2008. The Crisis Intervention Team member was informed that an initial assessment had been completed in the past and the case was closed, but a new assessment would be undertaken. In November 2008, the social worker informed the Crisis Intervention Team that a home visit had been conducted and explained that the case was closed as the parents were supportive. The family had been referred for intensive support, but the social worker indicated that the case would not be considered by a child protection conference unless there was evidence of the parents failing to protect the child.

5.18. The IMR<sup>29</sup> undertaken by Rochdale Council is frank about this failure:

*“Decisions made in the case of Child 41 for ‘no further action’ after she had made allegations of sexual exploitation in August/September 2008 were not in her best interests. They were made based on flawed and unchallenged assessments, made without sufficient awareness and knowledge of child sexual exploitation and the dynamics of grooming and power imbalances between exploitative adult and child victims. There was no management challenge to the fact that she had not been seen and spoken with by the social worker until November 2008, some three months after the original referral.”*

5.19. We would go further. The decision to close the case of Child 41 was a clear dereliction of the duty to protect her. This was despite the Crisis Intervention Team repeatedly informing children’s social care of the risks to Child 41 following the decision to close her case. It is also clear to the review team that without the persistence of the Crisis Intervention Team, Child 41 may never have provided a formal statement to the police.

The scale of the problem was known to the statutory agencies by the end of 2008.

5.20. By the middle of 2008 Child 41 and Child 46 had provided GMP with the names of many perpetrators and the names of additional children being exploited at the takeaway restaurants in Rochdale.

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<sup>29</sup> The guidance in place at the time required that once a serious case review had been commissioned each relevant service should undertake an individual management review (IMR) of its involvement with the child and family. We have considered those IMRs produced by Rochdale Borough Council, GMP and Pennine Care NHS Foundation Trust.



5.21. On 13 August 2008, Child 34's mother disclosed to the Crisis Intervention Team that her daughter was getting into Asian men's cars and had returned home with love bites on her face<sup>30</sup>. Child 34 would later be cited as a victim in the trial of the Operation Span defendants in 2012. The next day Sara Rowbotham sent a referral to Rochdale children's social care expressing concerns about Child 34 and "*her vulnerability to sexual exploitation by a number of older Asian men*". A child protection case conference was held, which recommended that: "*Child 34 to be allocated a social worker [and] Child Care Services to follow up concerns about potential sexual exploitation and organise a strategy meeting*". Child 34 left her placement in January 2009 and concerns remained about her vulnerability to exploitation. However, there was no evidence of this issue having been risk assessed; the focus was on practical matters relating to accommodation and benefits.

5.22. On 11 December 2008, Sara Rowbotham wrote a further letter to the chair of Rochdale LSCB. This letter expressed concerns about an additional four children.

- Child 75 was described as having a relationship with Nominal 48 and that "*she knows the relationship will not last forever but is happy with him now*".
- Child 89 was in a relationship with Nominal 49. She also stated that Child 70 used to have sex for money.
- Child 69 had been grounded as she had been given a mobile phone by an Asian man. Her mother was concerned for her wellbeing.
- Child 70 had a number of boyfriends in a short space of time, including a 15-year-old and an 18-year-old (Nominal 50). She was known to be meeting these boys at [park]. Nominal 50 took Child 70 to a place she named. Child 70 had informed staff at the Crisis Intervention Team that this place was disgusting, with empty beer cans and a broken bed. This place had also been mentioned by another young person as somewhere Asian men took girls for sex and to drink alcohol or take drugs.

The letter highlighted that all these children were willing to share information about each other but did not necessarily acknowledge their risk-taking.

5.23. In summary, it was therefore clear by the end of 2008 that all agencies were aware they were dealing with widespread sexual exploitation of a significant number of children in the Rochdale area, but this failed to be dealt with as a strategic priority by either the council or GMP.

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<sup>30</sup> Independent management review by Pennine Care NHS Foundation Trust, 28 May 2013.

- 5.24. On 9 January 2009, Child 41 informed her Crisis Intervention Team worker that she was prepared to make a statement to the police about ongoing exploitation. On the same day, Sara Rowbotham sent this information to Detective Sergeant B, Rochdale LSCB, and the Pennine Care NHS Foundation Trust's lead nurse for child protection. Child 41 gave a written statement to GMP on 14 January 2009, detailing the sexual abuse she had experienced since July 2008.
- 5.25. This new information from Sara Rowbotham was considered by Rochdale Council's children's social care team manager and conference and reviewing officer. Child 41's allegations of CSE made in her police statement were deemed to be historical (relating to July 2008 events) and therefore had been previously dealt with by children's social care, and Child 41 was not perceived to be at any ongoing risk of harm. It was therefore agreed that there was no further role for children's social care. We regard this as a serious failure, given the significant exploitation Child 41 had disclosed and the risk of further exploitation.
- 5.26. On 22 January and 29 January 2009, the police conducted two further interviews with Child 41, who provided more about the abusive activities of several other men. She talked specifically about a man (Nominal 8) who allowed his flat to be used by British Pakistani men to have sex with children, including Child 44 and Amber. Child 41 also stated that Amber was actively involved in arranging sexual contacts for her, Child 44 and other children and that she was regularly bullied by her. Child 44 and Amber have always vehemently denied this allegation.
- 5.27. Detective Sergeant B initially believed they could manage the investigation alongside their existing workload but gradually came to the realisation, as they became aware of other potential victims and abusers, that additional resources were needed. Despite this, Detective Sergeant B continued to manage the investigation with limited resources. Detective Sergeant B recalled a conversation with Detective Inspector B about seeking the assistance of an analyst to identify links between abusers and victims that were beginning to emerge as the investigation progressed, but this help never materialised. The reason why is unknown. Detective Sergeant B did not make any further approaches to their supervisors for additional resources until 22 January 2009, when they made the following request to Detective Inspector B:
- "I am dealing with a 15-year-old called [Child 41] because she has been the victim of rape and sexual activity ... There are over 30 offenders, most of them are named and will possibly be traceable. Two other girls who are involved in this have been named by Social Services. I have spoken to one and she is willing to be video interviewed. The other is in care in [another local authority in*

*Greater Manchester] and I have not yet approached her but am told she will be video interviewed. From information received from The Crisis Intervention Team on the video interview, I will be told about other sexual offences involving vulnerable teenagers and adults ... This is going to be a lengthy inquiry with numerous people to arrest. It will have a high profile within Social Services with many multi-agency meetings ... I believe that this job is too big to run as a day-to-day job in the CID [criminal investigation department] and should have officers dedicated to the inquiry.”*

- 5.28. No additional resources were provided to Detective Sergeant B, who was left to continue with the investigation as best they could. Detective Sergeant B made several attempts to contact Child 41's social worker to arrange a safeguarding strategy meeting. It was not until 19 February that this request was finally responded to. Detective Sergeant B was advised that the council had conducted a review meeting and there was no requirement for a strategy meeting. We regard this as a further serious failure by the council's children's social care service.
- 5.29. On 17 February 2009, children's social care received yet another referral expressing concern that Child 41 remained vulnerable. The duty social worker decided that this latest development did not warrant any further action, apart from adding the information to the recording system. A visit was completed at the end of February but there is no record of any assessment. The case was closed and there was no further recorded contact with Child 41 or her family.
- 5.30. At the beginning of 2009, Sara Rowbotham also sent a letter to the safeguarding children's unit, Detective Sergeant B, the children's social care team manager and the named nurse for child protection, highlighting concerns regarding Child 44 about her drinking vodka at weekends as well as organised sexual exploitation.
- 5.31. A case conference was held on 9 February 2009 to discuss both Child 44 and Amber. It was agreed that Amber was still at significant risk of harm and should remain subject to a child protection plan under the category of sexual abuse. Amber was also known to be spending a lot of time at Nominal 25's home and there was no clear understanding or assessment of what this meant for her safety. She had refused to engage with the Crisis Intervention Team services and her school attendance was poor. Confidential police information was shared regarding a sexual exploitation investigation by the CID. This suggested that Child 44 and Amber had been 'promoted' by a group of exploitative Asian men into recruiting, grooming and coercing younger children for sexual activities. It was said that Amber was, in turn, threatened with violence from

the male sexual exploiters in her grooming activities. It appears that the police had come to this conclusion based on the information provided by Child 41. However, we have identified as part of our research that in August 2008 Child 41 had disclosed to the police in her interview that she had witnessed Amber being threatened with a knife and told she would be killed if she made any disclosures. Nonetheless, the police representative informed the conference they believed there was enough information for the police to arrest Amber at some stage on the basis that she was actively enabling the exploitation of others. The review team question the ethics of this, given that all those present were aware that Amber had herself been exploited, and the conference had heard that it was believed that she was being threatened with violence<sup>31</sup>.

- 5.32. The conference also heard that a further potential concern was Nominal 25, who had been implicated in a police witness video in respect of a young female allegedly performing oral sex on him.
- 5.33. Detective Inspector B convened a meeting in March 2009 to share information with other agencies about the extent of CSE in Rochdale at the time. According to Detective Inspector B, the social care manager had agreed to pull together all the information known to the Crisis Intervention Team and children's social care, and a nominated police officer was tasked with doing likewise on behalf of GMP. While the intention was to reconvene after this exercise was completed, no further meetings were ever held. The review team regards this as another significant missed opportunity to fully scope the substantial amount of information held by the various agencies on the widespread exploitation of children in the Rochdale area at the time. Furthermore, no additional resources were provided to the investigation, despite it being unrealistic to expect Detective Sergeant B to manage such a complex investigation with the existing resources.
- 5.34. On 5 March 2009, Child 44, when aged only 13, had a termination at Rochdale Hospital. GMP subsequently took possession of the foetus. The consent of neither Child 44 nor her mother was sought, nor was either party informed of the retention of the foetus. The foetus was subsequently forensically examined but none of the DNA matches related to possible suspects in the investigation at the time. The Human Tissue Authority codes of practice came into force in July 2006, and stipulate that it is not an offence to retain human tissue for a DNA

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<sup>31</sup> The review team interviewed Amber and she maintained that she had never done anything other than what many of the other sexually exploited children had done. Detective Constable Oliver also shared the same view with the review team.

examination if it is for a criminal investigation. However, we regard it as highly unacceptable that neither Child 44 nor her parents were informed of the retention and why GMP required it. Child 44 did not become aware of this information until 2011, when she was told by Detective Constable Oliver during Operation Span.

5.35. We interviewed Child 44, and she told us:

*“After the trial [a GMP officer] came to ask if I wanted a funeral for the baby I aborted. And that’s disgusting to ask someone something like that. I feel like it’s illegal for them to rob a foetus, a part of me, like that is disgusting they should’ve made me sign something. It was an abortion, I didn’t want it so I told them to get rid of it, and they robbed it. And that’s when they made me sign something to say they could discard it but that should’ve never been a conversation at all. They should never have robbed it, they should’ve asked permission, even though I was a minor they should’ve gone through my mum they shouldn’t have gone in and took it either way.”*

5.36. The GMP IMR submitted to Rochdale LSCB initially referred to this incident:

*“DS B faced an ethical and legal issue about an aborted foetus which had originated from Child 44, and which had been recovered by the police, who were exploring the option of extracting DNA from the foetus to support the criminal prosecution. The recovery of the foetus had taken place without Child 44’s knowledge or consent. This issue remained unresolved up to and after the point where the Crown Prosecution Service took the decision not to prosecute in these cases.”*

However, the final version submitted to the serious case review panel was silent on the matter and the author explained to the review team that he had been asked to remove this reference. The IMR co-author informed the review team that this and other similar instructions had subsequently caused him and his colleague to stand down from their role as IMR authors. Nonetheless, the overview report did refer to this incident, but it falls short in openly criticising the actions of GMP for what we regard as a deplorable disregard for the victim's wishes and feelings. The report said:

*“Greater Manchester Police have acknowledged that whilst their request to the hospital for the foetal material was lawful, and that they believe that the officer was acting in good faith, with hindsight this had not been handled in the most sensitive way and there was a lack of focus on the ethical issues.”*

5.37. At a strategy meeting on 10 March 2009, it was said that Amber was grooming Child 55 to lose her virginity. Child 55 was the daughter of Nominal

25. Detective Sergeant B recorded the intention to arrest both Amber and Nominal 25. Nominal 25 was arrested on 11 March 2009.

5.38. Amber (then aged 16) was arrested on 31 March 2009 on suspicion of inciting prostitution. Amber denied the allegations and no charges were brought against her. In an incredible example of poor practice, Amber, a known victim of CSE, was released on police bail with the requirement to reside with Nominal 25, who had himself been arrested on suspicion of CSE.

5.39. This is the last entry in Detective Sergeant B's casebook. We do not believe we have seen the complete record as one would have expected at the very least for Detective Sergeant B to have recorded the outcome of the interviews with Nominal 25 and Amber.

5.40. The police investigation into CSE that started on 4 August 2008 effectively ended on 26 August 2009, almost a year later, when the CPS formally decided that neither of the two principal suspects would be charged with any criminal offences about the sexual abuse allegations made by Child 41.

5.41. We have considered the paperwork that the investigating officer submitted to the CPS. The lawyer commented:

*"It was a tragic case that one so young had fallen into this lifestyle and had been taken advantage of in this way."*

However, they considered Child 41 to be an unreliable witness and did not believe a jury could be convinced that all the acts she complained of were without her consent. This has been widely reported in the public domain. The CPS also noted that the forensic evidence relating to Child 41's underwear was problematic. What has not been made so clear is that the detective responsible for the investigation also submitted the following comment to the CPS:

*"She [Child 41] stated that Asian males from Rochdale had been having sex with her for money. She pointed out several addresses to the police. These addresses have been looked at and some people have been arrested. None have admitted to having sex with Child 41. All have been NFA'd [marked for no further action]. Child 41 does not wish to try and take these suspects to court. She was 15 at the time and realised the difficulties with a prosecution as she appeared a willing participant."*

We regard this as highly problematic for several reasons, set out below.

5.42. Child 41 was only 15 at the time of the offences and clearly described multiple examples of rape. She could in no way have been described as a willing

participant. She had identified several addresses where she had been raped but based on a denial, these cases had been marked as no further action (NFA). We would have expected more investigative work to be undertaken to corroborate Child 41's evidence. The specialist tier five interview advisor who had reviewed the MG6<sup>32</sup> described this information as "*duplicious and deceitful*" and designed to engineer a poor decision from the CPS. We are unable to form a judgement on the motivation, but we note there are no additional entries in the investigating officer's casebook after March 2009 and no record of Child 41's apparent unwillingness to support a prosecution.

- 5.43. Furthermore, we have discovered that the crimes in respect of Child 46 were never properly investigated. In fact, in September 2009, and for reasons we are unable to explain, another sergeant filed the crimes against Child 46 as NFA<sup>33</sup> as Detective Sergeant B had recorded the same CPS decision from the Child 41 crime on the Child 46 crime. We regard this as a further serious weakness. The review by GMP into Operation Span<sup>34</sup> commented:

*"During the investigation of the 2 crimes, there are issues of Officer 9 missing progress dates, not submitting relevant crimes, not updating the offender menus, victim contact pages, and cutting and pasting updates from the Child 41 crime onto the Child 46 crime. This caused the Child 46 crime to lose focus on tracing and arrest the Nominal 18 before being filed on the Crown Prosecution Service result relating to the Child 41 crime."*

- 5.44. In June 2012, the Chief Constable of GMP and Detective Chief Superintendent B gave evidence to the Home Affairs Select Committee. The minutes of oral and written evidence to the committee record that the Chief Constable was asked the following question:

*"Is it not right, Chief Constable, that the fact remains that following that Crown Prosecution Service decision, the Manchester Police dropped all further investigations into several similar allegations—yes, or no?"*

Detective Chief Superintendent B responded:

*"They were not dropped immediately as a result. We did not just go, 'Stop investigating'. We continued to investigate."*

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<sup>32</sup> This is the information provided by the investigating officer to the CPS to support decision-making.

<sup>33</sup> Requiring no further action.

<sup>34</sup> GMP Professional Standards Branch investigation into Operation Span, supervised by the Independent Police Complaints Commission (IPCC), March 2013.

Chair: *“But they were dropped eventually.”*

Detective Chief Superintendent B: *“But we had had a threshold that we did not think we could get past.”*

- 5.45. Detective Chief Superintendent B may not have been aware of the detail, but all the evidence we have seen conclusively confirms that the investigations were not pursued after the CPS made a decision about one victim, Child 41. This was despite GMP being made aware of the names of many other victims and many other perpetrators. The reality was that GMP had put insufficient resources into the investigation and closed it down prematurely. As a result, many perpetrators were left to continue to abuse children and many more children were left vulnerable to exploitation during the following months and years.



# Chapter 6. January to December 2010: The Sunrise Team at Rochdale

## Summary and conclusions

- 6.1. In this chapter we have considered the allegations of child sexual exploitation (CSE) reviewed by the emerging Sunrise Team in Rochdale. This was a specialist multi-agency CSE team first approved by Rochdale LSCB in 2008. Despite the urgency, funding was not agreed to commence until April 2009 and then for only two years. The team members did not start to assemble until the latter half of the year. A social worker was not assigned to the team until the end of 2009 and was then given a substantial caseload by children's social care, diverting the social worker's full attention away from the team. It had originally been agreed that two experienced child protection police officers would be included in the team, but the Rochdale division was reluctant to place staff of this calibre within the team. In early 2010, in the absence of suitably qualified and experienced individuals, Police Constable A<sup>35</sup> was added to the Sunrise Team.
- 6.2. Through research into past cases, Police Constable A identified a complex CSE network in Rochdale. This coincided with the significant disclosures made by Child 44, initially to her social worker, about the widescale abuse of children by up to 60 men.
- 6.3. Following support from a GMP analyst and the tier five specialist interview advisor, the responsible detective inspector submitted a compelling picture to the Rochdale division senior command team. This set out the details of the organised CSE of numerous children and requested additional staffing to resource this complex operation.
- 6.4. These resources were not made available, and yet again children were left at the mercy of their abusers because of an inadequate response by GMP and Rochdale Council to the serious exploitation of vulnerable children.

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<sup>35</sup> Police Constable A later progressed to being a detective. We refer in later sections to the same individual as Detective Constable F.

- 6.5. It was not until December 2010, almost 12 months after Child 41's disclosures, that GMP finally put in place a major incident team (MIT) to tackle the exploitation centred around the two takeaway restaurants, first brought to police attention in August 2008.

## **Detailed findings: Sunrise Team**

### **The setting up of the Sunrise Team**

- 6.6. Despite the existence of an ongoing investigation in Rochdale and a list of over 50 children who had potentially been sexually exploited, the statutory agencies took far too long to assemble a fully functioning Sunrise Team. Although the need for urgency was recognised when the proposal was accepted on 23 June 2008, little progress was made for many months. Funding was not agreed to commence until April 2009 for two years and the team members did not start to assemble fully until the latter half of the year. A Crisis Intervention Team worker had been attached to the team since 2008 and the 'Early Break' staff member (an adolescent services support worker) arrived around August 2009 but on a part-time basis. A social worker was not assigned to the team until the end of 2009 and, even then, was given a substantial caseload by children's social care, diverting their full attention away from the Sunshine Team.
- 6.7. From the outset, it had been envisaged that two full-time experienced police officers, with some degree of expertise in child protection and criminal investigation techniques, would be seconded to the team. However, no such personnel were made available, and Detective Inspector A of the Rochdale public protection and investigation unit (PPIU) recalled that the division was unwilling to invest two officers in Sunrise and felt there was little support or interest in the project. In early 2010, in the absence of suitably qualified and experienced individuals, Police Constable A was placed on the team. Detective Inspector A believed that, although the constable lacked experience, their past performance in the PPIU suggested they would be an asset to the Sunrise Team.
- 6.8. Police Constable A was tasked with reviewing all the investigation files held by the Sunrise Team. At that point, 23 inquiries had been registered on the computer system; these had not been properly progressed as there was little or no information recorded on the accounts. Some of the accounts were being investigated by the criminal investigation department (CID) and progressed through its crime recording system, but this was not apparent on the Sunrise

log. There were also a further five current investigations that required accounts to be created on the system. It had been assumed that the responsibility for creating and updating the accounts fell to another member of staff, the administrative assistant, but this staff member was completely unfamiliar with the police computer system and had been unable to complete this task.

- 6.9. In early 2010, there remained significant concerns in respect of Child 44 and her association with men involved in CSE. A social worker was tasked to engage with Child 44 and her family to establish the identities of those who were sexually exploiting her. On 10 March 2010, when Child 44 was still only 14, she disclosed to this social worker that she had been sexually abused by six older (Asian) men when she was 13. The abuse was still ongoing, and Child 44 was still on a child protection plan. She said she was willing to talk in more detail to the police.
- 6.10. Child 44 gave a detailed statement to Police Constable A in the Sunrise Team about having been involved in sexual activity with several adult males. She was encouraged to introduce other female minors to the group. She said there were over 60 men involved and she was offered £80 for a contact. She had been contacted by text and asked for sex and had been taken to Yorkshire for sex (where she was sexually abused).
- 6.11. On 19 March 2010, Child 47, who was known to be friends with Child 44 and Amber, disclosed that she had been raped by Asian men. Police Constable A reviewed the case of Child 47, who had been absconding regularly and socialising with Child 44 and Amber. Police Constable A explained to the GMP independent management review (IMR) author:
- “When I looked at the [Child 47] case and saw comparisons with the [Child 41] case in 2008, there were obvious similarities including the offenders, locations, takeaways, and other victims. This suggested a linkage of these cases.”*
- Police Constable A set about gathering the material together to mount an investigation and recorded more than 30 potential offenders to be arrested and numerous victims.*
- 6.12. Further evidence received the following month (April 2010) suggested that Amber was pregnant and that both Child 44 and Amber were at risk of leaving the country and being taken to Pakistan by named men.
- 6.13. On 19 March 2010, Detective Inspector A made a request to their supervisor, Detective Chief Inspector A, for a force analyst:

*“I hope you can help with advice re' the analysis of intelligence surrounding child sexual exploitation issues in Rochdale. Over the past few years, the division has investigated numerous cases of abuse and rape of children who have been groomed and supplied with drugs and alcohol in return for sexual favours or raped whilst intoxicated. These incidents invariably involve the victimisation of our most vulnerable young people – particularly those in care or who persistently are reported as being missing from home.*

*“The investigations have produced a large volume of information and intelligence which I hope can be used to support further policing activity. I think I need help to analyse the material which will provide clear investigative opportunities to detect offences and where possible help us to prevent further victimisation.*

*“Can you assist in reviewing the material we have – and give some guidance as to what products we could expect an analyst to be able to provide to support the investigations? I hope that we can then accurately task the work on division. Please let me know if you can help and I hope we can meet sometime next week to discuss.”*

This clearly demonstrated that Detective Chief Inspector A was fully aware of the previous evidence of the widespread sexual exploitation of vulnerable children.

- 6.14. This coincided with a meeting between Police Constable A and the tier five interview advisor attached to the serious crime division (SCD). Following this meeting, the interview advisor sent an email to Detective Inspector A on 19 March 2010:

*“Before finishing, on a more important note perhaps, having had the briefing from [Police Constable A], I completely support your view re organisational risk (particularly post WARBOYS etc.), this is potentially a resource intensive investigation with a lot of pro-active opportunity. Whilst forensic opportunity may now be limited, there may be CCTV opportunity which is time critical. There is a clear need for some systems (paper or HOLMES) and with the greatest of respect to PC A, deserves a commensurate level of investigative skill and experience to complement the superb commitment and dedication already demonstrated by her. I'd willingly support any DIA<sup>36</sup> you submitted with my command in SCD.”*

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<sup>36</sup> Divisional investigative assessment. The DIA was a formal process of assessment of investigations that might represent a threat to the division or force (*Chief Constables Order 2007/34*).

- 6.15. With the support of the force analyst, the interview advisor, and Police Constable A, Detective Inspector A submitted a detailed DIA requesting consideration of additional resources to investigate CSE in Rochdale. This listed 35 victims aged between 14 and 17. These were set out in four distinct groups. One group comprised boys. There was a list of the names and dates of birth of nine suspects, and their home addresses. Three of these suspects were linked to the two restaurants in Rochdale. The DIA listed 12 offence locations, including residential addresses, the two takeaway restaurants previously investigated and two identified taxis. The section of the DIA ended with the following observation:

*” From reports from victims and intelligence, it is believed that there are in excess of forty males from mainly Asian ethnic backgrounds who are participating in the organised systematic abuse of vulnerable children. It is believed that initial victims e.g. Amber is now engaged in the supply of mainly girls to this group under extreme duress and threats. Group 1 are the main victims of this ethnic group. Group 3 are those connected to [takeaway restaurant]. Group 2 and 4 are believed to be sexually exploited children however have not as yet been linked to the main organised group. Tenuous links are currently being researched. Group 4 children have known abuse links to Eastern European Males in the [area of Manchester] area. There are other links between Oldham, Bury and Central Manchester. There are also known links to another force area mainly Bradford and Leeds (West Yorks) and Blackpool (Lancs).*

*“What is clearly emerging is an organised industry where vulnerable young children are being targeted for sexual abuse by processes including grooming with the use of money and gifts, threats of injury and/or death if non-compliant, and that is not just an issue within the Rochdale area.”*

- 6.16. The DIA also set out the political and community consequences of not tackling these crimes:

*“Potentially there may be questions asked in the future regarding initial disclosures and investigation which has not yet been progressed fully. There is also the matter of a previous investigation and child exploitation regarding [the restaurant] which resulted in NFA by Crown Prosecution Service last year.*

*“Just last week, Jim Gamble (head of CEOP [Child Exploitation and Online Protection Centre]) made representations to forces to consider prioritisation of sexually abused children and identified the need for all agencies to afford it the resources necessary to challenge offenders and protect our most vulnerable.*

*“If it is discovered that this is continuing unchecked and unchallenged in Rochdale possibility of a media induced public backlash. There is no evidence of this at this time, but this will need to be regularly monitored and reviewed.”*

- 6.17. Our view is that, given the content of the DIA, Detective Chief Inspector A, Superintendent B and Chief Superintendent B had sufficient information before them to have determined this as a critical incident<sup>37</sup> and it was a serious organisational failure that none of them responded appropriately.
- 6.18. Regrettably, the DIA report was never submitted to GMP senior management and, in the view of Detective Inspector A, was not objectively considered by senior management within the Rochdale division. The GMP IMR goes to some length to explain the failure to refer the DIA through the appropriate channels but concluded that all members of the Rochdale senior leadership team had subsequently expressed regret for not having done this.
- 6.19. On 13 April 2010, Detective Inspector A emailed Chief Superintendent B, and attached to this email was the DIA. The email emphasised Detective Inspector A's concern that the division was not recognising what was a huge risk to children and that this would also impact on public confidence if the matter was not addressed sooner rather than later. The detective inspector identified that the investigation had the potential to mushroom beyond the scale of divisional management and sought the assistance of the force to progress the investigation but expressed a reluctance to request the investigation to be allocated to an MIT syndicate or the main CID office. As the Sunrise Team was set up to tackle CSE, removing the investigation from Sunrise could be counterproductive. Detective Inspector A believed the DIA was discussed at a resource meeting in April 2010, the result being not to ask for resources but to allocate a divisional CID officer to the PPIU. Detective Inspector A explained that this detective, Detective Constable C, was placed in the Sunrise Team, which effectively left the child protection team a detective down. Detective Constable C was tasked with reviewing the initial investigation from 2008 to see if there was any further investigative opportunity that had not yet been explored.
- 6.20. Chief Superintendent B explained in an interview with the GMP Professional Standards Branch that Detective Inspector A's request and submission of the DIA had been discussed with the detective inspector, who was also informed that the division was supplying more staff and that analyst support had been agreed. He asked in light of this, if the DIA did need to be submitted. Chief Superintendent B stated that Detective Inspector A was comfortable with that decision and that the DIA did not require progressing.

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<sup>37</sup> A critical incident is defined as "Any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family and/or the community". (Chief Constables Order 2007/34).

6.21. We cannot reconcile these two conflicting accounts. What is clear, however, is that the DIA had laid out in great detail the level of risk presented to vulnerable children, the complexity of the investigation and the potential for significant reputational damage. It should have been clear to all reading this submission that the provision of an additional detective to supplement the existing team of one detective was a wholly inadequate police response to the threats outlined.

Detective Inspector A had no alternative but to investigate with the inadequate resources at their disposal, and stated when interviewed by the review team:

*“I never received anything that said that I was going to get the support that I had asked for. We got to the stage where we had submitted all the crimes and arrested one offender, I can’t remember who that was.”*

6.22. As a result, the investigation stalled yet again for several months. The GMP IMR noted:

*“What is apparent from reading the FSI log (FSI/10/0003611) that refers to this phase of the police investigation is that a process for inter-agency information sharing was in place however the account of this period provided by Police Constable A (a Sunrise officer) suggests that there was real inter-agency reluctance to meaningfully share information because of the lack of structure, lack of agreed managerial oversight and lack of a ToR [terms of reference] or operating protocol for the Sunrise Team at this time.”*

We asked to interview Police Constable A, now a serving detective with GMP, but this officer declined to participate in the review.

6.23. It seems the abuse of Child 44 and Amber continued and was known to the statutory agencies. On 20 August 2010, it was recorded that Amber was 24 weeks pregnant. At a CSE strategy meeting on 24 August 2010, Amber’s social worker reported that Amber was being coerced to leave the country for Pakistan.

6.24. In September 2010, the PPIU began a series of interviews with Child 41. These interviews reassessed the allegations she originally made in 2008. A child protection review conference was held on 5 October 2010 on Child 44 and Amber. During this meeting, the police confirmed that further information had come to light in respect of Nominal 25, which would lead to his arrest. On 12 November 2010, Nominal 25 was arrested and charged with sexual activity with a child under the age of 16 years.

6.25. Following the serious disclosures made by Child 44 to her social worker, GMP had once more failed to adequately resource what was a complex investigation. The DIA made clear to the senior command team the scale and

magnitude of the exploitation of vulnerable children. Nothing was done to protect them for a further 12 months, when some of the men who were abusing them were finally arrested.

- 6.26. In conversations with the IMR authors, Assistant Chief Constable A recalled that, in November 2010, the issues surrounding the Sunrise Team's lack of progress on the investigation had been raised at previous quarterly performance meetings, but dates for the arrest of the offenders kept being put back for various reasons.
- 6.27. It was not until December 2010, following a visit to the Rochdale division by Assistant Chief Constable A, that steps were taken to resource the inquiry as a major investigation to be known as Operation Span. Assistant Chief Constable A declined to be interviewed by the review team. However, Detective Chief Superintendent B gave the review team the following opinion:

*"[The ACC] was poking around in Rochdale because their rape detection performance was so bad, and he was getting beaten up over it as an ACC, I think, not as a Divisional Commander, by then there'd been two more since him. So, he was poking around the rape detection when he found what effectively amounted to then Operation Span, and also around that time it leaked to the press<sup>38</sup>. So, we had really little choice but to make a job of it and put some resource into it and kick it off, and it needed a gold meeting because it was quite clear from the start that there was a lot of fairly senior people who were going to be asking, or being asked, some very difficult questions around what went on in 2004, 2005, 2006, 2007, 2008 and they weren't going to be able to answer them very easily at all. So, he could sort of see the writing on the wall. He wasn't the stupidest man by any stretch of the imagination, he was a clever man, and he could see what was coming. And he had little choice but to put a gold strategy and structure around it, and that's what he did."*

We cover our findings on Operation Span in the next chapter.

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<sup>38</sup> Assistant Chief Constable A's response to the review team's draft report stated that Detective Chief Superintendent B's views were completely inaccurate, and the ACC had no recollection of ever being challenged on rape detection.



# Chapter 7. Operation Span: December 2011 to May 2012

## Summary and conclusions

- 7.1. Operation Span, which led to the conviction of nine men in May 2012, was described at the time by GMP as “*comprehensive and effective, mitigating threat risk and harm*”<sup>39</sup>. However, we have found that Operation Span was a relatively limited offender-focused investigation that primarily addressed a small number of perpetrators who had not been prosecuted following the earlier disclosures in 2008.
- 7.2. Despite its apparent strategic importance, no further gold group meetings were held following the first one<sup>40</sup>, other than to coordinate the arrangements for the trial. The senior command at GMP appeared to have little ongoing oversight of progress.
- 7.3. The operation suffered because of successive changes of leadership. The first senior investigating officer (SIO 1), an experienced detective superintendent, was intent on leading a victim-centred investigation and set out a commendable and comprehensive strategy. However, SIO 1 was quickly replaced by a detective chief inspector (SIO 2) with no previous experience in managing a major operation. SIO 2 was subsequently given responsibility for overseeing the Rochdale public protection and investigation unit (PPIU) as well as Operation Span. SIO 2 was replaced a few months later, in August 2011, by a detective inspector (SIO 3). These changes suggest the operation was not considered a priority by the GMP senior command team.

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<sup>39</sup> GMP individual management review (IMR), August 2013.

<sup>40</sup> The College of Policing explains the gold (strategic) commander and gold group as follows.

*“The gold commander assumes and retains overall command for the operation or incident. They have overall responsibility and authority for the gold strategy and any tactical parameters that silver or bronze commanders should follow. The gold commander, however, should not make tactical decisions. They are responsible for ensuring that any tactics deployed are proportionate to the risks identified, meet the objectives of the strategy and are legally compliant, particularly in terms of the Human Rights Act 1998. The gold commander chairs the gold group or the strategic coordinating group (SCG)”.*

- 7.4. Although its terms of reference were comprehensive and included identifying all victims, within a short period the investigation began to focus on a limited number of victims and witnesses who could support the prosecution of a small number of men identified as suspects from the outset.
- 7.5. We have heard evidence that many victims gave interviews identifying numerous men who had exploited them in the belief that these men would be charged with offences against them. We have found that many of these crimes were not formally recorded or investigated by GMP. Furthermore, promises to support the victims during and after the trial were not forthcoming and these young people were left to be harassed and intimidated by the men who had previously abused them. GMP required the engagement of these individuals to achieve a successful prosecution. It is not surprising, given the lack of support the victims we interviewed described, that so many survivors declined to engage in subsequent investigations. We will describe this in more detail in Chapter 9 on Operation Doublet.
- 7.6. In summary, we conclude that while Operation Span successfully convicted nine men, it failed to address the numerous crimes that were brought to GMP's notice at the time. We also conclude that, as alleged by both Maggie Oliver and Sara Rowbotham, during Operation Span many children's testimonies were ignored and their abusers were not brought justice. We conclude that these allegations are accurate.
- 7.7. In 2012, Operation Span was presented as having resolved the matter of child sexual exploitation (CSE) in Rochdale. However, the commendable and comprehensive investigative strategy set out by the first SIO was not followed through after this officer's departure. In the public statements GMP and Rochdale Council made at the conclusion of the trial, nowhere did they indicate that Operation Span had only scraped the surface of the problem and that many men who had serially abused children had not been apprehended, including the organised crime gang first drawn to their attention in 2007.

## **Detailed findings: Operation Span**

- 7.8. The GMP individual management review (IMR) completed for the Rotherham LSCB serious case review in 2012 noted:

*“When the requirement for an intensive police response to the issue of child sexual exploitation in Rochdale was identified by ACC A in December 2010 the immediate police and partners’ response was comprehensive and*

*effective. The joint agency investigation that followed mitigated threat, risk, and harm; resulting in the conviction of nine men for a series of sexual offences against vulnerable young people. The ‘gold’ meeting chaired by ACC A on 14<sup>th</sup> December 2010 not only definitively identified the potential scale of the issue in Rochdale it also sought to identify previously unrecognised CSE cases across the Force. In doing so it initiated a hugely significant change in GMP’s corporate response to child sexual exploitation.”*

We will show in this chapter that the police response was far from comprehensive and only tackled a small proportion of the children sexually exploited in Rochdale over the previous 10 years. Furthermore, the GMP IMR and the subsequent Rochdale LSCB serious case review overview report it contributed to, made no mention of the considerable number of children who were not investigated and the number of perpetrators who were not apprehended and brought to justice.

- 7.9. We interviewed one of the co-authors of the original GMP IMR. He explained to the review team that neither he nor his colleague at the time were the authors of the final IMR report submitted to the Rochdale serious case review. He stated that both authors effectively withdrew from their roles in the IMR process after disagreeing with senior officers within GMP at the time, who they believed were attempting to unduly influence the content of the draft IMR report.
- 7.10. On 14 December 2010, Assistant Chief Constable A called a gold meeting about what was described as:

*“an investigation which commenced in 2008 involving Child Sexual Exploitation and Rape. The offenses in question were predominantly committed in [local area] and Rochdale areas of the P division. They had initially been led by Detective Sergeant B and had been filed NFA by either the Police or Crown Prosecution Service”.*

The SIO’s policy book<sup>41</sup> recorded that the work by Detective Constable F (by this time a temporary detective) and Detective Constable C had identified apparent failings in the initial investigation and poor management of resources.

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<sup>41</sup> The primary objective of the SIO’s policy book or decision log is to record investigative direction, instruction, parameters and priorities for major crime investigations and other complex investigations while complying with the requirements of the Criminal Procedure and Investigations Act (CPIA) 1996. The CPIA code of practice (paragraph 2) requires senior investigating officers (SIOs) to record and retain records of information and other material in an investigation.

- 7.11. The gold meeting set up the following command structure:
- Gold – Assistant Chief Constable A
  - Silver – Chief Superintendent A
  - Bronze – SIO Detective Superintendent (SIO 1)
  - Deputy SIO Detective Inspector D (SIO 3).
- 7.12. Staffing from the new inquiry came from the serious crime unit and the major incident team (MIT) and an overtime budget was provided.
- 7.13. There were no other gold meetings throughout the life of the active operation other than those initiated to manage the subsequent trials. This contrasts with Operation Augusta, where we found evidence of gold meetings being regularly held and minuted. We interviewed SIO 1, who explained:
- “[Assistant Chief Constable A] came to one or two of the briefings in the morning, as did the Chief Super. I’m not sure they were minuted, I’m surprised you’ve got minutes there of a gold meeting, I don’t think they minuted many gold meetings at Head Quarters, but I didn’t probably go to a great deal of them either and, had I done, I probably wouldn’t have been given copies, but I suspect it might have been a tactical move not to minute them.”<sup>42</sup>*
- 7.14. We were told this was not an unusual approach in GMP at the time. Nonetheless, it is poor practice, and we will show that, as the investigation stalled, the lack of senior management oversight caused a critical difficulty in terms of adequately resourcing this operation.
- 7.15. Operation Span commenced with a commendable and comprehensive strategy. We will consider in more detail later in this chapter how Operation Span met these objectives. SIO 1 made it clear when interviewed by the review team that the intention was to lead a victim-focused investigation, stating:
- “We’ve got, I can’t remember the numbers, we’ve got this big pool of children, and we knew, we knew exactly who they are, names, addresses, dates of birth, full trip, so somehow, I had to carve up, for want of a better description, forty kids to however many outside inquiry DCs I had, let’s say that was ten,*

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<sup>42</sup> In a response to our draft report, SIO 1 clarified these comments as follows: “In any major enquiry daily briefings are held by the SIO to ensure an investigative strategy is being followed and to share information with the team. These have never been minuted but notes are made by the management team to capture progress.”

*that's four apiece. Their task is, to make contact with these children and try and gain their confidence and trust such that we can get them, ultimately, in front of a video interview suite to gather whatever evidence they'd already told the CIT girls, get that into evidence, so that we can move this forward and, hopefully, bring these suspects in and charge them.*

*"Engage with them, gain their trust, and let's see what happens. Well, we got evidence from, I don't know, half a dozen, that was, maybe ten were willing to engage, some refused, some just wouldn't engage, some parents said no, this is all behind them, we're not getting involved in it, so we were left with what we were left with, which were those children we were able to gain their trust of and get in front on an interview suite and get their evidence, if you like, about what had happened to them, their evidence."*

*We asked SIO 1: "So you'd get a child to engage, and that child names twenty-five people that had abused [them] are you absolutely clear with us that you, you would pursue all those lines of inquiry?" SIO 1 answered: "Absolutely."*

7.16. There is some evidence to support SIO 1's assertion as we found multiple entries in the HOLMES (Home Office Large Major Enquiry System) account of efforts to collect information and develop intelligence in respect of potential victims who appeared to have no connection to the suspects referred to at the gold meeting.

7.17. SIO 1 also told the review team about efforts to challenge children's social care on their practices, stating:

*"I went to some meetings with the Executive Director of Children's Services, the Director of Targeted Services, health must have been there, and there was a bit of a denial around the room that this was a problem and I remember saying to the Executive Director, we need access to all this material, we need your full support and she said what's the issue, this is going on all over the country, and, sure enough, she was right, but what's the issue worried me and I remember saying, you know, you need to change your practices, your working practices have to change, and you need to put something in place that can be tested and seen to be working before you end up with press all over your back and before this gets to court, cos nobody could see, I don't think, what was going to happen when the press got hold of this job."*

7.18. The first entry in SIO 1's policy book included references to a broad proactive approach to taxi drivers in Rochdale, engaging with partners such as environmental health to visit all "Asian takeaways" and an application for covert resources. The level of detail in this strategy is in accordance with our

expectations of an experienced SIO developing an investigative strategy to combat the problem of widespread CSE involving multiple perpetrators and victims. SIO 1 explained during our interview:

*“I want any Pakistani-looking taxi driver, carrying a female passenger, whose a child, stopped by Division from tomorrow until further notice and I want to make sure that any child is in a proper taxi ride, a fared taxi ride and where they’re going to, and I want Divisional traffic patrol, Panda cars etcetera, to stop any such vehicle being driven on their patch, and in Oldham, that fits that description, to stop them, to safeguard that lone female in that taxi. If the driver can’t account for the fare, PPO them, Police Protection Order, snatch them, arrest the driver, impound the car, let’s go into it big style and disrupt it.*

*“How many people do you think got stopped? None, none. Now, why don’t they get stopped? Because most, I don’t know about most, but there’s an awful lot, Oldham, Ashton, Rochdale, there are huge Pakistani, Indian communities up there, lots of the taxi drivers, a big proportion of the taxi drivers are from that background, so why weren’t any stopped? I can only guess that GMP patrols were frightened of being tarnished with a race brush for doing it.”*

In our judgement, this failure to follow through on an effective disruption strategy would normally have been overcome by effective senior leadership oversight through a gold command structure.

7.19. SIO 1 initially prioritised the following children in addition to those already interviewed:

- Child 48
- Child 46
- Child 49
- Child 42 (who had previously been interviewed in respect of an abduction by Nominal 6)
- Child 50.

7.20. SIO 1 also noted that a foetus, being the terminated baby of Child 44, had been discovered in the freezer at Rochdale Police Station<sup>43</sup> and further work needed to be completed to establish who the father was following DNA analysis.

7.21. The first entry of the SIO policy book on 14 December 2010 stated:

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<sup>43</sup> This had been discovered following a routine property review.

*“Gold asserted that the matters be reinvestigated and the suspects where possible be arrested on 21 December, charged, and remanded into custody.”*

7.22. We believe this was an unrealistic objective based on the evidence available at the time and the difficulties associated with obtaining evidence from the witnesses. SIO 1 recalled when interviewed by the review team that he was concerned about the vulnerability of the victims over the Christmas period. SIO 1 had intended to go for an early arrest, disrupt the activities of the perpetrators and separate the suspects from children within their family. SIO 1 prioritised several suspects for arrest: Nominal 8, Nominal 9, Nominal 10 and Nominal 11 (all relating to rape and/or sexual activity with Child 41). and Nominal 12 and Nominal 13 for rape and sexual activity with Child 47. Nominal 6 was not included in this target list.

7.23. SIO 1 explained to the review team:

*“I was concerned that we’d got these kids who had been raped by these Pakistanis in Rochdale who are, who have groomed them, who have given them food and drink, whatever else, free rides in taxis, I’m thinking at the time that they probably felt more love from these idiots than they were getting at home. We’ve got Christmas around the corner, i.e., ten days away, and my concern was, one I don’t want these children being raped on my watch, and two this is probably the most vulnerable time for them. If they wake up on Christmas morning and there are not lovely gifts there all gift-wrapped and Christmas lunch waiting for them, they might just put their coat on, get out and meet up with these people and get raped again. So, rightly or wrongly, I decided, or I was told, and I found a reason why I should do it, that we’d arrest them a week before Christmas because, whilst that probably wouldn’t provide us with a great deal of evidence, it would certainly disrupt it, and it would certainly allow us to put some kind of conditions on their bail when they were bailed, and it gives us opportunity to search their home addresses but, more importantly, it gives us opportunity to find out who they’re living with and what other children, if any, are vulnerable and could be being abused by this group of men.”*

7.24. On 17 December 2010, five further MIT detectives joined the operation. On 20 December 2010, SIO 1 recorded that the arrests would be organised in three phases owing to the pressure on time to identify interview teams. He explained

that Phase 3 would be to reinvestigate offences committed in 2008 and 2009 by Nominal 6, Nominal 7<sup>44</sup>, Nominal 16, Nominal 25 and Nominal 18.

- 7.25. In summary, within a little over one week, SIO 1 had arranged to arrest seven of the nine men who were subsequently convicted. We acknowledge that there is a judgement call to be made about when to arrest suspects in any investigation. There are advantages in making early arrests in that it allows an opportunity to conduct searches, it may encourage other victims to come forward and it also provides an opportunity for a multi-agency risk assessment of the children within a suspect's own family. However, if there was no likelihood of charging the suspects at this stage of the investigation without them making admissions, then this strategy risked alerting the perpetrators without having first put in place significant protection plans for the victims. We therefore believe the risks outweighed the benefits given the obvious vulnerability of the witnesses and victims. Without the prospect of remanding the suspects into custody, this strategy presented an opportunity for the suspects to subsequently approach and intimidate witnesses.
- 7.26. Nonetheless, SIO 1's tactic of early arrests did achieve some success. Eight arrests were made on 21 December 2010. These were Nominals 8, 9, 10, 11, 12, 13 and Nominal 6. In addition, there was one further arrest of an individual not previously mentioned by SIO 1, Nominal 19. In an interview, Nominal 9 admitted to paying Amber to engage in sexual acts in his taxi when she was 15 years old. He also admitted to driving Child 44, Child 46 and Child 41 as fares to various locations. The suspects were all bailed with conditions to prevent them from having contact with any child under 18 or any witnesses. SIO 1 recorded that safeguarding referrals were made to Rochdale Council, which undertook Section 47 enquiries.
- 7.27. On 12 January 2011, SIO 1 recorded that a strategy meeting had concluded that "*none of the suspect's children are in danger and case conferences will not be held in relation to them*". We have not seen the assessments that were undertaken to support this conclusion, but we are aware that no assessment was undertaken on Nominal 6 by Oldham Council<sup>45</sup> and given his background and offences this should have been addressed.

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<sup>44</sup> Nominal 7 and Nominal 16 were convicted at Liverpool Crown Court in May 2012.

<sup>45</sup> We have covered this issue in our second report *The review into historic safeguarding practices in the borough of Oldham* (June 2022).



- 7.28. On 22 December 2010, SIO 1 recorded a note on Amber:
- “It is accepted and understood that she has been involved in the incitement of girls under the age of 16 to become prostitutes after she herself had been raped and abused by suspects. She was clearly a victim first although never treated as such and then became an offender subsequently ... If she were to become a Crown witness her evidence would be crucial and compelling and it is very likely other victims would be happier to come forward ... There is little trust in existence at present and this needs to be established by Detective Constable Oliver and Detective Constable E.”*
- 7.29. On 14 January 2011, a staff briefing heard that the Crisis Intervention Team had been approached by Child 3, who said she wished to be interviewed as a victim. She identified another child, Child 23, who had also identified herself as a victim.
- 7.30. On 19 January 2011, Detective Constable Oliver reported that Child 44 continued to be a victim of sexual exploitation, SIO 1 noted that: *“It is imperative that we protect Child 44 from these offences.”* On 20 January 2011, Nominal 10 and Nominal 16 were arrested. Both these men were subsequently convicted at the Operation Span trial in 2012. On 28 January 2011, Nominal 21 was arrested on suspicion of the rape of Child 41. On the same day, the Crown Prosecution Service (CPS) confirmed that Amber should be treated as a witness and *“a victim first and foremost”*. We will set out in the next chapter how Amber was subsequently cruelly let down by GMP and the CPS and the serious implications this had on her and her young child.
- 7.31. By the end of January 2011, with several suspects positively identified, SIO 1 noted that the CPS was unable to consider charging decisions until the beginning of March. The SIO recorded in his policy book that:
- “Crown Prosecutor A is fully employed with other work over the next two weeks and will not be able to concentrate on this case ... The time constraints and magnitude of this operation would give us huge difficulties if we wanted to be in a position to charge /remand into custody any of the suspects. She will not have had sufficient time to deal with or have knowledge of the investigation to be able to comment by 1 March 2011.”*
- 7.32. Crown Prosecutor A informed the review team that they had only been allocated the case on 18 January 2011. The evidential transcripts alone ran to 3,391 pages (37 video interviews/50 viewing hours). This did not include all other evidence. There were unused accounts of 39 children, some of whom were dealt with in other operations, and significant third-party material. Crown

Prosecutor A's view was that it was unrealistic to expect charging decisions within six weeks.

7.33. Nonetheless, we regard this delay as highly problematic. SIO 1 had, with the best of intentions, moved quickly to arrest several suspects but the failure to put the men before a court and to request that they be remanded into custody left the children who had made disclosures against them vulnerable to further coercion and intimidation.

7.34. On 3 February 2011, SIO 1 recorded that an email had been sent to the Crisis Intervention Team coordinator to ensure that any new referrals were made to P division<sup>46</sup> and not the incident room. SIO 1 noted:

*"This is to ensure keep (sic) investigation focussed into our terms of reference and not diverted into other investigations."*

We discussed this email with SIO 1 in our interview. SIO 1 explained that he had intended that only new referrals made after the date of the commencement of the investigation should be referred to the division, but that he remained open to any relevant historical referrals. It is clear to the review team that SIO 1 had, by this point, identified that there was a danger that the scale of the operation was now exceeding the resources at his disposal, and this was compounded by the delays in securing advice from the CPS.

7.35. On 17 February Child 17 was interviewed and disclosed accounts of offences against her perpetrated by Nominal 6 and another man referred to only by his nickname. On 21 February 2011, Child 53 was visited but she was reluctant to support the investigation as she had reportedly received threats through Facebook.

7.36. In an extraordinary move, on 28 February 2011, Detective Chief Superintendent B replaced SIO 1 with his deputy, Detective Chief Inspector B, (SIO 2). SIO 1 explained in his interview with the review team that Detective Chief Superintendent B had taken him off the operation as she wanted him to lead a restructuring of the public protection division. SIO 1 informed the review team that he believed this to be a poor decision as he felt that SIO 2 was insufficiently experienced to deal with a complex large investigation. SIO 2 did not have a background in major investigations and had only recently

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<sup>46</sup> The area covered by GMP is split into geographical divisions, with each district being assigned to one of these. Rochdale is assigned as P division.

completed HOLMES training. SIO 1 felt this was a major weakness. The view of another of our interviewees was that this was a deliberate decision to put in a more pliable SIO.

- 7.37. We raised these concerns in our interview with Detective Chief Superintendent B who explained that she had removed SIO 1 as she was concerned about his competence. She believed he had limited experience of working in a child protection context, which required good multi-agency partnership working, skills she believed he lacked. We have struggled to see the rationale for this change only two months after the operation began. SIO 1, in his interview, informed the review team that he had been hand-picked by Assistant Chief Constable A based on their past working relationship. At no time during that period had Chief Superintendent B expressed concerns about his ability to continue to lead this investigation, so it came as a surprise to him to be removed from it to assist her in the formation of the new public protection division. From our reading of the SIO policy book and the interviews we have held, it is apparent that the operation was progressing positively and at pace. It was also clear that SIO 1 was asking his superiors to set up a multi-agency strategic board to share information with all relevant partners to achieve the aim of safeguarding children. Our view is that replacing SIO 1 with a significantly less experienced SIO, at a critical time in the operation, could not have helped the continuity and progress of the investigation.
- 7.38. On 8 March 2011, SIO 2 recorded that the CPS would not be able to review the evidence before 15 March 2011. Consequently, the suspects were bailed for a further period until 27 April 2011.
- 7.39. On 15 March 2011, Nominal 6 was arrested for offences of sexual assault against Child 17 and Child 54. He was charged with multiple offences of rape and remanded into custody. However, the CPS was still not in a position to give its advice with respect to the remaining suspects and the decision was made not to arrest the suspects before April 27, as previously planned.
- 7.40. On 14 April 2011, Child 44 attended the first of a series of interviews with the police. Her final interview was completed on 16 June 2011. Amber was also interviewed over this period.
- 7.41. On 28 April 2011, SIO 2 recorded the following limitations to the investigation:  
*“Operation Span will investigate all reported sexual offences involving the current list of suspects or offence locations already pointed out by victims of this enquiry. Any other offences by other offenders will be passed to the*

*relevant division- this includes offences against our current victims/witnesses by other unrelated individuals who have not featured in the Span investigation thus far ... An official handover is required so that there is no doubt who is responsible for different/splinter investigations. It may well transpire that Rochdale are unable to service a large number of allegations, but it is important that they apply for further resources. My staff must concentrate on the current investigation rather than get involved in other unrelated matters.”*

- 7.42. While we appreciate that SIO 2’s intention was to not be diverted from securing convictions against the suspects already identified, it was an unsatisfactory solution for all new referrals to be directed back to the division when its lack of resources and expertise had led to previous failures to tackle the widespread exploitation of children in Rochdale. We have already demonstrated that the division neither had the resources nor the skills to carry on this complex work. We believe that SIO 2 should have raised any concerns that the operation’s scale far exceeded what was previously anticipated with the senior leadership team, and either suggested an additional supplementary investigation team or an enhancement of the resources within the SIO’s direct control. This goes to the heart of the allegations made by Sara Rowbotham and Maggie Oliver that many perpetrators and many of their victims fell through the cracks of Operation Span.
- 7.43. These limitations have been confirmed by interviewees who told us there was no further investigative work after the charges were made. On 27 June 2011, SIO 2 and a detective sergeant carried out an ‘action review’. SIO 2 recorded that several actions had been referred<sup>47</sup> for the following reasons:
- a. *“They do not progress the investigation against those already charged.*
  - b. *There is no likelihood of identification of the suspect.*
  - c. *A minor offence has been committed in comparison to those charged.*
  - d. *The victim is unwilling/unable to assist in the prosecution of the case.*
  - e. *There is information that is not corroborated by any other source.”*
- Most concerning, SIO 2 went on to stipulate two further reasons:
- f. *“It is important that I utilise my resources in the most productive way, concentrating on those victims and suspects that will be appearing in court.*
  - g. *The court system cannot/does not appear to be able to accommodate more than 14 suspects at any one time.”*

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<sup>47</sup> ‘Referred’ effectively means closed to this investigation.

For the avoidance of doubt, SIO 2 added:

*“No new actions to be raised unless they provide evidence for or against our current suspects (Charged + Nominal 15, Nominal 22, and Nominal 23).”*

- 7.44. In this way, SIO 2 explicitly recorded that the operation parameters were set by the resources available and the ability of the court to manage multiple defendants, rather than because the investigation had reached a natural conclusion, with all victims protected and all perpetrators brought before the court.

Furthermore, there is no evidence within this referral process that the victims excluded from Operation Span were subject to an alternative, appropriate multi-agency framework that provided them with adequate protection. We would have liked to have put these issues to SIO 2, but she did not make herself available for interview.

- 7.45. In the closing paragraphs of the policy book, on 20 July 2011 SIO 2 noted that a gold meeting would be set up in September 2011. The main aim of this seems to be to ensure that arrangements were in place with Merseyside Police to deal with security issues at the court.
- 7.46. On 31 August 2011, in another extraordinary move, SIO 2 was replaced as the Operation Span SIO by Detective Inspector C (SIO 3) – the third SIO in eight months.

SIO 2 recorded in the policy book:

*“DI C is now the “SIO” for this investigation and will now sign off documents albeit I will be made aware of any significant developments and will attend some of the briefings. I am now (1/9/11) in charge of 4 divisional PPIUs and unable to give 100% of my time attached to Op Span.”*

- 7.47. The SIO policy book ends at that point with no further actions, no further arrests, and no further interviews recorded. There is no evidence on the file that the operation was formally closed by the gold commander or that this decision was taken with partners. It is highly regrettable that, having set up an ambitious and aspirational operation to resolve the long-term historical abuse in Rochdale, the basic framework of a good operation was not put in place and that the gold commander, Assistant Chief Constable A, failed to assure himself that the earlier parameters of the investigation had been fulfilled.

7.48. We acknowledge that in 2012 many police forces were still grappling with the complexities of investigating this type of sexual exploitation. However, there was some guidance available, notably from the National Policing Improvement Agency (NPIA) which was endorsed by the Association of Chief Police Officers (ACPO) to provide guidance to forces on a range of subjects. The NPIA's *Guidance on investigating child abuse and safeguarding children* (second edition, 2009) provides examples of complex abuse, including the type of exploitation investigated by Operation Span, and suggests several investigative approaches that may have assisted. For instance, the guidance explicitly states that: "*The investigation of complex child abuse is time-consuming and requires specialist skills from both police and children's social care.*"

7.49. When interviewed by the review team, SIO 1 said even though he was no longer formally involved in the operation, he was subsequently contacted by the CPS, which was concerned appropriate actions were not in place to support a successful prosecution. SIO 1 stated:

*"[The lead barrister for the prosecution] leading the inquiry sent me an email expressing her concerns about how the file was being put together or the time it was taking and told me to, give a kick up the arse to SIO 3 and get involved in it to try and get it sorted and find out what was going wrong. I got the file back on track and everything running as best I could to the timescales that had been set, and I got more and more involved in it, having not been involved for twelve months, because there were loads of other issues, as you can imagine, with a file build-up. Not only file build up, it went off-circuit, and I can't remember why, I think it's possible because Manchester didn't have a courtroom big enough for the number of defendants, so it went to Liverpool."*

7.50. Maggie Oliver has been supporting Child 3, Child 44, and Amber for many years<sup>48</sup>. With her help, we interviewed Child 44, Amber, and Child 3. They were central to the investigation, and all three were able to provide GMP with evidence of serious sexual exploitation and abuse by numerous men over several years.

- Amber had been designated as a victim by both the inquiry and the CPS. She had originally been seen as central to the successful prosecution of the Operation Span offenders. Although initially reluctant, she had been successfully engaged through the persistence and reassurance of Detective Constable Oliver. Amber provided hours of interviews over a

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<sup>48</sup> In April 2022, the new Chief Constable issued a public apology to Child 44, Amber, and Child 3.

period of four months, during which she provided extensive and detailed accounts of the abuse she and other children had suffered over many years. She identified numerous men who had assaulted her. She also agreed to go on 'drive-rounds' with Detective Constable Oliver to identify relevant locations where abuse had taken place and provided GMP with a list of information about suspects. She described how she would be "*passed around*" between these men, who would give her alcohol and cigarettes and have sex with her only when she was drunk. On occasions she would be trafficked to various locations to have sex with other men she did not know. On one occasion, she was threatened with a gun by Nominal 51 when she refused to comply with his demand that she have sex with him. Child 41 had also given a police statement in which she had witnessed Amber being threatened with a knife and death by Nominal 52 if she told her mother about her abuse. Despite all this, Amber later learned that GMP had never formally recorded any crimes committed against her. None of her abusers was charged with offences against her, although some were charged with offences committed against other children. Ultimately, given the crucial nature of her evidence, a decision was taken to indict Amber as a co-conspirator to ensure this evidence could be heard in court. We discuss this disturbing tactic in more detail in Chapter 8.

- Child 44 also provided hours of interviews identifying numerous suspects. We covered the retention of her foetus in Chapter 5. In her interview with the review team, she described the horrific abuse she had experienced as a child:

*"It was that one night when the rape started. We went into one room and then they took us into a few rooms. They told us not to go into the main room where we'd usually go so, they took us into another room, so we were sat drinking drinks and then they said, 'you're allowed to go into the other room now' and there were 20 or 30 Asian men in there. They just passed us around like a ball. I don't really remember much I had a lot of alcohol in me, and it wasn't mixed, they'd just give us it pure."*

It was decided that Child 44 would be called as a victim and witness to give evidence at the 2012 Operation Span trial. The CPS charged 12 men with conspiracy to engage in sexual activity with Child 44 and a further two children. Child 44 was particularly distressed to learn that the man who had groomed her into believing she was his 'girlfriend', and impregnated her at the age 13, was only found guilty of conspiracy and sentenced to eight years' imprisonment (to run concurrently) for trafficking for sexual exploitation. For reasons she did not understand, and still cannot agree with, he has never been charged with rape. The limited charges that were brought against some of those who were convicted meant they served relatively short sentences. The man who impregnated her was released

on licence from prison less than four years after he was sentenced. Child 44 described being threatened by a man with a gun prior to her trial and the total absence of any protection after the trial.

*“Me and my friend went to the shop, I got abuse hurled at me in the street, saying oh you got men done for rape. Loads of men chased us in the cars. I was also in the local Asda about four or five years after the trial and I bumped into my abuser who got me pregnant. I didn’t even know he was out of prison. Nobody had told me or asked me if I wanted to object to him being released. I see many of the men who abused me all the time, all around Rochdale all the time. I rang the Police.”*

- When we asked Child 44 how the police responded, she replied: *“They didn’t. They just said lock your door.”* We asked if there was any police protection or cameras and she said: *“No, nothing.”* Child 3 was part of a group of children who were subjected to rape and serious sexual assaults arranged by the organised crime gang leaders we discussed in Chapter 3. She was passed around between several men. She was also forced to transport drugs for them. She was raped on many occasions, usually while she was heavily intoxicated. She was also subjected to numerous violent and very frightening physical assaults. She agreed to give evidence as part of Operation Span. She assumed that this would be a chance for her abusers to face justice for what they had done to her and was encouraged by police officers to believe this would be the case. But she told us that when she was asked to attend police interviews, she was repeatedly discouraged from speaking about the abuse that had been perpetrated against her personally, and was asked instead to focus on any incidents she had witnessed involving another child. Child 3 explained to the review team:

*“I decided to talk after years of being ignored. I went ahead with it all and started doing videos and giving evidence and hours of interviews and then one day after doing it all they told me they were making arrests within a timescale and then came back to me and asked me to do them a favour and to act as a witness for another girl. I told them I would help and then it started getting sour, police officers would call the other girls to me and when we were doing interviews, I kept referring back to myself and the police officer slammed down on the recorder and told me to go outside. Outside he told me I was ruining the case by talking about my case, it wasn’t about me. I was told to shut up. I did the ID parade and then I went to court and they said they would put special measures in place, but nothing was put into place.”*

She went on to give evidence about these incidents at the 2012 trial. As she learned much later, the police had no intention of recording or prosecuting the crimes committed against her as part of Operation Span.



Furthermore, although she was informed by officers that they would return to her allegations of abuse at a later date, this never happened. In her interview with the review team, Child 3 described the disastrous impact appearing as a witness had on her welfare and that of her child:

*“I gave evidence as a witness and then they weren’t interested in me anymore. I got a phone call to say it was going to be in the media and I had no protection at all. It was left a couple of months and where I live is a predominantly English area. An Asian male pulled up outside my house and hand gestured a gun sign. I was shaking, I rang the police and explained it to them, they came out and patrolled the area and no one was there. A week later I had been out and when I got home my house was trashed, with slag and grass written across the wall, they ripped the carpet, burnt the shed down, and killed the chickens. I rang the police, and they said if they come back, get out, I was pregnant at the time. Then after that, my windows were smashed and I had Facebook messages saying that they knew where I lived, I reported this all to the police. One night my front door was unlocked, I rang my brother, and he came, but no one was there. I had just given birth; I packed my bags and went to stay at my dad’s on the sofa. I told the police and all they kept doing was apologising and they told me the investigation was over and there was nothing more they could do and told me to go to my local councillor. I had nowhere to go and I ended up with two babies in a homeless hostel. I had nothing, only the clothes I stood up in. I had to leave everything behind when my home was trashed by the offenders. I kept phoning my police officers begging for help, but they said they couldn’t help me as the case was closed.”*

7.51. GMP requires the cooperation of young people such as Child 44, Amber, and Child 3 to support any successful prosecution. It is not surprising, given the lack of support our interviewees described, that so many survivors declined to engage in this and subsequent investigations.

7.52. It is worth repeating how GMP described Operation Span on the conclusion of the investigation. The GMP independent management review (IMR) said:

*“When the requirement for an intensive police response to the issue of child sexual exploitation in Rochdale was identified by ACC A in December 2010 the immediate police and partners’ response was comprehensive and effective. The joint agency investigation that followed mitigated threat, risk, and harm; resulting in the conviction of nine men for a series of sexual offences against vulnerable young people.”*

7.53. We have seen that, despite its terms of reference and the early ambition, Operation Span quickly evolved into a limited investigation into a small number of men linked to the 2008–09 investigation into the two takeaway restaurants in Rochdale. Given the scale of the past sexual exploitation of children within Rochdale, this was neither comprehensive nor was it effective in addressing the widespread exploitation of children by numerous men in the preceding years.

In our interview with Detective Chief Superintendent B, she summed up the situation as follows:

*“It got conflated in that Span became synonymous with Rochdale and the whole CSE issue at Rochdale, which was never really the case. Span was that specific investigation and the CSE issue at Rochdale was something completely different but in people’s heads, in the press, and all the rest of it, Span became synonymous with the whole CSE problem.”*

While this is not inaccurate, it is also the case that in the public statements GMP made at the time, nowhere did the police indicate that Operation Span had only scraped the surface of the problem and that many men who had serially abused children had not been apprehended, including the organised crime gang first drawn to the force’s attention several years earlier.

# Chapter 8. The indictment of Amber and the role of the Crown Prosecution Service

## Summary and conclusions

- 8.1. In January 2011, Amber was considered by SIO 1 as a critical witness to the successful outcome of Operation Span. It was known to the SIO that Amber had previously been arrested in 2009 on suspicion of inciting females to engage in prostitution on behalf of the men who were abusing her. We have established that this arrest was made, even though GMP and Rochdale children's social care were aware that she had been a victim of sexual exploitation for several years. Amber denied any role in procuring children when interviewed by the police.
- 8.2. In February 2011, the head of the complex case unit at the Crown Prosecution Service (CPS) formally agreed that Amber would be designated as a victim and that she should never have been arrested in 2009. Detective Constable Maggie Oliver was tasked with befriending Amber and her family and winning her confidence to give evidence to the inquiry. Amber gave many hours of interviews and identified a significant number of men who had abused her and other children.
- 8.3. In our interview with Maggie Oliver, she asserted that at some point in 2011 GMP became concerned that Amber's evidence was likely to expand the investigation beyond that which the dedicated resources would allow. Given the evidence we have seen, we believe, on the balance of probabilities, that this was the case. We note that GMP has since acknowledged that none of Amber's evidence was entered as crimes against her on the police system<sup>49</sup> and did not form part of the forthcoming Operation Span trial.

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<sup>49</sup> In 2022, in a formal apology to Amber, the Chief Constable noted: "*Operation Exmoor is a current enquiry being led by a GMP team of specialist detectives dedicated to the investigation of non-recent CSE in Rochdale. A number of offences against you that were disclosed to GMP during Operation Span have now been recorded as crimes under Operation Exmoor ... I fully understand your complaint is of crimes against you not having been recorded at the time at which disclosures were first made to GMP by you or by others and for this I apologise.*"

- 8.4. In September 2011, it became apparent that the evidence Amber held was critical to the successful prosecution of Operation Span. The CPS, in consultation with GMP, decided to name Amber as a conspirator in the sexual exploitation of other children and included her name on the indictment for the trial. We understand this was a legal tactical decision by the lead barrister for the prosecution to ensure the jury heard Amber's critical evidence to the case. This decision was made despite the previous commitments given to Amber, and in the full knowledge that she had been coerced by her abusers. We regard the lack of concern by GMP and the CPS about the impact on a vulnerable survivor as unacceptable. Amber was not informed that she would be named on the court indictment and was unable at any stage of the procedure to defend herself against these allegations. We can find no evidence to indicate that any consideration was given to how the decision would affect Amber personally or what the repercussions of the decision might be for her family. By naming her as a co-conspirator, in our judgement, there was a foreseeable risk to her and her family's personal safety that was either ignored or not considered. We regard this as a deplorable further abuse of a survivor.
- 8.5. Amber's exposure through the court process had a long-term damaging impact on her welfare. It is disappointing that although the GMP and Rochdale Council independent management reviews (IMRs) and the Rochdale LSCB serious case review overview report covered the period up to and including the Operation Span trial, none of these reports mentioned the treatment of Amber and the deleterious consequences of her designation as an offender rather than a victim.
- 8.6. On 12 April 2022, the GMP Chief Constable issued Amber with a public apology for failing to investigate the crimes against her and failing to recognise her as a child victim. However, no apology has been made by the CPS<sup>50</sup> for including her name on the indictment without informing her or providing her with any support or protection from the repercussions<sup>51</sup>.

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<sup>50</sup> In response to our draft report, the CPS made the following comment: *"It is correct that the CPS has made no apology in relation to the inclusion of Amber on the indictment. (This issue is currently the subject of civil proceedings)."*

<sup>51</sup> In response to our draft report the Chief Prosecutor for Northwest England at the time informed the review team that regardless of the merits of the decision there was no excuse for not informing Amber and he was not aware that she had not been.

## Detailed findings: The indictment of Amber

- 8.7. On 31 March 2009, Amber was arrested and subsequently interviewed by the police on suspicion of inciting females to engage in prostitution. Amber declined to answer questions during the interview but did provide a prepared statement through her legal representative as follows:

*"I wish to state the following about an allegation of inciting girls aged thirteen to seventeen to prostitution. I deny being involved in any activities relating to the above matter. I've never threatened anyone with the aim of them engaging in prostitution, nor have I used violence to achieve the same. I have never encouraged anyone to engage in prostitution. I've never received or distributed any money to anyone in connection with prostitution. I've never distributed free alcohol with the aim of inciting prostitution."*

- 8.8. Amber has described this arrest as one of the most traumatising and permanently damaging aspects of her experiences following her abuse. We have set out in the previous chapters how Amber had been raped and abused by countless men over several years. At the time of her arrest, she was still a child, only 16 years old. She had been made subject to a child protection plan due to the risks of sexual abuse and it was believed by both the police and children's social care that she was being forced under the threat of violence to procure children by the same men who had raped and abused her. We also question why Amber was singled out in this way for arrest. In our judgement, all the evidence pointed to the fact that she was just one of a group of children of similar age who were being sexually exploited in return for money drugs, food and alcohol. As a general observation, it is not unusual for child victims in these cases to involve other children in the abuse following pressure from abusers to do so. This was also confirmed in our interview with Detective Constable Oliver, who had interviewed Amber on a number of occasions. She stated that she never saw any evidence that Amber acted in any way differently from the other victims in this case. All the victims were on occasions given money and plied with large quantities of alcohol.

- 8.9. As we have set out in Chapter 6, Amber was subsequently viewed as critical in the successful prosecution of the Span defendants. On 14 January 2011, SIO 1 (then responsible for Operation Span) recorded that a case conference was held with solicitors from the CPS, Detective Chief Inspector B, Detective Inspector C, the tier five interview advisor, a GMP force analyst and three detectives working on the investigation. At the conference, SIO 1 outlined the options for interviewing Amber as follows:

- She is dealt with as a suspect.

- She is classified as a witness by the SIO since she was a victim before embarking on any criminal endeavours. SIO 1 noted: *“It is not in the public interest to deal with her in an alternative way.”*
- The CPS exercises prosecutorial discretion to treat Amber as a witness, as established under the witness immunity and assisted offenders’ legislation within SOCPA<sup>52</sup>.
- A SOCPA agreement is entered into with full CPS support and Amber’s offending is dealt with to use her as a prosecution witness.

The CPS agreed to consider these options so that a decision would be available before Detective Constable Oliver attempted to win the trust of Amber and her family.

- 8.10. On 28 January 2011, SIO 1 recorded in his policy book that the CPS had confirmed that Amber should be treated as a witness:

*“We will use the prosecutorial arm- irrespective of any criminal offences she has/may have committed, she is a witness and a victim first and foremost.”*

- 8.11. On 7 February 2011, the head of the CPS North West Complex Case Unit confirmed that Amber was a victim and should never have been arrested in 2009. He noted on the CPS file that he believed the system failed her.

- 8.12. SIO 1 had tasked Detective Constable Oliver with building a rapport with the family and winning her confidence. Over many weeks Amber began to trust Detective Constable Oliver and gave countless hours of her time helping to identify premises where she was abused and giving lengthy video interviews.

- On 7 March 2011, a video interview was conducted by Detective Constable Oliver and Detective Constable E. Amber explained that the exploitation had started when she was at secondary school when she was introduced by Child 44 and Child 46 to the restaurant where the abuse occurred. She went to various addresses for two years and Nominal 6 would buy beer and kebabs for all three children and Child 42. Amber described sex with at least 15 separate men and informed the detectives that she had been to sex parties between four and 10 times.
- On 18 March 2011, in a second video interview, Amber talked about sex with multiple men and described 13 of her abusers. She explained that she

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<sup>52</sup> Serious Organised Crime and Police Act 2005.

was paid for sex but was not paid to get other girls to have sex. She was involved from the ages of 14 to 16.

- On 7 April 2011, GMP was informed that while Amber was out with her mother one of the men she had named among her abusers made a gun gesture towards her.
- On 24 May 2011, Amber was interviewed and disclosed becoming sexually involved with two Asian men, referred to as Nominal 53 and his driver, Nominal 54.
- On 25 May 2011, Amber was further interviewed by the police in connection with child sexual exploitation (CSE). She mentioned having sex with an Asian taxi driver, Nominal 55. She also said that Child 41 had had sex with Nominal 53.

8.13. At some point in 2011, it is apparent that the GMP decided to no longer consider Amber as a victim and witness. In her interview with the review team, Detective Constable Oliver said she believed this decision was influenced by the desire not to augment the operation with new suspects and new enquiries. We are unable to provide any assurance on this matter as the SIO policy book ends on 14 July 2011. It is of significance, however, that on 27 June 2011 the SIO had recorded:

*“No new actions to be raised unless they provide evidence against our current suspects (charged plus Nominal 56 Nominal 57 Nominal 58 and current victims.”*

8.14. We have established that by the beginning of August 2011 the CPS and GMP had decided to exclude Amber as a witness from the forthcoming trial. A draft indictment for the forthcoming trial made no mention of Amber, either as a victim or as a co-conspirator. Given the volume of information about the dangerous men who had abused her, it is difficult to understand the rationale for this. While some of our interviewees have justified this based on her volatility, we are not persuaded by this argument. This is not an unusual trait in many such cases and given Amber’s substantial formal statements we believe this could have been managed as her family were also supporting the prosecution. In our interview with the CPS Head of the Complex Crime Unit in 2018, he pointed out that Amber had identified eight or nine additional suspects, which could have expanded the operation. All the evidence we have seen supports Detective Constable Oliver’s assertion that GMP did not wish to extend the operation to include the multiple offenders Amber had implicated. Regrettably, GMP concluded that it had sufficient information to go forward on the small number of suspects it had already identified as central to the case.

- 8.15. The exclusion of Amber, however, presented a difficulty to the prosecution case given the corroboration her evidence had provided. Notes of a conference on 21 September 2011 stated that the barrister advising the CPS had recommended that Amber be named as a co-conspirator on the indictment and the CPS agreed with this recommendation. This has been described to the review team as a tactical decision by the prosecution to include the corroborative evidence Amber had provided while excluding her as a victim in the case. In July 2018, we formally asked the CPS to provide a copy of the minutes of the meeting held on 21 September 2011. The CPS refused to supply this information, stating that any advice provided by the barrister was subject to legal professional privilege. Ultimately Amber was never called as a witness, nor were the crimes against her ever investigated.
- 8.16. We regard this decision as extremely disturbing. A tactical approach by a group of lawyers and GMP officers had disregarded the carefully considered decision, made at the beginning of the year, to treat Amber as a victim as well as all the commitments given to Amber to win her cooperation. It is particularly concerning that a decision was taken by these same professionals not to disclose to Amber that she would be named in court as conspiring with the same men who had exploited and abused her.
- 8.17. In June 2018, we interviewed the head of the CPS North West complex case unit. We asked him, irrespective of the merits of naming Amber as a co-conspirator, why Amber had not been informed that this decision had been taken. He explained that on 19 December 2011 there had been a further meeting when a discussion took place about whether the family should be notified of the decision to name Amber as a conspirator. It was agreed not to notify Amber or her family because of “*the risk of contamination*” between Amber and other witnesses. He acknowledged, from the notes he had considered, that there did not appear to have been any consideration of seeking to anonymise Amber in open court. Furthermore, there did not seem to have been any consideration to put in place a package of welfare support and protection for Amber, either immediately before, during or after the trial. In July 2018, we formally asked the CPS to provide either a copy of the barrister’s advice or notes from any of the relevant meetings. The CPS declined to share this information, stating that the advice was subject “*to legal professional privilege*”.
- 8.18. As a review team, we find it most troubling that a vulnerable individual exploited for many years as a child could, without advance notice, find herself named in court on an indictment for an offence for which she had not been formally charged, through a mechanism that meant she could neither respond



to the allegations made about her nor defend herself. This tactic was achieved by publicly naming her on the indictment and then indicating that it was not in the public interest to proceed with the charges against her. No request was made to anonymise her name in open court nor was any consideration put in place to support and protect Amber from the consequences of this decision.

8.19. While this might have been convenient for the case for the prosecution, it had a lasting and catastrophic impact on the welfare of Amber and set in chain a series of events that were to affect her for many years into the future.

8.20. The lead barrister for the prosecution, in her opening address<sup>53</sup>, stated:

*“The Prosecution case is that [Amber] was an important person in this case. She was also having sex with adult men, and getting food and alcohol for doing so, but she moved on to play an active role in helping men including these Defendants sexually exploit the other girls. [Amber] introduced [Child 41] to many different men who wanted to have sex with her, with or without her consent. [Amber] was herself having sex with large numbers of men and being paid for doing so, with cash, alcohol or food, but she introduced Child 41 into this environment and was paid in the same way for her part in procuring Child 41 for the men.”*

8.21. In this way, Amber was presented as a significant participant in the offences by the men who were standing trial. The barrister’s opening statement is silent on the fact that it was incontrovertible by this time, given the hours of video evidence provided by Amber, that she too had been raped, abused, exploited and threatened with violence.

8.22. It had not gone unnoticed by the media that Amber had not been prosecuted, despite the allegations put forward by the prosecution. On 1 May 2012, the CPS communications officer prepared a draft press release. This was forwarded to the lead barrister for the prosecution that evening. On 2 May 2012, as the case was drawing to a close, the lead barrister for the prosecution communicated with the CPS:

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<sup>53</sup> The purpose of the prosecution opening address in a criminal trial is to summarise the prosecution case, concisely outlining the facts and the matters likely to be in dispute. In other words, it is to explain the indictment to the jury and give them an introduction to the evidence on which the prosecution intends to rely and which the jury will go on to see and hear during the trial.

*“Further to the discussions about a press release re Amber, here is my contribution. I don't get internet access except in the courtroom, hence the delay in sending this.*

*“I have had the advantage (should you want to call it that!) of hearing all the evidence and the closing speeches in this case, which is what the journalists heard, and which may be the basis for their questions about Amber. In that context, it seems to me that essentially what they want to know is why Amber was not prosecuted. The allegation made in the trial is that she was not prosecuted because she was white and because it did not suit us to make public what she had to say.*

*“May I suggest the following for your consideration:*

*“The 'Operation Span' investigation included an investigation into Amber including her circumstances and events involving her, whether instigated by her or otherwise. Necessarily, that involved consideration of her role as a potential suspect and as a potential witness. A careful assessment of the totality of the evidence demonstrated her involvement in the conspiracy with which the Defendants were eventually charged. As a result, it was necessary and appropriate to identify her on the indictment to clearly present the evidence of the conspiracy to the jury.*

*“In considering whether or not to prosecute her, the Crown Prosecution Service<sup>54</sup> applied the two-stage test for prosecutors and determined that it was not in the public interest to do so. Factors taken into consideration in this determination included but were not limited to, her age at the time of the offences (15-16), her background and the circumstances in which she became involved in these events. It is not appropriate to make public all the factors taken into account. Her gender and her ethnicity were not factors which were relevant in any way to the decision which was reached.*

*“Relevant material concerning Amber gathered during the investigation was disclosed to all the Defendants' legal representatives (pursuant to the usual regime required by the CPIA [Criminal Procedure and Investigations Act 1996]) well in advance of the trial. They were therefore in a position to decide whether and how to seek to use that material to advance their defences at trial.*

*“I think this covers all the points which you have been considering in your discussions thus far and might more readily reflect the tenor of matters raised in court here.”*

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<sup>54</sup> This is the 'Full Code Test' set out in *The Code for Crown Prosecutors 2018*.

- 8.23. We have not seen the actual press release but given this had been developed with the support of the Chief Prosecutor for Northwest England and the lead barrister for the prosecution we are confident that it reflected what ultimately was provided to the press. The statement is silent, as was the opening address, on the vulnerability of Amber, her own abuse and the coercion and violence used against her.
- 8.24. Being presented in this way, was to have a lasting and damaging effect on Amber. On 8 May 2012, the *Daily Mail* reported the following:
- “A teenage girl pimp who used intimidation and bullying to get vulnerable young women to partake in sex with older men avoided prosecution because authorities felt it was not in the public interest. The teenager, who cannot be named for legal reasons, was dubbed ‘The Honey Monster’ because of the sick role she played in procuring girls for a gang of men in Rochdale between 2008 and 2009. Young victims from ‘chaotic’ ‘council estate’ backgrounds were coerced by the teenager, who was 15 at the time, from popular ‘honeypot’ locations such as outside takeaway restaurants, Liverpool Crown Court heard. One victim told jurors that ‘The Honey Monster’ was the key player in the sex abuse. She said: ‘She was intimidating, she was nasty, she was scary. ‘If it was up to me, she would be on trial getting worse than they are because she is the main one in this. ‘I believe if it was not for her, I would not have got into what was going on’.”*
- 8.25. In her interview with the review team, Amber explained that, following the trial, someone threatened to petrol bomb her house and postings were made on social media identifying her house as the home of a “paedo”. Amber also informed the review team that following the trial, Rochdale children’s social care initiated care proceedings primarily, she believed, based on this indictment. It is disappointing that, although the GMP and Rochdale Council IMRs and the Rochdale LSCB serious case review overview report covered the period up to and including the Operation Span trial, none of these reports mentioned how Amber was treated and the deleterious consequences of decisions made around her designation as an offender rather than as a victim.

# Chapter 9. Operation Doublet 2012–13

## Summary and conclusions

- 9.1. Operation Doublet, initiated in May 2012, was triggered by growing concerns in the media that a significant number of perpetrators remained at large following Operation Span. As a follow-up investigation to Operation Span, we have reviewed the first phase of Operation Doublet during the period from May 2012 to December 2013.
- 9.2. The scope of Operation Doublet initially included some existing small-scale investigations and identified a total of ten children as potential victims. It is concerning that Child 3, Child 44 and Amber were never included in this operation given the significant evidence they had shared with GMP during the previous Operation Span investigation. Furthermore, detectives had made a commitment to Child 3 during Operation Span that she would first be used as a witness and then they would investigate the crimes committed against her. We regard this failure as particularly deplorable as Child 3 had disclosed significant abuse by the organised crime gang we discussed in earlier chapters.
- 9.3. By November 2012, the senior investigating officer (SIO), Detective Chief Inspector D (SIO 4) had included 42 children in total in Operation Doublet. However, we have discovered that the multi-agency child sexual exploitation (CSE) group chaired by the Rochdale divisional commander, Chief Superintendent C, had identified by October 2012 approximately 127 referrals of potential victims made by the Crisis Intervention Team to children's social care over the years but not acted on. This figure later grew to 260 potential victims, of which only 90 had been approached by Doublet and its related operations. Despite public outrage about failed children in Rochdale, senior managers in both GMP and Rochdale Council decided to take no positive action in respect of the remaining 170 potential victims unless they formally came forward. SIO 4, to his credit, made several representations to Rochdale Council and his divisional commander, expressing concern about the impact of this policy, setting out the risk of further reputational damage.
- 9.4. This policy decision was not reversed until February 2013, after the media received a report that 34 children believed to have been sexually exploited had not been included in the Doublet investigation. The SIO noted in the policy book that he believed the source of this story was the staff at the Crisis

Intervention Team who had become very concerned about the decision by the CSE strategic group to take no positive action on the large number of potential victims.

- 9.5. The media report led to the Pennine Care NHS Foundation Trust sending the list<sup>55</sup> of 54 children the Crisis Intervention Team believed had been victims of CSE to the Rochdale division of GMP. Doublet had already considered 20 of these children, leaving 34 not being investigated. The decision was, therefore taken by Chief Superintendent C that these 34 children would fall under the auspices of the CSE strategic group but that, in the first instance, they would be reviewed by Doublet to ensure there were no overlaps in offenders. By March 2013, the number of potential victims not originally included in Operation Doublet requiring further investigation had grown to 55.
- 9.6. Operation Doublet experienced a very high drop-out rate of victims. We believe this was primarily because the operation did not have sufficient resources to work at the pace of the survivors and provide them with sufficient support and ongoing contact to sustain their commitment. Two of our interviewees have stated they believe the survivors were given only three opportunities to make a formal statement to the investigation, and if they did not provide a statement after three approaches, they were required to sign a disclaimer to that effect. We can find no record of that policy being instigated in the SIO's policy book, but it would go some way to explain the high numbers of survivors who disengaged from the investigation. By June 2013, only five victims were still engaged with Operation Doublet and only four of these had made a formal complaint. The number of perpetrators identified stood at 52 at this point. A further 34 potential victims still needed to be approached.
- 9.7. While the public face of GMP was reassuring the public that the investigation of the past exploitation of children in Rochdale was a priority, it is clear from our research that this was far from the case on the ground. As we have seen with earlier operations, SIO 4 repeatedly struggled to sustain sufficient resources to meet the demands of a complex organisation and on many occasions lost staff to support investigations viewed as a higher priority by his superiors. In April 2013, to meet the increase in the number of potential victims SIO 4 put in a request for 12 additional detectives. The SIO was only granted permission to appoint eight agency staff for six months, a far from

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<sup>55</sup> It is this list that we have used as the basis of our sample (See Chapter 11. The children).

ideal situation when detectives were expected to build relationships with survivors. In 2013, the MIT<sup>56</sup>, SIO 4's core team of detectives, was taken away on two separate occasions to assist with murder enquiries, and progress was also hindered by staff absences through sickness and holidays. At the end of September 2013, the SIO was informed that he would be required to take responsibility for the serious sexual offences unit in addition to his responsibilities with Doublet. The SIO noted that he was highly concerned that this would affect his ability to manage Operation Doublet. In November Assistant Chief Constable C, recognising this workload was unrealistic, replaced SIO 4 with another detective chief inspector.

- 9.8. Our terms of reference did not extend beyond December 2013. However, in November 2023, GMP provided the review team with a schedule of convictions resulting from the three major operations that have occurred following the conclusion of Operation Span. These were Operation Routh, Operation Doublet and Operation Lytton. We have only included data concerning convictions and nothing in respect of future criminal trials to avoid publishing material that may inadvertently jeopardise a criminal prosecution. In summary, this information demonstrated that in total 30 men had been convicted and most had received lengthy prison sentences. While this is a significant number of successful convictions, we have noted that these trials only included 13 children in total, of whom only six had previously been known to the Crisis Intervention Team and are included in our cohort of 74 children. These findings are set out in the table in Chapter 9.
- 9.9. We do acknowledge the considerable amount of effort that was dedicated to achieving these successful convictions. Nonetheless, the number of children included in these trials was a very small proportion of the children who were known to be sexually exploited in Rochdale over the period we have covered. We will therefore return to this matter in our final report, when we will review the criminal justice outcomes and wider outcomes for the remaining 68 children where we have concluded in this report that there is substantial evidence, they were being sexually exploited between 2002 and 2012.

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<sup>56</sup> Major incident team.

## Detailed findings: Operation Doublet 2012–13

9.10. On 1 May 2012, following a meeting of senior officers, it was agreed to set up a second major investigation led by MIT syndicate 5. The meeting heard that although there were follow-up operations Routh (Child 26) and Sheering (Child 8, 9 and 56), the public protection and investigation unit (PPIU) at Rochdale had indicated that *“there could be other CSE investigations known to them which ought to be considered”*. The SIO’s policy book noted that these CSE issues had reputational risks and needed to be managed sensitively. It was agreed to resource a major investigation to be known as Operation Doublet. As we have shown, Operation Span had effectively been closed down to any new enquiries since the middle of 2011. We believe that the timing and the rationale recorded in the SIO’s policy book indicate that the public concern generated by the trial precipitated a re-evaluation of this approach.

9.11. On 9 May 2012, an article had already been published in the *Daily Telegraph* under the headline *“Rochdale grooming trial, police knew about sex abuse in 2002 but failed to act”*. The article went on to state:

*“Police and social workers failed to tackle the issue of Asian men grooming underage white girls for up to a decade, the Daily Telegraph can reveal.”*  
(Nigel Bunyan 09 May 2012).

*The police believed the source of this information was a relative of one of the children.*

On 16 May the *Manchester Evening News* ran the following story:

*“Detectives who smashed the Rochdale child sex grooming ring are poised to make more arrests. We have learned officers have identified four more suspects alleged to have abused the brave witness whose evidence helped nail nine gang members.*

*“As they were convicted following an 11-week trial, it emerged police believe the gang may have had FIFTY members. Many of the men were identified to the girls only by nicknames and have proved difficult to track down. Officers are still trying to establish the real identities of the men – some of whom were referred to in court as Goofy, Ray, Juicy, Arfan, Ali, Manni, Mamma, Pino and Arfan. But we understand police believe they have established the names of four men alleged to have sexually abused the prosecution’s main witness at a ‘sex party’ in 2008”.*

9.12. On Monday 21 May 2012, it was agreed that the scope of the operation would include Operation Routh, Child 24, Child 26, Child 1, Child 4, Child 8, Child 9,

Child 56, Child 57, Child 58 and Child 59. As far as we are aware Child 56, Child 57, Child 58 and Child 59 were not previously in scope for Operation Span and were not on the Crisis Intervention Team list. It was also agreed that Child 90 Child 60, Child 61 and Child 62 would continue to be dealt with by Rochdale PPIU. The rationale given in the SIO's policy book was that *"these cases had either been concluded or are under finalisation and therefore will not form part of this investigation"*.

- 9.13. It is concerning that Child 3, Child 44 and Amber were never included in this operation, given the significant evidence they had shared with GMP during the previous Operation Span investigation. Detectives had told Child 3 during Span that she would first be used as a witness and afterwards they would investigate the crimes committed against her. We regard this failure as particularly deplorable as Child 3 had disclosed significant abuse by the organised crime gang we discussed in earlier chapters.
- 9.14. On 22 May 2012, a briefing meeting was held between the Rochdale divisional commander (Chief Superintendent C), Rochdale Council's director of children's services, the Operation Doublet SIO and two detectives. This outlined the potential victims already identified by GMP who would form part of the investigation. It was agreed that the council would provide two researchers with access to local authority information and that a memorandum of understanding would be drafted to ensure the timely sharing of information.
- 9.15. However, as we have seen in all the preceding investigations, the operation was hampered almost immediately by insufficient resources. On 30 May 2012, the Operation Doublet was suspended to accommodate the demand caused by a shooting in another division. It did not recommence until 11 June 2012. On 14 June SIO 4 reviewed Operation Routh and commented: *"It is apparent that the enquiry has stagnated somewhat."*
- 9.16. On 15 June 2012, the SIO reviewed progress against the identified victims and recorded the following main points from a briefing meeting held that day. Child 4 had reported rape in 2004; the investigation in 2007 was dropped *"after allegations of money for dropping allegations emerged"*. Child 4 was interviewed by Operation Span. During that interview, she indicated she had been exploited but did not wish to engage as family proceedings were progressing with respect to her children.



Child 9 had been interviewed three times by Operation Span and had reported abuse between the ages of 14 to 18 and had named one of her abusers as Nominal 30.

Child 26 was reported to not be attending appointments with the police.

Child 56 was another child who had not been a part of the previous investigations. She had been placed in Rochdale by another local authority and had reported that she had been subject to exploitation by Nominal 46.

Child 1 had approached a professional support worker about the abuse she had suffered since the age of 13. She had not previously been a part of the Operation Span investigation. She had been visited by police but had not been interviewed.

Child 57 was reported to have been subjected to a one-off sexual assault and it was not clear whether she wished to make a complaint. It was agreed to close this aspect of the case.

Progress had since been made on Operation Routh and complaints made by Child 24. *“Three persons being case built against and five awaiting Crown Prosecution Service charge decision.”*

9.17. In summary, by this point, Operation Doublet had been condensed into considering investigations into complaints made by six children. Only three (Child 1, Child 4, and Child 9) had been subject to earlier investigations going back to 2004. Child 24 and Child 26 were exploited during the same period but had not been part of a formal investigation and had also been identified as vulnerable by the Crisis Intervention Team. Child 56 had not been subject to any previous inquiry.

9.18. On 28 June 2012, SIO 4 recorded the following progress:

- Child 9 had identified over 12 men who had raped or trafficked her.
- Child 1 had undertaken several lengthy interviews and had provided details of six offenders who had exploited her from 2004 onwards.
- Child 56 who had detailed four acts of rape against her between 2004 and 2005.

Given these disclosures, SIO 4 noted that, following some background research, early arrests would be made to *“show victims were being taken seriously by police and other agencies to gain confidence”*. We regard this as an error – the same error of judgement we have criticised in Operation Span. Without any prospect of a custodial remand, any arrest followed by release could potentially leave witnesses and victims vulnerable to intimidation and coercion.

- 9.19. On 30 June 2012, SIO 4 noted that Child 4 was no longer supportive of the operation and recorded that: *“This enquiry will not pursue Child 4 CSE due to Child 4 being unsupportive at this time.”*
- 9.20. We have seen this pattern repeat itself so many times both before and after Operation Doublet, with numerous examples of victims providing statements and later withdrawing from the investigation. We put this down to lack of support for the victims and the failure to protect them from the risk of intimidation and coercion by the dangerous men they were complaining about. This is all the more disappointing as Detective Chief Superintendent B had made the following claim to the Home Affairs Select Committee when giving evidence in June 2012:
- “Can I just add that it is about building trust and rapport, and trying to understand it from your young person’s point of view? We have certainly learnt through the Rochdale case, with the help of people such as Sheila Taylor of the National Working Group, that it is about investing time in these young people, listening to them and not forcing them to do things they do not want to do. It is not forcing them to make snap decisions, and allowing a relationship to form that is a little bit like the relationship that often forms in homicide between a family liaison officer and a victim’s family. This is having a dedicated, bespoke contact officer, preferably specially trained in sexual offences, who spends time with and invests time in that young person. What we found was that people who were initially unwilling to see themselves as victims, after working with the police, the local authority and the third sector—Barnardo’s in particular—were more willing to, or would, become better at understanding their situation and the riskiness of their behaviours. It requires a considerable investment and that is something that GMP has done in terms of the multi-agency teams— there is not just a multi-agency team at Rochdale. We will invest time in those victims to allow them to go through the decision-making process and to understand what is happening to them.”*
- 9.21. It is therefore clear to us that, while there might have been an aspiration for supporting victims over a consistent period to achieve disclosure, this was not followed through in practice in either Operation Span or Operation Doublet.
- 9.22. On 29 June 2012, SIO 4 recorded that Nominal 31, Nominal 32, Nominal 33, Nominal 34, Nominal 35 and Nominal 36 would be arrested. These had all been named by Child 16 as having offended against her when she was 15 years old.

9.23. Two further arrests of Nominals 37 and 38, were made on 6 July 2012.

SIO 4 became concerned about the scale of the growing operation. On 19 July 2012, he put down limitations as to its scope:

*“SIO made aware that actions are being raised that may identify other potential victims of CSE which may fall into this enquiry in line with entry No 10. To manage this the following policy will be adopted.”*

The entry in the SIO’s policy book went on to set out an expectation that if the nominal was already known to a CSE safeguarding team in the area (namely Messenger, Sunrise or Zanzibar<sup>57</sup>) the case would be referred to that team.

*“When they are not known to these safeguarding teams the enquiry will approach these individuals if they have CSE as a feature linked to one of our original key nominals who has made a disclosure and is supportive of police action. This will only be done where possible at a moment in time when it would not expose victims to be at risk of intimidation further. By doing this the SIO seeks to stop the enquiry becoming too large and unmanageable and supporting the original nominals of which the enquiry was set up to investigate.”*

9.24. On 3 August 2012, SIO 4 went on annual leave and a detective inspector was left to head up the operation during his absence. On his return on 28 August, the SIO recorded that on 7 August two of his detective inspectors, along with the MIT syndicate staff, had been removed from the inquiry, one detective permanently to support a murder investigation. SIO 4 noted:

*“Consequently, the remaining staff have been without SIO support and MIT has stagnated.”*

9.25. On 30 August 2012, it was noted that Child 56 had not cooperated with Operation Doublet and was struggling with psychological issues:

*“Therefore, SIO decides that police will not be pursuing these allegations for her own welfare.”*

9.26. On 1 October 2012, a gold meeting took place at Rochdale Police Station. The meeting included Chief Executive B of Rochdale Council. During this meeting, it was highlighted that a substantial number of referrals had been made by the Crisis Intervention Team to children’s social care that had not been acted on over the years. These were believed to total approximately 127

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<sup>57</sup> Messenger and Zanzibar, like Sunrise, were multi-agency teams set up in other areas of Greater Manchester to tackle child sexual exploitation.

referrals, some of which had been included in Operation Span and Operation Doublet, but a strategy meeting was required on all those not already involved in those two operations.

- 9.27. On 2 October 2012, the health worker in the Sunrise Team reported to SIO 4 that both Child 3 and Child 64 were supportive of the operation. However, they needed to move away from the area given the gravity of what they were prepared to say. The health worker reported that Child 3 had previously been given similar assurance by Operation Span, but this had not been acted on and she felt let down.
- 9.28. In her interview with the review team, Sara Rowbotham explained that a health worker from the Crisis Intervention Team was given a contract for just six weeks to gather evidence from a list of 49 young people. Sara Rowbotham was critical of the approach taken to engage the potential witnesses. She explained that the health worker was told to begin by cold calling each young person, even though there had been no contact for many years. The young person was then given three opportunities to engage over a two-week period. The young person was subsequently asked to complete a disclaimer if they did not wish to engage with the operation. In the review team's interview with Maggie Oliver, she made a similar criticism. While there is no reference to this tactic in the SIO's policy book, it would go some way to explain the very high levels of disengagement by the young people.
- 9.29. By November 2012, SIO 4 had included 42 children in Operation Doublet. He categorised them as follows:
- Approached and willing to be interviewed  
Child 64, Child 1, Child 110, Child 22, Child 8, Child 11, Child 28, Child 7 and Child 9. Also included in this group were the names of three children we have not previously come across in our research. One of these children had been known to the Crisis Intervention Team.
  - Yet to be approached  
Child 6, Child 32, Child 36, Child 5, Child 106, Child 101, Child 65, Child 37 and Child 3. This list also included the names of five children we have not previously come across in our research. Two of these were known to the Crisis Intervention Team.
  - Approached and not made any disclosures or declined to cooperate  
Child 99, Child 2, Child 35, Child 103, Child 10 and Child 25. The list also included nine children we have not previously come across in our research. Four of these were known to the Crisis Intervention Team.

9.30. On 26 November 2012, SIO 4 recorded his concern at the considerable delay in approaching potential victims and witnesses. It had been agreed that the Crisis Intervention Team would facilitate this and accompany officers, but for various reasons they had not been available to make the necessary contacts. SIO 4 therefore decided that his officers would, if the Crisis Intervention Team worker was unavailable, make approaches to individuals, either alone or with other relevant agencies.

9.31. In December 2012, SIO 4 became increasingly concerned about the lack of action by children's social care in developing a strategy to address the large number of historical allegations of CSE put forward by the Crisis Intervention Team at the gold meeting in October 2012. Given these concerns, SIO 4 sent the following communication to Superintendent C:

*"During the course of Operation Span, several individuals were spoken to whose complaints were not pursued at the time due to the circumstances of the victims along with investigative parameters. Then following the conclusion of Op Span trial, a number of further victims came forward who wished to make complaints as regards historical CSE in Rochdale.*

*"This left a combination of unresolved allegations to deal with. The Force response was to form Operation Doublet and an investigation began with a core group of individuals a number of which fell out of the enquiry with remaining complainants being from Child 8 Child 9 and Child 1.*

*"It became apparent to investigators that the aforementioned victims had been offended against by the same core of perpetrators. This led to the discovery of documentation by Operation Doublet of a further number of now young persons who are thought to be potential victims, some 42 in total. Some of these are previously known to police and Children's Social Care but as history has shown no action had been taken. Operation Doublet now continues to approach these forty-two individuals with a view to bringing those responsible to justice. Due to the historical nature of the allegations some dating back to 2005 and the complexities in the case, it is proving to be a lengthy process."*

9.32. SIO 4's communication moved on to set out concerns for the large number of victims not included in Operation Doublet:

*"It has come to my attention that partners have drawn up a list that captures all names from various partner agencies of potential CSE victims. This amounts to approximately 260 names, the master list is held by Rochdale Children's Social Services. I understand not all are historic victims but much of this list originates from the Pennine Trust Crisis Intervention Team, the originators to whom many of the victims previously turned to.*

*“Some of these young people have already been given an opportunity through Operation Span Operation Routh or currently Operation Doublet to make disclosure (approximately 90). But it remains a fact that there are many other potential historical victims of CSE that may exist and currently sit outside these investigations.”*

- 9.33. SIO 4 continued by requesting that a gold group be put in place to address these issues:

*“If unresolved and no strategy is put in place to manage historic CSE victims as they are identified the situation will continue to perpetuate badly affecting public confidence.”*

- 9.34. By January 2013 Operation Doublet was actively working with only 14 designated victims. SIO 4 recorded:

*“Of the original 42 approaches to potential victims this has now been completed. 28 have declined to co-operate or not been approached for recorded reasons. Leaving currently 14 still within the enquiry.”*

SIO 4 also noted further concerns that the inquiry was not getting sufficient support from children’s social care, leaving his staff vulnerable in dealing with the victims who had various social problems.

- 9.35. SIO 4 held a further meeting with senior managers in children’s social care on 7 January 2013 and reiterated the need for support from children’s social care to the inquiry. During this meeting, it was noted that children’s social care had a list of 270 individual children that was an amalgamation of potential CSE victims submitted by various agencies. It was agreed that children’s social care would review all these children, completing chronologies on a case-by-case basis, and any cases causing concern would be presented to the strategic working group chaired by the Rochdale divisional commander, Chief Superintendent C.

- 9.36. Visits in January 2013 led to further victims withdrawing from the enquiry, while others were determined by officers not to be at a point in their lives when they could speak to the police because of their drug dependency and/or mental health issues. This left only eight individuals subject to ongoing investigation at the end of January. Seven were from the original cohort of 42 – Child 1, Child 8, Child 9, Child 65, Child 11, Child 32 and one of the children we had not previously come across in our research. There was also a new referral; the offenders of this child had been linked to those of Child 9.

- 9.37. On 14 February 2013, the divisional commander removed a sergeant from the operation due to other work pressures. This left Operation Doublet with no supporting officers from the Rochdale division.
- 9.38. On 25 February 2013, SIO became concerned that the media were receiving reports about children who had fallen outside the Operation Doublet inquiry, Operation Span and Operation Routh. SIO 4 believed these names had been leaked by members of the Crisis Intervention Team who were making waves to ensure the children not included in Operation Doublet received a service.
- 9.39. SIO 4 recorded:
- “There are further names that are supposed to have been addressed under CSE Strategic Group. SIO 4 was made aware that a position statement is going to be put out via this group of no positive action on historical victims of CSE unless further victims come forward. SIO4 is highly concerned they Children’s Services have taken this decision supported by Chief Superintendent C without liaison with Crisis Intervention Team and material they hold on these names, and they are making themselves blind to info which could affect this decision ... SIO 4 makes representations of these concerns and asks for urgent meeting with Chief Superintendent C.”*
- 9.40. On 26 February 2013, the SIO noted in the policy book that Chief Superintendent C had spoken to SIO 4 and expressed dismay that SIO 4 kept raising concerns in respect of the victims not included in Operation Doublet. SIO 4 recorded in the policy book:
- “SIO 4 states that the 34 names fed to journalists should have been dealt with via the CSE strategic group. They as a group have not properly sought out or examined material in possession of CIT. Therefore, the level of assessment as agreed has not been done and they could not correctly make this decision for a position statement of no positive action without a positive witness complaint. The CIT know this and are making waves to get the matter dealt with.”*
- 9.41. SIO 4 recorded in the policy book that he had met with Chief Superintendent C, his superintendent, and the detective chief inspector to discuss this list. The SIO noted that of the 54 names, 20 were known to Doublet and Span, leaving 34, and this could be the subject of the media inquiry. It was agreed that these 34 would fall under the CSE strategic group but Doublet would review these first to ensure there were no overlaps with offenders. SIO 4 subsequently recorded in the policy book:
- “It now appears that Chief Superintendent C was happy or under the impression that [children’s social care] were going to underwrite decision*

*of the positional statement done and was happy to let them do this as regards outside investigations. When [children's social care] stated it was a joint decision via CSE strategic group chaired by Chief Superintendent C then her position has changed, and she now wants them to be assessed and for this to now fall to Op Doublet."*

- 9.42. In March 2013, the *Sunday Times* printed a report alleging that 76 more victims of grooming had been identified in Rochdale.
- 9.43. On 11 March 2013, Superintendent C directed that Operation Doublet move to Nexus House, GMP headquarters, and co-locate and support another inquiry with its resources. SIO 4 noted that Operation Doublet had insufficient resources and could not support another inquiry, and could not continue successfully unless resources were increased to cope with demands on it.
- 9.44. On 22 March 2013, Superintendent C moved a detective sergeant from Operation Doublet to another investigation. This was despite protestations that the detective sergeant had been working with Child 1<sup>58</sup> for many weeks and his removal would set this work back significantly.
- 9.45. At the end of March 2013, SIO 4 had established that 102 names had been identified as being outside the three police investigations (Doublet, Span and Routh). These names had been screened against police systems and a large number had previously been addressed by GMP. Nonetheless, there were another 55 that required further investigation. SIO 4 noted:
- "This creates a potential for a further number of trace interviews actions for Op Doublet. This additional work will have to be undertaken but has resource implications as with the current staffing level of Op Doublet would be unable to do this."*
- 9.46. At this point, the SIO had 19 staff in total, comprising 14 detectives, an analyst and four administrators, and noted:
- "SIO 4 deems this is inadequate for an enquiry of this magnitude. Will make a request for further staff."*

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<sup>58</sup> Child 1 subsequently disengaged from Operation Doublet.



- 9.47. On 4 April 2013, SIO 4 put in a report for 12 additional staff. He was subsequently granted ten additional agency staff for six months, which he felt was far from ideal given the need to build rapport with victims over a long period. A week later the SIO was informed that, given other pressures, the ten agency staff had been reduced to eight.
- 9.48. On 1 May 2013, Child 11 decided not to cooperate further with the inquiry.
- 9.49. By June 2013, 42 of the 76 potential CSE victims identified by Operation Doublet had been approached. However, at this point, only five victims were still engaged with the operation and just four of these had made a formal complaint. The number of perpetrators identified stood at 52. A further 34 potential victims still needed to be approached. The SIO made a further request for additional resources.
- 9.50. The operation made limited progress over the summer of 2013. The MIT was taken away on two separate occasions to assist murder inquiries and progress was also hindered by staff absences through sickness and holidays. In September, however, SIO 4 was ready to begin an arrest phase. But at the end of September 2013, Superintendent C informed SIO 4 he would be required to take responsibility for the serious sexual offences unit (rape teams) in addition to his responsibilities with Doublet. SIO 4 noted that he was highly concerned that this would affect his ability to manage Operation Doublet. In November, Detective Chief Superintendent B recognised this workload was unrealistic and by the end of the year SIO 4 was replaced on Doublet by another detective chief inspector.
- 9.51. On 20 December 2013, the serious case review report into Young Persons 1–6 and Young Person 7 was published by Rochdale LSCB. The report criticised the Crisis Intervention Team for overstating the number of referrals it had made, even though it had become clear in the previous 12 months that more than 120 referrals from the team had not been dealt with appropriately by children’s social care. We will cover this in more detail in Chapter 12.
- Our terms of reference did not extend beyond December 2013. However, in November 2023 GMP provided the review team with a schedule of convictions resulting from the three major operations that occurred after the conclusion of Operation Span. These were Operation Routh, Operation Doublet and Operation Lytton. We have only included data concerning convictions and nothing in respect of future criminal trials to avoid publishing material that may inadvertently jeopardise a criminal prosecution.

In summary, this information demonstrated that in total 30 men had been convicted, and most received lengthy prison sentences. While this is a significant number of successful convictions, we have noted that these trials only included 13 children in total, and just six of these were previously known to the Crisis Intervention Team and are included in our cohort of 74 children. These findings are set out in the table below.

We do acknowledge the considerable amount of effort that was dedicated to achieving these successful convictions. Nonetheless, the number of children included in these trials was a very small proportion of the children who were known to be sexually exploited in Rochdale over the period we have covered. We will therefore return to this matter in our final report, when we will review the criminal justice outcomes and wider outcomes for the remaining 68 children where we have concluded in this report that there is substantial evidence, they were being sexually exploited between 2002 and 2012.

### Table of convictions following Operation Span

Operation Routh	Victims	Suspects charged	Convictions
Trial 1 September to October 2013	One child in total. This child was known to the Crisis Intervention Team and is included in our cohort of 74	9	5 convictions in total <ul style="list-style-type: none"> <li>• 8.5 years' imprisonment</li> <li>• 6.5 years' imprisonment</li> <li>• 5 years' imprisonment</li> <li>• 4 years' imprisonment</li> <li>• 2.5 years' imprisonment</li> </ul>
Operation Doublet	Victims	Suspects charged	Convictions
Trials 1 and 2 February 2016	Five children. Two were known to the Crisis Intervention Team and are in our cohort of 74 children. Three were unknown to the Crisis Intervention Team.	10	Ten convictions <ul style="list-style-type: none"> <li>• 25 years' imprisonment</li> <li>• 19 years' imprisonment</li> <li>• 5.5 years' imprisonment</li> <li>• 7 years' imprisonment</li> <li>• 9 years' imprisonment</li> <li>• 16 years' imprisonment</li> <li>• 6.5 years' imprisonment</li> <li>• 5 years' imprisonment</li> <li>• 11 years' imprisonment</li> <li>• 31 years' imprisonment</li> </ul>
Trial 3	Two children. They were known to the Crisis Intervention Team and included in our cohort of 74 children. One of these children was included in Trials 1 and 2.	5	Five convictions <ul style="list-style-type: none"> <li>• 7 years' imprisonment</li> <li>• 19 years' imprisonment</li> <li>• 20 months' imprisonment</li> <li>• 12 years' imprisonment</li> <li>• 17 years' imprisonment</li> <li>• 7 years' imprisonment</li> </ul>

Trial 4	One child. This child was included in Trials 1 and 2 and was known to the Crisis Intervention Team and is included in the cohort of 74.	4	Four convictions <ul style="list-style-type: none"> <li>• 9 years' imprisonment</li> <li>• 10 years' imprisonment</li> <li>• 11 years' imprisonment</li> <li>• 7 years' imprisonment</li> </ul>
Trial 5	One child . This child was known to the Crisis Intervention Team and is included in our cohort of 74 children. This child was included in Trials 1–3.	1	One conviction <ul style="list-style-type: none"> <li>• 20 months' imprisonment</li> </ul>
<b>Operation Lytton</b>	<b>Victims</b>	<b>Suspects charged</b>	<b>Convictions</b>
Trial 1 May to August 2023	Two children. Both were known to the Crisis Intervention Team and are included in our cohort of 74 children.	8	Five convictions <ul style="list-style-type: none"> <li>• 14 years' imprisonment</li> <li>• 17 years' imprisonment</li> <li>• 8 years' imprisonment</li> <li>• 20 years' imprisonment</li> <li>• 12.5 years' imprisonment</li> </ul>

# Chapter 10. Individuals who potentially pose a risk to children

## Summary and conclusions

- 10.1. In our research we have identified at least 96 individuals who potentially pose a risk to children. We note there may be an element of duplication as some of the individuals we identified are recorded by only one name or a nickname. We believe this is only a proportion of the individuals engaged in child sexual exploitation (CSE) over this period.
- 10.2. We conclude that the successive operations we have considered failed to tackle the widespread exploitation of children by these men. The three major operations were consistently under-resourced in providing the necessary support to victims to disclose their abuse and for them to remain engaged with the investigation.
- 10.3. GMP and Rochdale Council failed throughout the period to consistently use disruption tactics to break up the activities of these men. There is only limited evidence of GMP using child abduction warning notices and risk of sexual harm orders and very few examples of GMP liaising with the licensing and environmental health departments to tackle the sexual exploitation of children within the taxi and restaurant industries. This was even though the prevalence of CSE in these industries was well known to GMP and Rochdale Council.  
  
There is little evidence, other than the individuals formally charged as part of Operation Span, that GMP and Rochdale children's social care conducted the necessary risk assessments in respect of the risk posed by the suspects to their own and other children they had contact with. However, we noted that SIO 1 recorded that a strategy meeting concluded that:  
  
*"None of the suspect's children are in danger and case conferences will not be held in relation to them."*
- 10.4. We have not seen the assessments that were undertaken to support this conclusion, but we are aware that no assessment was carried out on Nominal 6 by Oldham Council, and given his background and offences, this should have been addressed.

10.5. In conclusion, the statutory agencies made insufficient progress in Rochdale to identify and respond effectively to those who pose a risk to children, and we are not able to provide assurance that enough was done to bring those individuals to justice or protect other children they may have had contact with.

### **Detailed findings: Individuals who potentially pose a risk to children.**

10.6. In this chapter we have considered individuals who appeared to pose a risk to children between 2004 and 2012 and whether they were appropriately dealt with by GMP and Rochdale Council. We have sought to form a judgement on the various partnership responses to information known about those individuals.

10.7. We are mindful that survivors of exploitation may at any time seek justice and therefore any information we include in this chapter is limited by our desire not to adversely affect any future criminal justice processes or jeopardise an individual's right to a fair trial. These important considerations have inevitably meant that our ability to include judgements concerning specific individuals who potentially pose a risk to children is constrained.

10.8. Operation Augusta, conducted in 2004-05 following the death of Victoria Agoglia, was the subject of our first report. At the conclusion of Operation Augusta in August 2005, a 'learning the lessons' document<sup>59</sup> included a recommendation for a multi-agency specialist response to CSE. It also emphasised the importance of disruption and the requirement to assess the risk an individual may pose to a broader range of children beyond just the complainant. In summary, our assessment of the key lessons from Augusta concerning perpetrators were that:

- Child victims require significant wraparound support when disclosing and potentially making criminal complaints against exploiters.
- Perpetrators should be subject to multi-agency child protection considerations with respect to their own and other children they have access to.
- Every opportunity to disrupt the ability of perpetrators to target vulnerable children should be considered.

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<sup>59</sup> *Operation Augusta Evaluation Report* (GMP, August 2005).

- 10.9. In our analysis for this report, we anticipated that we would be able to identify positive improvements in multi-agency operational practice since Operation Augusta.
- 10.10. In 2011, Operation Span identified 58 names it designated as “*named suspects that needed to be traced and interviewed*”. In our review of the HOLMES (Home Office Large Major Enquiry System) Span account, we found an additional two individuals we would determine as suspects. Only three of these people were eliminated and only 12 of them were eventually charged.
- 10.11. In addition, we have identified from the available GMP and social care records an additional 37 individuals where we believe there was evidence that they were involved in the exploitation of children. While there may be some duplicates within this cohort of 95 potential perpetrators, we believe it represents only a proportion of the individuals who were sexually exploiting children over this period.
- 10.12. We have focused the rest of this chapter on the three substantial investigations undertaken between 2007 and 2012.

## **The 2007 enquiry**

- 10.13. We have summarised the failures of the 2007 investigation in Chapter 4. Although the Crisis Intervention Team had alerted GMP and Rochdale Council to the names of 11 children they believed were at risk of sexual exploitation from organised criminals, the police and their partners chose not to progress any investigation against these men because they were told the children were too frightened to assist any inquiry.
- 10.14. The small-scale police investigation that began in 2007 was run by a single detective (Detective Constable A). While concerns had been raised about sexual exploitation by the criminal gang identified by the Crisis Intervention Team, the investigation failed to address those allegations because they were viewed as “*historical*”. Strategy meetings were held in January, February and April 2007 to consider the “*sexual exploitation of subject by Asian males in the [red-light district] of Rochdale*”. It was agreed that a “*dedicated operation was to be set up to address the serious issues raised*” and during those strategy meetings, information was provided about individuals who potentially posed a risk to children. Also included were references to a large number of victims, an

acknowledgement that this issue involved a "*number*" of local Asian men and consideration of surveillance opportunities.

- 10.15. There is no record of a dedicated operation being set up. After the three initial meetings, no further strategy meetings were put in place and there was no other structured means for sharing the information. This was a missed opportunity to conduct appropriate multi-agency risk assessments concerning the individuals believed to pose a risk, which may have prevented further abuse of children, or to effectively investigate these matters to bring perpetrators to justice.
- 10.16. In total, the investigation considered five suspects, who were all arrested. None of these was linked to the organised crime gang referred to by the Crisis Intervention Team. GMP under-resourced the inquiry, despite repeated requests for support from the officers involved. This investigation resulted in no charges or convictions. The investigating officer elected to not submit a file to the Crown Prosecution Service (CPS) in the belief there was insufficient evidence to support a prosecution. Furthermore, the investigation appeared to be closed by GMP without any consultation with partner agencies.
- 10.17. There is no evidence of a meaningful disruption strategy by GMP within this investigation and, while the investigating officer considered the possibility of a surveillance operation, there is no evidence that non-traditional covert policing opportunities were followed through. There is no evidence that GMP and children's social care considered the risk posed by the suspects to their own and other children they had contact with.
- 10.18. We conclude that the response by GMP and Rochdale children's social care services to those individuals who potentially pose a risk to children fell significantly short of what we would expect to be a proportionate response to the issues. No police investigation or action was taken against the two main suspects and their associates, who were identified by the Crisis Intervention Team as having sexually exploited a significant number of children. No charges were brought against the five suspects actively considered in the investigation. There is no evidence that any criminal justice action was taken against any of the men who were believed to have exploited and harmed children and we can provide no assurance that their abuse of children did not continue unchecked.

## **The 2008 investigation into the two restaurants in Rochdale**

- 10.19. We have summarised the failures in the 2008–09 investigation in Chapter 5. This investigation identified widespread sexual exploitation of many vulnerable children by at least 30 adult perpetrators. This was a complex inquiry and GMP failed to resource it sufficiently. Consequently, the investigation only scraped the surface of what had occurred and ultimately the CPS determined that the main victim, Child 41, was an unreliable witness and the available forensic evidence was problematic. Another child, Child 46, had made a similar disclosure, but her evidence was never submitted to the CPS for consideration. Both CPS and GMP apologised for this failure in 2012 after the conviction of the Operation Span defendants.
- 10.20. The investigation was led by a lead investigator at detective sergeant rank (Detective Sergeant B), supported by several detectives. The investigating officers attempted to conduct a traditional reactive investigation reliant on witness testimony, forensic examination and phone analysis. The investigation was hindered by being part of a generic detective, non-specialist team with a high workload of various crime types to investigate. As the offences were not within the remit of the public protection units in place, the investigation team relied on specialist child protection police officers to deliver the multi-agency response, leading to miscommunication and differing expectations. We identified many of the same issues concerning the response to suspects as we saw in the 2007 investigation.
- 10.21. The multi-agency processes in place to identify and respond to complex child sexual abuse were weak and still overly reliant on child victims to make disclosures to law enforcement agencies as a way of keeping them safe. There is no meaningful evidence that multi-agency assessments were put in place for individuals who posed a risk to children.
- 10.22. We found only one record of an attempt at disruption based on liaison with the taxi enforcement team (presumably to seek to revoke an individual's licence) and no evidence that covert tactics were considered. It has been suggested to the review team that in GMP at that time there was an unofficial understanding that covert resources would only be used for major and serious crime investigations, such as murder, firearms offences and drug supply, and that was the case across all forces in England and Wales. While there may be some truth in this, it is also a fact that the senior investigation officer (SIO) in charge of Operation Augusta identified the need to explore covert opportunities in 2004 and we have seen that Detective Constable A also considered the same approach in 2007. The failure to identify this



investigation as one requiring an enhanced response with a suitably experienced and qualified SIO was a missed opportunity that would almost certainly have increased the opportunities for a more successful criminal justice outcome.

10.23. The lead investigator (Detective Sergeant B) originally identified 30 offenders and stated that most of them were named and possibly traceable. Ultimately, however, only two of these suspects were arrested and questioned and no individuals were charged as a result of this investigation. As no criminal justice action was taken against any of the many suspects identified by Child 41 and Child 46, we can provide no assurance that their abuse of children did not continue unchecked. While Operation Span subsequently convicted nine of these men, we believe this only dealt with a small number of the men who were exploiting children in Rochdale at this time.

## Operation Span

10.24. Operation Span, which led to the conviction in May 2012 of nine men, was described at the time by GMP as “*comprehensive and effective, mitigating threat risk and harm*”. However, as we set out in Chapter 7, we have found that it was a limited, offender-focused, investigation addressing primarily a small number of perpetrators who had not been prosecuted following the disclosures in respect of exploitation at the two Rochdale restaurants.

10.25. In summary, the principal deficiencies in Operation Span were as follows:

- No senior management ownership through an ongoing gold command structure.
- Successive changes of leadership.
- Within a few months Operation Span began to focus only on a limited number of victims and witnesses who could support the prosecution of a small number of men identified as suspects from the beginning.
- We conclude that while Operation Span successfully convicted nine men, it failed to address the numerous crimes that were brought to the attention of GMP and Rochdale Council at the time.

10.26. A key objective of Operation Span was “*to bring identified subjects to justice for any criminal offences that reassure the community of the effectiveness of the police response to sexual crime*”. However, at the first (and only) gold group meeting it is noted that “*this was a complex investigation involving*

*probably 9 -10 males*", which implied it was an investigation limited in its objectives and focused on bringing to justice a small number of individuals.

10.27. The first entry in the SIO policy book is comprehensive and includes references to a broad proactive approach to taxi drivers in Rochdale, proactive use of partners such as environmental health to visit all "*Asian takeaways*", and an application for covert resources. The level of detail in this strategy is in accordance with our expectations of an experienced SIO developing an investigative strategy to combat a wide-ranging problem of CSE involving multiple perpetrators and victims.

In our research into the HOLMES Span account, we discovered that the operation had identified 58 individuals recorded as suspects<sup>60</sup> who needed to be traced and possibly interviewed. We identified an additional two individuals who, we believe, should have been included in this list, one of whom was eventually charged.

Only 12 of the individuals on the list were subsequently charged. Within the remaining 48, there were 28 suspects whose full name was known. Of these, we found that no action had been taken to trace and interview 19 of them. For the remaining 20, only a nickname or first name was known, although two had their place of employment given. Some of these latter entries may have been duplicates or aliases used by the same individual. However, it supports the proposition that the operation was aware of a relatively large number of individuals who potentially posed a risk to children in addition to those identified at the gold meeting of December 2010. Furthermore, we are aware that this list may not have incorporated the many suspects Amber disclosed in her video interviews with Detective Constable Oliver.

We therefore conclude that we are not able to provide assurance that these individuals, who potentially pose a risk to children, were subject to an appropriate follow-up investigation or a multi-agency risk assessment in every instance.

10.28. As we have set out, by April 2011 the second SIO (Detective Chief Inspector B) had made an important policy decision to limit the scale of the operation's objectives:

*"Op Span will investigate all reported sexual offences involving the current list of suspects or offence locations already pointed out by victims of this inquiry. Any other offences by other offenders will be passed to the relevant*

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<sup>60</sup>Category C13 had 58 names on it. This category had the title 'Trace, Interview named suspects'.

*division. This includes offences against our current victims/witnesses by other unrelated individuals who have not featured in the Span investigation thus far. Should it transpire that the offences do feature our existing list of offenders and be positively identified (by way of Viper procedures [video-recorded ID parades]) the Op Span officers [will be] involved accordingly.”*

10.29. We accept that any multi-agency investigation such as Operation Span must operate within appropriate parameters to maintain focus on achieving its objectives. We also acknowledge that the conviction of nine men may have contributed to increased public confidence and there is evidence that some survivors came forward as a result of the successful Span trial. However, if the intention was ever to have a significant impact on perpetrators within Rochdale, as set out in the original objectives of the operation, then it failed in that intention.

10.30. In conclusion, the statutory agencies made insufficient progress in Rochdale to identify and respond effectively to those who pose a risk to children, and we are not able to provide assurance that enough was done to bring those individuals to justice or protect other children they may have had contact with.

# Chapter 11. The Children

## Summary and conclusions

- 11.1. Our review considered the effectiveness of responses to safeguarding children at risk of child sexual exploitation (CSE) from 2004 to the conclusion of Operation Span. We therefore set the following tests to consider in relation to the records held by GMP and Rochdale Council.
- Was there a significant probability from the information on the files that the child was being sexually exploited?
  - Could we provide assurance that this abuse was appropriately addressed by either GMP or Rochdale Council? In this regard, we judged the response in line with the procedures that were in place at the time.
- 11.2. In our formal sample of 59 children, we concluded that there was a significant probability that 45 children had been sexually exploited. Of these 45, we found that we could only provide assurance that three children were appropriately protected by the statutory agencies. In 37 of the cases, there were serious failures to protect the children.
- 11.3. We also considered an additional 52 children mentioned in the GMP and Rochdale Council files we reviewed, bringing the total number of children to 111. We believe there was a significant probability that 74 of the total number of children we considered were being sexually exploited. Of these 74, we found that we could only provide assurance that three children were appropriately protected by the protective agencies. In 48 of the cases, there were serious failures to protect the children.
- 11.4. On 1 August 2023, we asked GMP to provide the review team with a list of all the criminal justice outcomes and a summary of the engagement with successive operations achieved on behalf of these 74 children. We will include an analysis of our findings in our fourth report.
- 11.5. We have judged the quality of practice by the policy and procedures in place at the time. While we accept that professional awareness of CSE has since improved, we have concluded that there was, at the time, a clear understanding of the prevalence of CSE within the borough of Rochdale. This knowledge was held by senior and middle managers in both GMP and children's social care. The legislative and procedural obligations to protect

children from significant harm caused by CSE were clear, and police and local authorities had a range of powers to intervene, protect children and disrupt offenders.

- 11.6. GMP failed to learn the lessons from the tragic death of Victoria Agoglia and the failure of Operation Augusta. The detection, disruption and prosecution of sexual offences against children were not given sufficient priority during the period covered by this review. Despite the clear evidence that organised crime gangs had been sexually exploiting children in Rochdale for many years, and the evidence of the prolific serial rape of countless children in Rochdale, it was not until January 2011 that GMP placed a police officer in Sunrise, the multi-agency CSE team in Rochdale, and then it was only one inexperienced police constable. We regard this as a lamentable strategic failure by the successive senior leaders. While so many of the failures have been put down to the individual approaches of frontline detectives, we have seen that investigations into CSE were, repeatedly, insufficiently resourced and supported given the scale of the offending within the Rochdale area. The missed opportunities to learn from the death of Victoria Agoglia and to prioritise an effective strategic response to the detection, disruption and prosecution of organised CSE should firmly be laid at the door of the senior officers in GMP throughout this period.

## **Detailed findings: The Children**

- 11.7. Our formal sample comprised 59 children. This included the 54 children whose names were shared with GMP in February 2013 by the Pennine Care NHS Foundation Trust. This list contained the names of children the trust's Crisis Intervention Team believed had disclosed details of the perpetrators who had sexually exploited them. When we reviewed the Crisis Intervention Team's total database of 163 children, we found an additional five children we believed might have information in respect of perpetrators who may have abused them. We added these five names to our sample, making a total of 59 children.
- 11.8. After several years of debate, we agreed on a process with GMP and Rochdale Council that allowed us to examine the records they held about these children. In 2023, we were also given access to specific documents we requested, produced by the Crisis Intervention Team and held by Pennine Care Trust. We were therefore able to produce a detailed history of the multi-agency practice in respect of these 59 children.

11.9. As we reviewed the records in relation to this period provided by GMP, Rochdale Council and Pennine Care Trust, we came across an additional 52 children, bringing the total number of children within the scope of our research to 111. As we had no formal agreement with GMP or Rochdale Council to look at the additional children, our level of knowledge about these children varied. Our final judgements have reflected this.

11.10. In summary, our overall findings are as follows:

**For the 59 children in our formal sample**

In total, we considered 59 children in our sample. These were all known to the Crisis Intervention Team. We believe there was a significant probability that 45 of the children we considered had been sexually exploited. Of these 45 we found that we could only provide assurance that three children were appropriately protected by the statutory agencies. In 37 of the cases there were serious failures to protect the children, and in a further five cases we did not have access to sufficient information to form a judgement.

**In respect of the additional 52 children**

In total, we considered an additional 52 children; 34 of them were known to the Crisis Intervention Team. We believe there was a significant probability that 29 of the additional children we considered had been sexually exploited. Of these 29, we found that we could not provide assurance that any children were appropriately protected by the protective agencies. In 11 of the cases there were serious failures to protect the children, and in a further 18 cases we did not have access to sufficient information to form a judgement.

**Total children considered**

In conclusion, in total we considered 111 children; 93 of them were known to the Crisis Intervention Team. We believe there was a significant probability that 74 of the children we considered were being sexually exploited. Of these 74, we found that we could only provide assurance that three children were appropriately protected by the protective agencies. In 48 of the cases there were serious failures to protect the children, and in a further 23 cases we did not have access to sufficient information to form a judgement.

11.11. On 1 August 2023, we asked GMP to provide the review team with a list of all the criminal justice outcomes and a summary of the engagement with successive operations achieved on behalf of these 74 children. We will include an analysis of our findings in our fourth report.

11.12. The exploitation of these children was profound and sustained over a long period as the case histories in our earlier chapters have illustrated.

Was the exploitation of children appropriately addressed by either GMP or Rochdale Council? In this regard, we judged the response in line with the procedures in place at the time.

11.13. In this section, we shall consider how well the children were protected. In forming these judgements, we have been careful to apply the standards in place at the time the allegations occurred. It has been put to us by several of our interviewees that the knowledge and understanding of CSE was still at an early stage during this period. While this may have been the case, we believe, nonetheless, that there was at the time a clear expectation that the statutory agencies were required to protect children from sexual exploitation and abuse of this nature.

11.14. Awareness of CSE developed during the 1990s through several institutional abuse investigations across the UK. These highlighted the need for dedicated teams of police officers and social workers, working in collaboration with the Crown Prosecution Service (CPS), to obtain positive outcomes. Many of these investigations focused on abuse within residential establishments and highlighted the methods of grooming and the difficulties encountered by young people in disclosing abuse.

11.15. In May 2000, the Home Office and Department of Health jointly published guidance<sup>61</sup> on safeguarding children involved in prostitution<sup>62</sup>. The guidance promoted an approach whereby agencies should work together to:

- recognise the problem
- treat the child primarily as a victim of abuse
- safeguard the children involved and promote their welfare
- work together to prevent abuse and provide children with opportunities and strategies to exit from prostitution investigate and prosecute those who coerce, exploit and abuse children.

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<sup>61</sup> *Safeguarding Children Involved in Prostitution: Supplementary Guidance to Working Together to Safeguard Children* (Department of Health, Home Office, Department for Education and Employment, 2000).

<sup>62</sup> Child prostitution was the term commonly used in legislation until 2015. Following a campaign by Ann Coffey MP, the Serious Crime Act 2015 replaced the term with child sexual exploitation.

The guidance also stated that local agencies should develop inter-agency protocols to guide action when there were concerns that a child was involved in prostitution, including guidance on sharing concerns about a child's safety.

11.16. National guidance had been issued in 2002 by the Home Office and Department of Health on the investigation of complex child abuse. This guidance emphasised the importance of agencies working closely together and the need to address the welfare needs of “*child victims or adult survivors*”. The 2006 edition of *Working Together to Safeguard Children* contained a section on “*Investigating complex (organised or multiple) abuses*”, which said:

*“Complex abuse occurs both as part of a network of abuse across a family or community and within institutions such as residential homes or schools. Such abuse is profoundly traumatic for the children who become involved. Its investigation is time-consuming and demanding work requiring specialist skills from both police and social work staff. Some investigations become extremely complex because of the number of places and people involved, and the timescale over which abuse is alleged to have occurred.”*

11.17. The Sexual Offences Act 2003 made it an offence to:

- pay for the sexual services of a child
- cause or incite child prostitution or involve a child in pornography
- control a child prostitute or a child involved in pornography
- arrange or facilitate child prostitution or pornography.

11.18. The Sexual Offences Act 2003 also introduced risk of sexual harm orders, which could be made by a magistrates' court on the application of a chief police officer to prevent the defendant from doing anything described in the order. The order was designed to prohibit activity when it was necessary to protect children from harm from the defendant. Again, we are struck by how little evidence there is of these orders being used in our sample.

11.19. Furthermore, while it was clear at the time, and is still the case, that children under 16 could not by law consent to sex, it was also an offence for any person to engage in sexual activity with a child under 18 for money or by other exploitative means. We are again struck by the lack of intervention by both the police and children's social care when it was known that older adult males were having sexual relations with children who were said to be “*consenting*”.



11.20. On the conclusion of Operation August<sup>63</sup>, two evaluation reports were produced, one by a Manchester City Council quality assurance officer in July 2005, and one by a GMP detective sergeant on 25 August 2005. The quality assurance officer's report helpfully included a copy of the Manchester area child protection child sexual exploitation procedures, which were described as being recently updated. We have been unable to locate a similar document for Rochdale Council. These procedures do, however, present a compelling contemporary view of what was understood within GMP concerning CSE and set out the expectations for managing this by both police and social care. We would then reasonably expect these standards to be applied by GMP across the Greater Manchester area and equally expect similar processes to have been in place in Rochdale at the time. The key elements of this guidance were:

- *“Where there is concern regarding CSE an initial assessment must be concluded*
- *If the assessment determines the child is actually or likely to suffer significant harm due to CSE a Section 47 Strategy Discussion should be held*
- *If the strategy discussion/meeting determines that there is actual or likelihood that a child is suffering significant harm due to CSE then formal child protection procedures must be initiated.”*

The procedures were also clear that if the child was looked after by another authority, then the local social worker was responsible for the assessment and strategy discussion and, if significant harm was indicated, to ensure a CSE meeting was held in the placement authority. These expectations are no surprise to the review team. These standards reflect the 1989 Children Act<sup>64</sup> and the statutory duty of local authorities to take action to safeguard children from significant harm. There was no doubt that these children were at risk of significant harm and there was no justification for not taking action to protect them.

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<sup>63</sup> We covered Operation Augusta in our first report, *An assurance review of Operation Augusta* (2020).

<sup>64</sup> The Children Act 1989 sets out: *“Local authority’s duty to investigate. Where a local authority ... have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child’s welfare.”*

11.21. The Rochdale children's social care individual management review (IMR) goes to some length to explain what it terms a "*blind spot*" to CSE in the council's duty and assessment team. Among the contributory factors it set out were:

- a lack of recognition of and training on CSE
- the high volume of work, low staffing levels and the very significant increase in child protection referrals following the 'Baby P' case in 2008–10. Team priorities were thus focused on young children at risk of significant harm
- a prevailing practice belief that children's social care had the primary responsibility for dealing with cases of intra-familial sexual abuse through the normal child protection procedures and that cases of "*extra familial stranger abuse*" such as "*child prostitution/child sexual exploitation*" were the primary responsibility and province of the criminal justice agencies, principally the police.

11.22. While this may have been the prevailing view within the duty and assessment team, we do not lay the primary responsibility for the systemic failure to protect children on the manager of that team and the small group of staff who worked in it. One group of professionals, the Crisis Intervention Team, had no difficulty in recognising the widespread sexual exploitation of children and were prepared to challenge other agencies about this inaction. As we have shown, the concerns about CSE had been consistently raised with both the police and children's social care at the highest level by Sara Rowbotham and her colleagues. Senior and middle managers across both organisations were aware of this but they failed to act. These children were being subjected to significant harm and the statutory agencies let them down, because they found it just too difficult a problem to address.

11.23. As well as their primary duty to safeguard children, the police had a range of additional powers to tackle CSE. The police were given powers under the Child Abduction Act 1984 to issue child abduction warning notices (formerly known as harbouring notices) to protect children under 16 and those in public care until they were 18. These orders could be issued against individuals who were suspected of grooming children by stating that they had no permission to associate with the named child and that if they did so they could be arrested under the Child Abduction Act 1984 and Children Act 1989. It is striking in our consideration of all of the children that this was a rarely used deterrent.

11.24. In conclusion, the quality of practice in the vast majority of these cases fell far short of what could have been reasonably expected to be in place at the

time and countless children known to be at significant risk of harm were left unprotected and their abusers left to continue to exploit children with impunity.

In our first report, we covered the tragic death of Victoria Agoglia<sup>65</sup> in 2003. Victoria Agoglia was a child in the care of Manchester City Council. In September 2004, the City of Manchester Area Child Protection Committee (ACPC) produced a Part 8<sup>66</sup> review in respect of Victoria's death.

11.25. The Part 8 review into her death recommended the following:

*“Joint police and social services investigation should take place where there is evidence that a child is involved in commercial sexual exploitation, this should occur in all circumstances, including those when a child refuses to make a complaint. There should never be an expectation that vulnerable children/young people can provide protection for themselves.”*

11.26. Although this recommendation was a key lesson learned from the death of Victoria Agoglia in 2003, we found, in Operation Augusta, a continued over-reliance by investigators on the cooperation of the child victims despite the obvious coercion and control exhibited by their perpetrators. Regrettably, we have found this approach to victims also continued throughout this period in Rochdale, as well as a failure to use the legal sanctions available through the legislation to warn off offenders. Furthermore, we found, as we did in Operation Augusta, only very limited attempts by the successive operations in Rochdale to take disruptive action, using powers under the Police and Criminal Evidence Act 1984 (PACE) to arrest, question and search premises. We also found only very few examples of working with the licensing authority to oppose the licences of the premises or taxi companies that had been identified as central to the exploitation<sup>67</sup> or use of non-traditional police tactics such as surveillance.

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<sup>65</sup> We covered the death of Victoria Agoglia in our first report, *An assurance review of Operation Augusta*.

<sup>66</sup> *Working Together to Safeguard Children* (1991) followed the Children Act 1989 and introduced 'Part 8', setting out the following duty: *“Whenever a case involves an incident leading to the death of a child where child abuse is confirmed or suspected, or a child protection issue likely to be of major public concern arises, there should be an individual review by each agency and a composite review by the ACPC.”*

<sup>67</sup> While the SIO for Operation Span (SIO 1) had set out the aim of disrupting of taxi companies transporting vulnerable children, he told the review team his recommendations were never followed through by the division.

11.27. It is therefore beyond doubt that the practice standards in place for the police at the time required robust and assertive action in respect of any intelligence received about CSE and that the reluctance of the child to make a complaint was not a reason for not pursuing these matters.

11.28. What is also without question is that despite the clear lessons that needed to be learned from the death of Victoria Agoglia, GMP failed to prioritise CSE. The *Operation Augusta Evaluation Report*, produced by a detective sergeant in August 2005, concluded:

*“Our fear is that now the operation has concluded the ineffective response to child sexual exploitation will continue. The preferred recommendation therefore is for a full-time dedicated multi-agency team, primarily consisting of police officers and social workers which in the first instance would cover all the Manchester divisions. This team could be a pilot for consideration of other similar teams in other parts of Greater Manchester subject to levels of need.”*

11.29. In November 2007, the Force Director of Intelligence (FIB), published the annual strategic assessment document, which gave an overview of CSE as it was known to GMP at that time:

*“Currently, Greater Manchester police do not have a force-level initiative that examines child sexual exploitation, and investigations are typically undertaken by divisional resources. Our understanding of this subject is limited, and the true extent of the problem is unclear.”*

11.30. The following year’s strategic assessment indicated that little corporate progress had been made in the field of CSE, but two proactive operations were held up as exemplars of good practice. Operation Protect in the City of Manchester (established in January 2007) and Operation Messenger in Oldham (launched in September 2006) were multi-agency partnership initiatives intended to protect vulnerable young children from the sexual advances of older men.

One of the 2008 strategic assessment’s key findings stated:

*“GMP does not currently have a definition of Child Sexual Exploitation (CSE) or an accompanying Force policy in place. As such, the approach taken by divisions across the force remains inconsistent and reflects a distinct lack of knowledge and understanding about the extent and reach of this type of criminality and victim awareness across the Greater Manchester Force area.”*

The report went on to make the following recommendation:

*“The Local Policing Improvement Branch should undertake a review of the basic principles and guidelines of Operation Messenger and Operation*

*Protect to identify good practice and coordinate its implementation across the GMP. This will include determining an appropriate force-wide definition for Child Sexual Exploitation with an accompanying policy.”*

11.31. Despite the clear evidence that organised crime gangs had been sexually exploiting children in Rochdale at the time this recommendation was written, and the evidence of the prolific serial rape of countless children in Rochdale, it was not until January 2011 that GMP finally established a multi-agency CSE team in Rochdale and even then, it was only initially staffed by one inexperienced police constable. We regard this as a lamentable strategic failure by successive senior leaders. While so many of the failures have been put down to the individual approaches of frontline detectives, on numerous occasions we have seen that investigations into CSE were insufficiently resourced and supported given the scale of the offending within the Rochdale borough. The missed opportunities to learn from the death of Victoria Agoglia and to prioritise an effective strategic response to the detection, disruption, and prosecution of organised CSE should firmly be laid at the door of senior officers within GMP throughout this period.

11.32. In her interview with the review team, Detective Chief Superintendent B set this out in the starkest of terms:

*“I had a very painful last few years in GMP as a result of trying to push the victims’ agenda in terms of vulnerability and the way we deal with victims, in particular the way we record crimes, and some of the ethical stuff around it. Not just me, there were a number of us, and we were hitting a very big brick wall. Pockets of good practice, pockets of things happening, but basically then overridden and overruled by this attitude that our victims are lying, particularly around sexual offences. And I don’t understand where it comes from because nobody automatically assumes if you’re reporting a burglary, you’re lying. But if a woman is reporting a rape, there is this assumption that they’re not telling the truth for whatever reason. And I couldn’t get past it. And there was a number of us tried for a very long time to get past it, and we never could. It just kept coming round and round and round again that actually, GMP is crap at dealing with victims because they don’t believe them half the time. And that is specifically around sexual offences, adult and child, and domestic abuse. And I don’t know why that is.”*

# Chapter 12. The allegation that the Crisis Intervention Team failed to appropriately refer their concerns to the statutory agencies

## Summary and conclusions

- 12.1. On the conviction of the nine Span defendants, a police source was quoted in the media as saying that the Crisis Intervention Team had come across innumerable vulnerable girls but did not always communicate this to the police and social services. In 2012, Sara Rowbotham the coordinator of the Crisis Intervention Team, refuted this and informed the Home Affairs Select Committee that since 2004 her team had made 103 referrals of child sexual exploitation (CSE) to either GMP or Rochdale Council. She also stated these were not being responded to appropriately.
- 12.2. However, the two serious case overview reports published by Rochdale LSCB in 2013 explicitly criticised the Crisis Intervention Team for not following child protection procedures and for not communicating appropriately with other agencies. The reports also disputed whether the Crisis Intervention Team had made the number of referrals suggested. However, we have established that, by October 2012, the multi-agency CSE strategy group chaired by Chief Superintendent C was aware of approximately 127 potential victims referred by the Crisis Intervention Team to children's social care that had not been acted on over the years. This figure later grew to 260 potential victims. This information was clear to all the partners three months before the publication of the serious case review overview reports in December 2013. We therefore find this level of misrepresentation disturbing. We would have liked to have put our concerns to both the author of the overview report and the chair of the serious case review panel. Both these individuals, however, declined to be interviewed by the review team.
- 12.3. In contrast, our review has found compelling evidence to support the view that the Crisis Intervention Team was sharing explicit information with the authorities on the exploitation of multiple children. We have also, as set out in previous chapters, evidenced that despite these explicit concerns GMP and Rochdale Council failed to take appropriate action.

- 12.4. For several years, Sara Rowbotham and her colleagues were lone voices in raising concerns about the sexual exploitation and abuse of these children. Both GMP and Rochdale Council failed to respond appropriately to these concerns, and it has been a gross misrepresentation to suggest that the Crisis Intervention Team in some way was complicit with this failure and to tarnish the reputation of this small group of professionals.

### **Detailed findings: The allegation that the Crisis Intervention Team failed to appropriately refer their concerns to the statutory agencies**

- 12.5. In May 2012, GMP issued a public apology regarding the Rochdale investigation. However, at the same time as the apology, a police source was reported as saying:

*“Rochdale's Crisis Intervention Team, set up to reduce teenage pregnancies, came across 'innumerable' vulnerable girls but did not always communicate with police and social services.”*

- 12.6. On 6 November 2012, Sara Rowbotham, the coordinator of the Crisis Intervention Team, gave evidence to the Home Affairs Select Committee. In response to questioning, she explained that she had been making referrals to both police and children's social care since 2004:

*“We were making referrals from 2004, very explicit referrals, which absolutely highlighted for protective services that young people were incredibly vulnerable. I tried to be as articulate as I possibly could to make Children's Social Care aware of the level of concern.”*

- 12.7. Sara Rowbotham went on to state that she had collated some figures from 2005 to 2011 and identified that her service had made 103 referrals. She also explained that as her referrals were not being responded to, she began to make the safeguarding children unit aware of the referrals she was making. She went on to refute any suggestion that the Crisis Intervention Team had not appropriately communicated its concerns with children's social care

- 12.8. On 20 November 2012, Detective Chief Superintendent B gave the following evidence to the Home Affairs Select Committee:

*“I think, as far as the police are concerned, what Sara Rowbotham said with regard to those 181 is not inaccurate. The referrals were made in a variety of different ways, not always as a formal referral, which did cause us some difficulties. It is not fair to say we did nothing. We did do something. We*

*perhaps didn't do it as effectively as we would have liked to, and that has resulted in the Rochdale case more recently and the ongoing investigations that we have."*

- 12.9. In her interview with the review team, Detective Chief Superintendent B elaborated on this further:

*"[Sara Rowbotham] did turn up at that Select Committee with this bloody list, and that was the first we'd heard of it, and she dropped it on our toes, and, you know, you think that's less than helpful. Now, it transpired she had been giving information to GMP but because GMP's practices, in terms of joint working with the Crisis Intervention Team, were less than useful, it'd been going to all sorts of different people. She'd given a bit of information to the Licensing Sergeant, for example, who'd gone oh no idea what to do with that, that looks horrible, put it in the bin. You know it was that sort of relationship in Rochdale between the agencies that made it that much more difficult. There were people saying, myself included, this is just the tip of the iceberg, we are not solving the world's problems with this. [Chair of Home Affairs Select Committee] in particular I think, allowed himself to become, the Select Committee to become, distracted by this single issue that was Span instead of being a little clearer around the broader issue that was CSE."*

- 12.10. The evidence does not support Detective Chief Superintendent B's assertion. We have shown in Chapter 9 on Operation Doublet that by 1 October 2012 the gold group had been made aware of approximately 127 referrals made by the Crisis Intervention Team to children's social care that had not been acted on over the years. The evidence of Sara Rowbotham to the Home Affairs Select Committee was therefore neither a surprise to GMP and Rochdale Council and nor was it inaccurate.

- 12.11. In January 2013, the two serious case overview reports on Young People 1–6 and Young Person 7 were published by Rochdale LSCB. While these undoubtedly clearly state that GMP and children's social care failed on many occasions to respond appropriately to information provided by the Crisis Intervention Team, the overview reports go to considerable pains to criticise the very service that was attempting to protect these children. In particular, the serious case review overview report on Young People 1–6 contains the following criticism of the Crisis Intervention Team:

*"An area of particular concern is the frequency of non-compliance by the Crisis Intervention Team in working to the Board's Child Protection Procedures and the absence of a fundamental understanding of their role in working as part of a partnership. Crisis Intervention Team stood out as*



*having been the first service to recognise explicitly that the young people were being exploited and that this was placing them at significant harm. This team played a crucial role in identifying CSE and in supporting young people. However, the serious gaps in their partnership working ultimately contributed to the collective failure to meet these young people's needs."*

We regard this as a very serious criticism and have considered in detail what these issues of non-compliance amounted to.

- The overview report refers to: *"The practice of sending letters to a range of people and teams within children's social care and also to Rochdale LSCB, which did not have a function in safeguarding individual children. Some letters were addressed 'To Whom It May Concern' rather than to a named person and there is, for example, no evidence that letters were received by LSCB."*

We have set out in previous chapters the many examples of children's social care failing to respond appropriately to concerns raised by the Crisis Intervention Team. This inevitably led to a practice, which others would view as commendable, to ensure that all relevant parties were made aware of the team's significant concerns. It is not the case that children's social care can abnegate its responsibilities for safeguarding children if the information is not presented in the correct format. Our analysis of the files shows that the Crisis Intervention Team repeatedly and explicitly shared concerns that were not responded to appropriately. In respect of communications being sent to Rochdale LSCB, we have shown in the previous chapter that in 2007 an explicit request was made to all agencies to send information directly to the LSCB about instances of CSE and knowledge of the perpetrators.

- The overview report also goes to some length to discredit the claim by the coordinator of the Crisis Intervention Team that the team had sent 103 referrals to children's social care. Pennine Care NHS Foundation Trust carried out a validation exercise consisting of a full audit of all the information shared by the team. The validation exercised took a very limiting view of a referral<sup>68</sup>. We cannot understand the purpose of this approach other than to attempt to discredit the Crisis Intervention Team and mitigate the numbers. Notwithstanding the highly restricted definition, the exercise concluded over 50 referrals had been made to children's social care. Nonetheless, we are confident this grossly underestimated the number of times the Crisis Intervention Team shared legitimate concerns with the council's children's social care service. We have shown in Chapter

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<sup>68</sup> The definition of referral was given in the audit report as *"a Multi-agency referral form, a communication by phone (verified by an entry in the case note); letter or fax termed "Referral" or the inclusion of an expression of absolute vulnerability to sexual exploitation"*.

9 (on Operation Doublet) that by October 2012, the multi-agency CSE strategy group had identified approximately 127 referrals of potential victims that had been made by the Crisis Intervention Team to children's social care that had not been acted on over the years. This figure later grew to 260 potential victims. This information was clear to all the partners three months before the publication of the serious case review overview reports in December 2013. We therefore find this level of misrepresentation disturbing. We would have liked to have put our concerns to both the author of the overview report and the chair of the serious case review panel. Both these individuals, however, declined to be interviewed by the review team.

- Sara Rowbotham was also personally criticised in the overview report:

*“The style of the Crisis Intervention Team Co-ordinator was not experienced as inclusive by many of the agencies and the outcome was that some of the important information held by the team did not impact effectively either with colleague practitioners or at a strategic level.”*

We regard this as a wholly inappropriate attack on an individual's reputation. We have no way of knowing how Sara Rowbotham was seen by partner agencies. We have seen evidence that she robustly put forward her concerns that the statutory agencies were failing to protect children and she is to be applauded for doing this. Whatever her personal style it should never have been an excuse for ignoring the information she was so clearly presenting.

12.12. The serious case overview report on Young Person 7 (who is referred to as Child 1 throughout our report) also contains criticisms of the Crisis Intervention Team's for failing to share information on this child relating to the following:

- Young Person 7's first presentation was at 13 years and nine months of age with a disclosure of sexual activity. However, we have established this was information held by another health provider, not the Crisis Intervention Team.
- Young Person 7 telling staff at the sexual health clinic (Crisis Intervention Team) that she had had unprotected oral and anal sex, sometimes against her wishes and that the men would hit her if she refused. However, we have established that this was shared in a fax by Sara Rowbotham to the social worker on 13 May 2005.
- Young Person 7 disclosing to the Crisis Intervention Team and a Connexions youth support worker that a man had poured petrol on her and threatened to set her alight because she refused to perform oral sex. However, we have established that it is clear from the notes of a meeting held to discuss placing Child 1 in secure accommodation that her social worker had been informed of this disclosure.

12.13. The same report also criticised the Crisis Intervention Team for advising the police not to contact the victims directly at their homes, saying:

*“It is also evident from the notes of the meeting that Crisis Intervention Team was strongly of the view that victims should not be contacted directly at their homes, and that most of the victims would not engage with the police. In effect, this meant that Crisis Intervention Team was in the position of screening the victims who could be approached. Crisis Intervention Team also made it a pre-condition that the police would undertake surveillance. It is noted that Crisis Intervention Team considered that “there is a culture of fear or a misconception about the nature of the relationship between the girls and the men, which could make it impossible to break through”. There was some dissension to this rather fatalistic view, including by Early Break and Legal Services, who both suggested other ways to intervene. However, the combination of the position taken by the Crisis Intervention Team and the view of the Police that a direct complaint was necessary to progress any prosecution effectively created a further obstacle in attempts to intervene.”*

We have not seen any reference to this in the notes from strategy meetings held on young people in early 2007. However, we would regard the Crisis Intervention Team’s focus on the vulnerability of the children as exemplary, and their fear that unsolicited approaches could put these children more at risk is well founded. We regard it as quite unreasonable that the overview report suggests this served as an obstacle to the progress of a prosecution.

12.14. We have set out in earlier chapters the many occasions when Sara Rowbotham formally reported her concerns about the prevalence of CSE in Rochdale.

12.15. In February 2007, she informed a strategy meeting of the details in respect of 11 children she believed were being sexually exploited by an organised crime group of dangerous Class A drug dealers.

12.16. On 11 February 2008, Sara Rowbotham produced a further report that summarised 23 children she believed were at risk of sexual exploitation. In this report, she linked these children with several named perpetrators she had already alerted the authorities to. This report was fed into the CSE scoping exercise commissioned by Rochdale LSCB.

12.17. We have also set out in earlier chapters the repeated and unheeded attempts Sara Rowbotham and her colleagues made to get GMP and Rochdale Council’s children’s social care to respond to the concerns they had about the safety of children they were working with.

12.18. We have also undertaken a detailed analysis of all 111 children we have considered as part of our review. Out of these 111 children, 94 were known to the Crisis Intervention Team. We found significant evidence that 68 of the children had been sexually exploited. We considered whether the Crisis Intervention Team had referred their concerns for these 68 children to the protective agencies appropriately. We found that in 59 cases the Crisis Intervention Team had shared their substantial concerns in respect of CSE with either the police or children's social care. In eight of the cases, we did not have access to sufficient information to form a view. In only one case did we find a reference to CSE on files held by the Crisis Intervention Team but could not find any record that this had been reported to the police or children's social care.

12.19. We conclude therefore that there is compelling evidence that throughout this period the Crisis Intervention Team were making great efforts to formally inform the statutory agencies of the widespread exploitation of children in Rochdale. The information they shared was specific, explicit, and compelling. This should have been sufficient for both GMP and Rochdale children's social care to take action to protect these children. For several years, Sara Rowbotham and her colleagues were lone voices in raising concerns about the sexual exploitation and abuse of these children. Both GMP and Rochdale Council failed to respond appropriately to these concerns, and it has been a gross misrepresentation to tarnish the reputation of this small group of professionals by suggesting they were in some way complicit in this failure.

# Appendices

- A. Chronology of main events.
- B. List of individuals referred to in the report
- C. Timeline for this report
- D. Information reviewed
- E. Terms of reference

## Appendix A

### Chronology of main events

<b>2002</b>	
	Rochdale Pennine Care NHS Foundation Trust commissioned the Crisis Intervention Team to deliver outreach sexual health services for vulnerable children.
<b>2003</b>	
	The death of Victoria Agoglia
<b>2004</b>	
	The Part 8 review on the death of Victoria Agoglia was completed.
<b>2005-6</b>	
	The Crisis Intervention Team made numerous referrals to Rochdale children's social care and GMP concerning child sexual exploitation.
<b>2007</b>	
<b>January</b>	Sara Rowbotham sent a letter informing Rochdale Council of the potential sexual exploitation of 11 children by an organised crime gang.  The first multi-agency strategy meeting was held about the allegations.  A GMP investigation commenced, led by one detective.
<b>February</b>	A second multi-agency strategy meeting was held.
<b>April</b>	A third multi-agency strategy meeting was held.
<b>2008</b>	
<b>February</b>	Sara Rowbotham produced another report summarising 23 children believed to be at risk of sexual exploitation.

<b>April</b>	GMP closed down the investigation set up in January 2007 with no charges made. There had been no investigation into the allegations against the organised crime gang.
<b>July</b>	<p>The head of children’s social care submitted a further report to Rochdale LSCB. This report identified that 50 children had fallen victim to child sexual exploitation in Rochdale during 2007<sup>69</sup>.</p> <p>Rochdale LSCB approved a plan for setting up a dedicated team <i>“as a matter of urgency in Rochdale to address the child sexual exploitation that is occurring in the borough.”</i></p>
<b>August</b>	<p>Child 41 was arrested on suspicion of causing criminal damage at a takeaway in Rochdale. Following her arrest, Child 41 disclosed that she had been raped and sexually assaulted by staff at a takeaway restaurant in Rochdale.</p> <p>The mother of Child 46 informed GMP that her daughter had disclosed she and numerous other local children, including Child 41, Child 44, and Amber, had been regularly engaging in sexual activity with members of staff from two nearby restaurants in return for food and alcohol.</p>
<b>2009</b>	
<b>January</b>	<p>Child 41 informed her Crisis Intervention Team worker that she was prepared to make a statement to the police about ongoing exploitation. Later in January Child 41 gave a written statement to GMP detailing the sexual abuse she had experienced since July 2008.</p> <p>The investigating officer recognised this was a complex inquiry, involving possibly 30 potential suspects. GMP did not allocate additional resources to support the investigation.</p>
<b>March</b>	<p>Child 44 had a termination. GMP took possession of the foetus as potential evidence without informing Child 44 or her family.</p> <p>Amber was arrested and questioned on suspicion of inciting females to engage in prostitution.</p>
<b>April</b>	Funding for Sunrise Team was approved for two years.
<b>August</b>	The Crown Prosecution Service declined to take the case of Child 41 forward to trial. The investigation was subsequently closed and Child 46’s case was also closed in error.

<sup>69</sup> *Update on Review of Sexual Exploitation Across the Borough*, head of children’s services report to Rochdale LSCB (dated 16 June 2008).

	A part-time Early Break adolescent services support worker joined the health worker in the Sunrise Team.
<b>December</b>	A social worker was assigned to the Sunrise Team.
<b>2010</b>	
<b>January</b>	Police Constable A joined the Sunrise Team.
<b>March</b>	Child 44 disclosed she had been sexually abused by six older Asian men.  Child 44 disclosed in her police interview that there were over 60 men involved.
<b>March</b>	Child 47 disclosed she had been raped by Asian men linked to the offenders who exploited Child 41.
<b>April</b>	Detective Inspector A submitted a divisional investigative assessment requesting additional resources to investigate offences against 35 victims and more than 40 men from mainly Asian backgrounds participating in organised systematic abuse of vulnerable children.  The divisional investigative assessment was never submitted to GMP senior management, and the division only allocated one additional detective to the investigation.
<b>December</b>	Operation Span commenced with a major incident team and senior investigating officer (SIO), Detective Superintendent A.
<b>December</b>	Eight suspects were arrested.
<b>2011</b>	
<b>January</b>	Child 3 indicated that she wished to be interviewed.
<b>February</b>	The Crown Prosecution Service formally agreed that Amber would be designated as a victim.
<b>February</b>	The first Operation Span SIO was removed and replaced by the second SIO, Detective Chief Inspector B.
<b>March</b>	Amber gave her first interview, describing sex with 15 separate men.  Nominal 6 was charged and remanded into custody.
<b>April</b>	The second SIO laid out limiting parameters to the investigation.
<b>August</b>	The second SIO was replaced by a third SIO, Detective Inspector C.



<b>September</b>	The Crown Prosecution Service and GMP made the decision to indict Amber as a co-conspirator.
<b>2012</b>	
<b>February</b>	The trial of nine defendants in Operation Span began.
<b>May</b>	<p>Following a meeting of senior officers, it was agreed to set up a second major investigation led by a major incident team. This was to become Operation Doublet.</p> <p>The Operation Span trial concluded with the conviction of nine men.</p>
<b>September</b>	Rochdale LSCB published its <i>Review of Multi-agency Responses to the Sexual Exploitation of Children</i> . This report considered 'Suzie', one of the victims cited in the Operation Span trial. The report noted that the Crisis Intervention Team had made several referrals to children's social care, but these referrals were not generally acted on by children's social care.
<b>October</b>	A gold command meeting took place that included GMP and Rochdale Council representatives. This highlighted that a substantial number of referrals had been made by the Crisis Intervention Team to children's social care that had not been acted on over the years. These were believed to total approximately 127.
<b>November</b>	<p>The new chief executive of Rochdale Council, the former chief executive of Rochdale Council and Sara Rowbotham the coordinator of the Crisis Intervention Team, all gave evidence to the Home Affairs Select Committee.</p> <p>At a separate hearing, the GMP Chief Constable and Detective Chief Superintendent B also gave evidence to the Home Affairs Select Committee.</p>
<b>2013</b>	
<b>March</b>	The <i>Sunday Times</i> printed a report alleging that 76 more victims of grooming had been identified in Rochdale.
<b>March</b>	The Operation Doublet SIO established that 102 children had been identified as being outside the three main police investigations.
<b>November 2013</b>	The first SIO for Operation Doublet was replaced.
<b>December 2013</b>	The serious case review reports into Young Persons 1–6 and Young Person 7 were published by Rochdale LSCB. The reports criticised the Crisis Intervention Team for overstating the number of referrals it had made, even though it had become clear in the previous 12 months that more than 120 referrals from the team had not been dealt with appropriately by children's social care.

# Appendix B

## List of individuals referred to in the report (mostly anonymised)

	Reference in report	Role
1	Sara Rowbotham	Managed the staff at the Crisis Intervention Team
2	Detective Constable A	Lead detective on the 2007 investigation
3	Detective Sergeant A	Detective sergeant on 2007 investigation
4	Head of Complex Case Unit	Head of Crown Prosecution Service complex case unit, 2008 to June 2011
5	Detective Inspector A	Detective inspector in charge of Rochdale public protection and investigation unit
6	Assistant Chief Constable A	Assistant chief constable and gold commander responsible for initiating Operation Span
7	Detective Constable B	Detective on the 2007 investigation
8	Detective Sergeant B	Detective sergeant responsible for investigation in 2008–09 into child sexual exploitation at two restaurants in Rochdale
9	Detective Inspector B	Detective inspector responsible for investigation in 2008–09 into child sexual exploitation at two restaurants in Rochdale
10	A social worker in the Sunrise Team	Social worker in the Sunrise Team in 2008
11	Detective Chief Inspector A	Crime manager who supervised Detective Inspector A in 2010
12	Tier five interview advisor	Specialist interview advisor, serious crime division
13	Detective Chief Inspector B	Second SIO on Operation Span
14	Detective Inspector C and SIO 3	Initially deputy SIO, then third SIO on Operation Span

<b>15</b>	Detective Constable C	Detective on Operation Span and Sunrise Team
<b>16</b>	Detective Chief Superintendent A	Silver command on Operation Span
<b>17</b>	Detective Superintendent A and SIO 1	First SIO on Operation Span
<b>18</b>	Detective Constable Maggie Oliver	Detective on Operation Span
<b>19</b>	Detective Constable E	Detective on Operation Span
<b>20</b>	Crown Prosecutor A	Crown Prosecution Service lawyer involved in Operation Span
<b>21</b>	Chair of LSCB A	Chair of Rochdale LSCB during Operation Span
<b>22</b>	Chair of LSCB B	Chair of Rochdale LSCB after Operation Span
<b>23</b>	A social care manager	Social care manager in Rochdale, 2009
<b>24</b>	Executive director of children's services	Executive director of Rochdale children's services prior to Operation Span trial
<b>25</b>	Chief executive of Rochdale Council A	Chief executive of Rochdale Council prior to Operation Span trial
<b>26</b>	Police Constable A Detective Constable F	Detective on Sunrise Team and Operation Doublet
<b>27</b>	Chief executive of Rochdale Council B	Chief executive of Rochdale Council after Operation Span trial
<b>28</b>	Superintendent B	Superintendent of Rochdale division
<b>29</b>	Chief Superintendent B	Chief superintendent of Rochdale division
<b>30</b>	Detective Chief Superintendent B	Detective chief superintendent responsible for Operations Span and Doublet
<b>31</b>	Detective Chief Inspector D and SIO 4	SIO on Operation Doublet
<b>32</b>	Chief Superintendent C	Rochdale divisional commander during Operation Doublet and chair of CSE strategy group
<b>33</b>	Superintendent C	Superintendent in Rochdale division during Operation Doublet

<b>34</b>	The barrister advising the Crown Prosecution Service	The lead barrister advising the Crown Prosecution Service during the Span Trial
<b>35</b>	Chief Prosecutor for North West England	Chief prosecutor, Crown Prosecution Service, North West England, 2012
<b>36</b>	Head of the complex case unit	Head of the Crown Prosecution Service complex case unit North West England, 2018
<b>37</b>	Child 44	Interviewee
<b>38</b>	Amber	Interviewee
<b>39</b>	Child 3	Interviewee
<b>40</b>	Chief Constable	Chief Constable of GMP 2008–15
<b>41</b>	Health promotion manager	Health promotion manager, Crisis Intervention Team
<b>42</b>	Author of GMP independent management review	Co-author of GMP independent management review on Young Persons 1–6 and 7
<b>43</b>	Author of serious case reviews	Author of serious case reviews on Young Persons 1–6 and 7
<b>44</b>	Chair of serious case review panel	Chair of serious case review panel
<b>45</b>	Assistant Chief Constable B	Assistant chief constable when Operation Span trial concluded
<b>46</b>	Assistant Chief Constable C	Assistant chief constable during Operation Doublet

# Appendix C

## Timeline for this report

<b>October 2017</b>	<b>Terms of reference agreed by steering group</b>
<b>October 2017</b>	First interview with Maggie Oliver First interview with Sara Rowbotham
<b>November 2017</b>	Second interview with Sara Rowbotham
<b>December 2017</b>	Second interview with Maggie Oliver
<b>December 2017</b>	Interview with health promotion manager
<b>December 2017</b>	Interview with tier five interview advisor
<b>February 2018</b>	The review team analysed databases held by Pennine Care NHS Foundation Trust on children at risk of sexual exploitation.
<b>March 2018</b>	The review team made its first request to Rochdale Council to access the social care files. Rochdale Council agreed to consider the legal position in respect of data protection.
<b>June 2018</b>	Interview with district crown prosecutor
<b>January 2020</b>	Report on Operation Augusta published
<b>January 2020</b>	Verbal agreement given by Rochdale Council to a data-sharing agreement with the review team
<b>January 2020</b>	GMP agreed to share the records of the 59 potential victims initially referred to GMP by the Crisis Intervention Team.
<b>February 2020</b>	At the request of GMP, the review team forwarded the names of the 59 children and copies of the two databases. GMP subsequently undertook a review of these cases and invited the team to set out its proposal for reviewing the HOLMES records.
<b>April 2020</b>	Briefing on the provenance of the Pennine Care Trust databases sent to GMP

<b>September 2020</b>	GMP notified the review team that it was not in agreement with the review team considering the records on those cases where there was a current and active investigation given <i>“the potential adverse impact upon any live investigation as a consequence of a non-statutory or judicial external review being given access to sensitive and confidential data from an active operation”</i> .
<b>November 2020</b>	Following this position being challenged by both the review team and Greater Manchester Combined Authority (GMCA), GMP proposed a protocol covering those active investigations. This protocol included consulting the Crown Prosecution Service (CPS).
<b>December 2020</b>	GMP took legal advice from its counsel. This stated in summary:  <i>“My conclusions are that there is a legal basis for disclosure by the GMP to the RT [review team] and that there is no limitation on the extent of the material requested, provided of course that the disclosure is done in an appropriate manner and with appropriate safeguards.”</i>  This advice was not shared with the review team or GMCA at the time.
<b>February 2021</b>	Data-sharing agreement with Rochdale Council signed by all parties
<b>March 2021</b>	Although GMP had received advice from counsel in December 2020, it remained concerned about the review team having access to personal data. In an attempt to resolve this impasse, the two counsels for GMP and GMCA met but no agreement could be reached on the way forward.
<b>April 2021</b>	GMP agreed to the review team having access to a screen-share that would enable the team to access a sample of cases, including names and addresses, obviating the need for anonymised data.
<b>May 2021</b>	The review team began a dummy run’ on one case to test the process proposed by GMP. This demonstrated that the arrangements were impractical.
<b>June 2021</b>	Following a meeting with the newly appointed Chief Constable, GMP released to GMCA a copy of the advice originally provided by its counsel. GMP officers maintained that they still had to have regard to giving access in an appropriate manner, and with appropriate safeguards, and rejected proposals by the review team to make the process workable
<b>June 2021</b>	Interview with Child 44

<b>June 2021</b>	Interview with Child 3
<b>October 2021</b>	GMCA sent a request to Pennine Care Trust for access to documentation produced by the Crisis Intervention Team on the sample of children.
<b>November 2021</b>	Data-sharing agreement with GMP agreed for Rochdale workstream
<b>December 2021</b>	The review team and GMCA met with the Pennine Care Trust, and it was agreed that the two organisations would work on drafting a data-processing agreement.
<b>December 2021</b>	GMP provided background documentation on GMP child sexual exploitation (CSE) investigations from 2007 to 2011. The review team commenced a review of GMP files and unredacted individual management reviews.
<b>January 2022</b>	Rochdale Council shared with the review team five audits on our sample of 59 children.
<b>February 2022</b>	GMP and the review team agreed a joint protocol for sharing information in respect of live investigations.
<b>March 2022</b>	The review team asked Pennine Care Trust to trace Crisis Intervention Team documentation held on the first child of our sample.  Further request made for data-sharing agreement with Pennine Care Trust
<b>March 2022</b>	GMP declined to share information requested by the review team on four children the police believed were subject to a live investigation and three suspects.
<b>April 2022</b>	Rochdale Council shared unredacted copies of the individual management reviews.
<b>June 2022</b>	Report on safeguarding practices in Oldham published
<b>June 2022</b>	Interview with Detective Inspector A
<b>August 2022</b>	An agreement was reached with GMP to allow the review team to review the records on those children and suspects in our sample who GMP had stated were subject to a live investigation. Work commenced on these cases.
<b>August 2022</b>	The review team sent Pennine Care Trust a detailed schedule of all the documents we wished to review against each child in our sample.  Pennine Care Trust agreed to test a process of information sharing on one case as an initial pilot.

<b>October 2022</b>	Interview with author of GMP individual management review
<b>October 2022</b>	Interview with SIO 1 and the tier five interview advisor
<b>November 2022</b>	Interview with Detective Chief Superintendent B
<b>December 2022</b>	Interview with Amber
<b>December 2022</b>	We received a further 25 audits from Rochdale Council on our sample children.
<b>December 2022</b>	Pennine Care Trust arranged for the transfer of relevant information on our sample from GMP.
<b>December 2022</b>	Rochdale Council supplied a further seven audits on our sample children.
<b>March 2023</b>	Rochdale Council supplied the remainder of the audits on our sample children.
<b>March 2023</b>	The review team sent Pennine Care Trust two schedules, one that set out the documents we wished to view held by GMP and one setting out documents held by Rochdale Council.  On 18 March 2023. the review team signed a data-sharing agreement with Pennine Care Trust.
<b>March 2023</b>	The review team undertook the due diligence exercise on the 59 cases at Rochdale Council.
<b>March 2023</b>	Pennine Care Trust gave authority to both GMP and Rochdale Council to release documentation they held that was produced by the Crisis Intervention Team.
<b>March</b>	Rochdale Council released information it held that was produced by the Crisis Intervention Team.
<b>April 2023</b>	The chair of the serious case review panel and the author of the two overview reports provided the review team with a joint statement.
<b>April 2023</b>	GMP released to the review team information it held that was produced originally by the Crisis Intervention Team.
<b>April 2023</b>	GMP declined to allow the review team to review the records of two potential perpetrators.
<b>May 2023</b>	Following intervention by the assistant chief constable, the review team was given access to the records on two perpetrators.



<b>May 2023</b>	The review team requested from Rochdale Council copies of the unredacted serious case review overview reports and serious case review panel minutes.
<b>July 2023</b>	Third interview with Maggie Oliver
<b>July 2023</b>	Interview with Chair of LSCB B
<b>August 2023</b>	Rochdale Council asked for further clarification on the purpose of requiring the unredacted overview reports. A clarification was sent by the review team, which also requested copies of the minutes of the serious case review screening panel if they could be located.
<b>September 2023</b>	<p>Report delivered to GMCA for legal review by counsel and a factual accuracy check by GMP, CPS, Pennine Care Trust and Rochdale Council.</p> <p>On 11 September 2023, we received notification from the current independent chair of the Rochdale Borough Safeguarding Children Partnership that she would not release to the review team the unredacted serious case reviews for legal reasons. On the same day we received a report from the current independent chair of the Rochdale Borough Safeguarding Children Partnership summarising the content of the serious review screening panels from 2011/12.</p>

# Appendix D

## Information reviewed

### Research on Operation Span

We undertook a detailed review of Operation Span. This included reviewing the following documentation (sources given in brackets):

#### Documentary review: Operation Span

- The senior investigating officers' (SIO) policy book (GMP)
- The Operation Span HOLMES<sup>70</sup> account in respect of 30 children in our sample (GMP)
- The minutes of the available gold meeting minutes (GMP)
- The indictments and draft indictments for Operation Span (CPS)
- The prosecution barrister's opening address to the jury (CPS)
- Case audits produced by Rochdale Council on our sample of 59 children. This included a 'deep dive' assurance exercise by the review team analysing the original contemporaneous records reports and meeting minutes (RMBC)
- The *Review of Multi-agency Responses to the Sexual Exploitation of Children* (Suzie) produced by Rochdale LSCB in 2012 (RMBC)
- The individual management reviews produced by GMP in respect of the two serious case reviews published in 2013 by Rochdale LSCB (GMP)
- The policy book kept by the author of the GMP individual management review (GMP)
- The *Review of allegations of rape and child sexual exploitation between 2008 and 2010 at Rochdale – Operation Span* produced by the major crime review unit, April 2011 (GMP)
- The individual management reviews produced by Rochdale Council in respect of the two serious case reviews published in 2013 by Rochdale LSCB (RMBC)
- The individual management reviews produced by Pennine Care Trust in respect of the two serious case reviews published in 2013 by Rochdale LSCB (PCT)
- The two redacted serious case review reports into Young Persons 1–6 and Young Person 7 in December 2013 (RMBC). We asked Rochdale Council for copies of the unredacted reports, but they declined to release these to **the**

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<sup>70</sup> The Home Office Large Major Enquiry System (HOLMES) is a computer system used by the police to manage serious and complex crime investigations.

review team Contemporaneous case records and reports produced by the Crisis Intervention Team on specific children within our sample (PCT)

- Copy of 2013 April Crisis Intervention Team records review (PCT)
- Copy of alleged perpetrators list (final), February 2013 (PCT)
- Copy of list of 163 children known to Crisis Intervention Team (PCT)
- Review D342 Pennine Care NHS notes and report, 3November 2012 (GMP)

We interviewed the following individuals in respect of Operation Span.

### **Interviews: Operation Span**

- With the help and support of the Maggie Oliver Foundation, three adult survivors who featured in Operation Span agreed to speak to the review team at length. They had all had recent experience of GMP. One was a victim in Operation Span (Child 44), one was a witness (Child 3) and one was originally formally identified as a victim but was subsequently named on the indictment as a defendant (Amber). In 2022, Amber was acknowledged by the new Chief Constable as a victim more than 10 years after she had been portrayed in court as an offender. GMP has now apologised to her and the offences against her that were disclosed to GMP during Operation Span have now been recorded as crimes under Operation Exmoor.
- The first senior investigating officer (SIO 1)
- Detective Constable Oliver
- The author of the GMP individual management review
- The tier five strategic interview advisor
- Sara Rowbotham
- The health promotion manager at the Crisis Intervention Team
- The chair of Rochdale LSCB at the time of the publication of the serious case review overview reports
- The head of the Crown Prosecution Service North West complex case unit (2018)
- The detective chief superintendent with command responsibility for Operation Span

We also invited for interview the following individuals, who either declined our offer or failed to respond.

- Assistant Chief Constable A – no response
- Police Constable A (later promoted to Detective Constable F), A detective in the Sunrise Team and on Operation Doublet – no response

- Detective Chief Inspector B (SIO 2), the second SIO – no response
- Detective Inspector C (SIO 3) the third SIO – no response
- The chair of the serious case review panel - declined and provided a joint written report with the author of the serious case review overview reports
- The author of the serious case review overview reports – declined and provided a joint written response with the chair of the serious case review panel
- The director of children’s services at the time – no response
- The head of children’s social care (targeted services) at the time – no response
- The previous head of children’s social care – Rochdale Council was unable to trace their address
- The chair of Rochdale LSCB during Operation Span – no response

We undertook a detailed review of the major operations that preceded Operation Span. This included the first investigation into exploitation at two restaurants in Rochdale between 2008 and 2009, and the investigation in 2007.

Research on investigations 2004 to 2010 (sources in brackets)

#### **Documentary review: 2004–10 investigations**

- The investigating officer’s casebook for the 2008–09 investigation (GMP)
- The police records in respect of three significant suspects (GMP)
- The log records kept by the investigating officer in the 2007 investigation (GMP)
- The HOLMES records on the 30 children within our sample, where relevant (GMP)
- Rochdale Council audits on our sample, where relevant (RMBC)
- Case records, reports and records of meetings produced by the Crisis Intervention Team within our sample of 59, where relevant (PCT)
- Gold meeting on Doublet minutes, 6 June 2012 (GMP)
- Gold meeting on Doublet minutes, 30 June 2012 (GMP)
- R14DI resume of 2007 scoping document, 5 March 2014 (GMP)

## **Interviews: 2004–10 investigations**

We interviewed one individual, Detective Inspector A, who was responsible for overseeing the operations from 2007 to 2008 and the Sunrise investigation. We also invited to interview the following former GMP officers, but they all failed to respond:

- Detective Constable A, responsible for the 2007 investigation
- Detective Sergeant A, who supervised the 2007 investigation
- Detective Sergeant B, responsible for the 2008–09 investigation
- Detective Constable B, who worked on the 2008–09 investigation
- Detective Chief Inspector A, who supervised Detective Inspector A in 2010

We intended to invite for interview the head of children's social care during the 2007 investigation, but Rochdale Council was unable to trace their whereabouts.

# Appendix E

## Terms of reference

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**BEV HUGHES**

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**DEPUTY  
MAYOR OF  
GREATER  
MANCHESTER**

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Assuring the effectiveness of multi-agency responses to child sexual exploitation in Greater Manchester

Terms of reference

13 October 2017

## **Purpose**

The purpose of this independent assurance exercise is to explore the current and potential future delivery model of the Greater Manchester response to child sexual exploitation (CSE). The exercise is forward facing and does not seek to reopen previous reviews. Its primary ambition is to build on the work already undertaken across Greater Manchester to take all possible steps to ensure that the current provision of services in Greater Manchester is fit for purpose and that all children across Greater Manchester are protected. The exercise will explore and seek to understand recent statements broadcast publicly regarding CSE in Greater Manchester. The exercise will also evaluate the current fitness for purpose and capacity to adapt to future challenges of the Greater Manchester response CSE, delivered across Greater Manchester by organisations under the Project Phoenix partnership arrangements that have been put in place by local authorities, Greater Manchester Police (GMP) and health partners.

## **Scope**

The assurance exercise has been commissioned by the Mayor of Greater Manchester in the exercise of his policing and crime functions.

The assurance exercise is to be undertaken across Greater Manchester and will consider the recommendations of previous reviews undertaken across Greater Manchester, the decision to close down Operation Augusta and the suitability of the Project Phoenix model for dealing with complex safeguarding issues across Greater Manchester now and in the future. Consent will be sought from partners to share their documents with the assurance team and consideration is being given to the need for a data-sharing agreement to be put in place. The exercise will seek only to identify any gaps in the implementation of recommendations from previous reviews and will not seek to reopen these reviews.

Advice has been sought on how the assurance team will interface with the national Independent Inquiry into Child Sexual Abuse (IICSA). An investigation lawyer in the team has indicated that the inquiry would not wish to adversely affect any processes that would develop child protection procedures, that any report produced would likely be of interest and that copies would be requested, and that the inquiry is kept in touch with the progression of the process.

The findings of the report completed by the assurance team will be published and communication enquiries will be dealt with by the Greater Manchester Combined Authority (GMCA) on behalf of the Mayor in consultation with the local authorities and other partners.

Regular gateway reviews will be built into the work programme for the team. The first review will be undertaken by the steering group following initial interviews with relevant people and the completion of the above work to determine any next steps.

## **Deliverables**

The assurance exercise will result in a report to the Mayor and the Deputy Mayor for Policing and Crime providing an independent assessment of the current Greater Manchester response to CSE. This will include the following:

- A detailed timeline of events, actions taken and decisions taken as identified in the previous reviews and reports
- An analysis of any gaps and risks that remain in light of report recommendations not being fully implemented, including an assessment of whether these suggest that CSE is not being adequately addressed in Greater Manchester
- An assessment of policies and processes now in place for members of the public, police officers and others working with potential victims to highlight concerns, and of the policies in place that outline how concerns should be dealt with, identifying good practice and areas for improvement across all partners
- Recommendations that help guide the future direction of the Greater Manchester response to CSE, including any changes that would prevent victimisation and enhance services provided to victims.

## **Methodology**

This exercise will provide assurance through:

### **A review of the decision to close down Operation Augusta to understand:**

- What decision-making processes were followed and how relevant local authorities, NHS organisations and other agencies were involved in the decision-making process.
- If learning from earlier cases was considered in the decision-making process.

### **An analysis of recent statements about CSE in Greater Manchester and all published inquiries and reviews completed following the 2012 convictions to:**

- Understand the statements broadcast publicly regarding CSE
- Establish what reviews (and other investigations into CSE in Greater Manchester) have taken place since 2012
- Analyse policies and procedures in place to raise concerns and deal with these concerns
- Analyse accountability structures specifically in relation to these mechanisms



- Analyse any gaps and risks that remain in light of report recommendations not being fully implemented, including to gain an understanding of the barriers to implementation and an assessment of whether any gaps provide evidence that CSE is not being adequately addressed in Greater Manchester.

### **An evaluation of the current partnership arrangements for Project Phoenix and future challenges**

Project Phoenix, the Greater Manchester response to CSE, commenced in 2013 following high-profile convictions for CSE. Many new processes have been implemented since then, to make the response to CSE more coordinated, consistent and safe.

For the purpose of the evaluation of the current arrangements for Project Phoenix, we have adopted the updated definition of CSE issued by the Home Office in February 2017.

*The new definition reads: "Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. Child sexual exploitation is never the victim's fault, even if there is some form of exchange."*

A common feature of CSE is that the child or young person does not recognise the coercive nature of the relationship and does not see themselves as a victim of exploitation. No child can consent to their own exploitation.

CSE by a group involves people who come together in person or online for the purpose of setting up, coordinating and/or taking part in the sexual exploitation of children in either an organised or opportunistic way.

The recent review of children's services undertaken by the GMCA and led by Salford City Council Chief Executive Jim Taylor identified emerging complex safeguarding risks to children, including female genital mutilation (FGM), radicalisation and involvement in serious and organised crime. Early discussions regarding the potential to develop a Greater Manchester approach to dealing with complex safeguarding have focused on the development of a hub and spoke model similar to that developed for Project Phoenix.

This approach could see the formation of a Greater Manchester-wide partnership developing strategic, operational and tactical responses to complex safeguarding risks, with teams in each district working to provide a joined-up, multi-agency response to dealing with safeguarding issues.

The methodology will include:

- An analysis of the organisational arrangements for delivering Project Phoenix
- An analysis of the current arrangements in comparison with practice elsewhere, recognising that each locality has designed its service to meet its assessment of local needs
- Analysis of performance information held by Project Phoenix
- Analysis of the latest Phoenix peer reviews undertaken for each local authority, what recommendations were made and how these have been implemented (consent from each local authority will be requested)
- Identification of the process for cascading learning from the peer reviews across Greater Manchester
- Analysis of resources and the ability of Project Phoenix to adequately to meet the demands placed on it
- Consideration of how well Project Phoenix is equipped to respond to the demands presented by new technology and the evolving nature of CSE, and if funding cuts have impacted on its efficacy
- An assessment of the level of assurance that can be provided to decision-makers about the Project Phoenix model to inform decisions about the suitability of the model for roll-out across all areas of complex safeguarding
- Consideration of the response to complex safeguarding in light of the issues raised in the children's services review undertaken by GMCA and Jim Taylor.

Following the conclusion of this work, and prior to the completion of a report, a 'gateway review' will be undertaken to determine any further steps that may be appropriate.

## **The assurance team**

The team will report directly to Baroness Beverley Hughes, Deputy Mayor of Greater Manchester, who will act as sponsor.

The team will be led by Malcolm Newsam CBE, who will be supported by Gary Ridgway.

Malcolm Newsam is an experienced childcare expert with extensive experience of providing diagnostics, interventions and improvement support to a range of councils across the country. In October 2014, the Secretary of State for Education appointed him as the Commissioner for Children's Social Care in Rotherham, and in February 2015, the Secretary of State for Communities and Local Government confirmed him as one of a team of five commissioners with executive powers over Rotherham Borough Council, where he remained until May 2016. In September 2016, the Secretary of State for Education appointed him as the Commissioner for Children's

Services in Sandwell Metropolitan Borough Council. He was awarded a CBE in the 2017 New Year's Honours for services to children's social care.

Gary Ridgway was previously a detective superintendent in Cambridgeshire Constabulary and Head of Public Protection. He has pioneered proactive victim-led CSE investigations and led Operation Erle, which resulted in the successful conviction of ten offenders. He now works as an independent consultant supporting the National Crime Agency, councils and police forces on CSE.

## **Governance**

- This work has been commissioned by the Mayor of Greater Manchester.
- The team will report directly to the Deputy Mayor in relation to progress and outcomes. The Deputy Mayor has invited Joanne Roney, Chief Executive of Manchester City Council and lead GMCA Chief Executive for Children, Jim Taylor, Chief Executive of Salford City Council and a former Director of Children's Services, and Debbie Ford, Assistant Chief Constable, GMP, to join her in providing governance and oversight of the exercise in the steering group.
- As a minimum, there will be a monthly meeting chaired by the Deputy Mayor to monitor progress, tackle any concerns and agree the next milestones. Additional meetings may be required, which will be arranged according to need.
- GMCA Deputy Chief Executive Andrew Lightfoot will be responsible for the management of the contracts with the external team and will oversee the budget.
- The review team will be asked to prepare a work plan that includes a suggested sequence of activity and estimated timeframe for the review for approval by the Deputy Mayor.

## **Resources and commitments**

- GMCA, on behalf of the Mayor, will engage with partner agencies, including GMP, local authorities, NHS colleagues and local safeguarding children board (LSCB) chairs to explain the scope of, and arrange cooperation with, the assurance team, and will organise meetings as required.
- GMCA, on behalf of the Mayor, will be responsible for all communications, in consultation with partners.
- On behalf of the Mayor, GMCA Deputy Chief Executive Andrew Lightfoot, will provide senior executive officer support to the assurance team to ensure it runs effectively and is adequately resourced.

- GMCA, on behalf of the Mayor, will provide legal advice to the assurance team as required and will provide legal input into the final drafting and publication of the report.
- GMCA, on behalf of the Mayor, will provide the research capacity to undertake the desktop elements of the work and will provide the secretarial support to organise meetings, interviews and appropriate venues.
- GMCA, on behalf of the Mayor, will provide a note-taker to be present at all interviews undertaken by team, and a minute-taker for all decision-making meetings.
- GMCA, on behalf of the Mayor, will provide a secure room for the team to be based during the work.
- The Deputy Mayor, GMCA's Deputy Chief Executive and the other steering group members will engage key partners in relation to this work to ensure that an agreement is in place in respect of access to case records, reports, correspondence and other information relevant to the work's enquiries.

End of published report.