Introduction to the GMP Professional Standards Branch investigation report titled Operation Span

Introduction

There have been a number of inquiries into how the various agencies have responded to child sexual exploitation in Rochdale over the last ten years.

GMP has faced legitimate criticism from a number of quarters including from former GMP officers who have worked in the safeguarding arena.

From a policing perspective there have been two key reports - the Serious Case Review (SCR) into Operation Span and the GMP misconduct investigation into the same operation, which was supervised by the IPCC.

It is the GMP Professional Standards Branch investigation report which focusses on whether there is a case to answer for serving officers for misconduct which is now being made public.

That is in effect the 'purpose' of the report.

GMP recognises that the public may find the report difficult to follow for a number of reasons:

- The report is an internal document which would ordinarily be examined by the IPCC and officers familiar with police misconduct investigations and terminology.

- The full report which explains in detail the victim's personal experiences through the investigation and criminal justice system has been redacted after GMP received legitimate challenge from partners whose responsibility it is to protect victims from being identified in accordance with legislation.

- Further redaction has been necessary to protect live investigations from the possibility of compromise as there are a number of ongoing critical matters which need to be heard first and foremost through the criminal courts.

Operation Span – the story

The PSB report can be better understood as having two parts. The first part examines in detail the initial investigation into the sexual abuse of Child 1 and Child 2 which came to GMP's attention in 2008. This criminal investigation then expanded in size to include other victims, most of whom did not support the police investigation at the time or since.

Introduction to the GMP Professional Standards Branch investigation report titled Operation Span

The second part of the GMP PSB investigation report explores the wider decision making by the Rochdale Senior Leadership Team as the issues around child sexual exploitation were developing in early 2010.

The 2012 criminal trial held at Liverpool Crown Court focussed upon the abuse against five children, Child 1, Child 3, Child 4, Child 5 and Child 6.

There are additional victims referred to in the report (by number to protect their identity) who were believed to have been the victims of abuse but for various reasons did not become witnesses in criminal trials.

The 2008 Criminal Investigation – Part one

Child 1 came to GMP's notice when she was arrested for causing damage at a takeaway in Rochdale in August 2008. During interview she disclosed that she had done this in response to being sexually abused by a number of staff working there.

Child 1 was supportive of this investigation from the outset. Following a review of the evidence, the CPS at that time determined that no charges should be brought against the suspects due to the unreliability of the victim and difficulties around forensic evidence.

Child 1 made further disclosures of sexual abuse in January 2009, where she named several other victims and many perpetrators. The other victims were spoken to but declined to report any offences. Many of the suspects were identified by nicknames only and no addresses were identified.

Child 1 eventually withdrew her support for these investigations and the investigation was then filed. The allegations made by Child 1 were reinvestigated in 2010 when additional support was made available to her.

Child 2 came to GMP's notice a few days prior to Child 1. Child 2 had been missing from home and when later spoken to by police officers, disclosed that she had been sexually assaulted by males working at the same fast food outlet as Child 1.

The main offender referred to by a nickname was not and has never since been traced. Child 2 has maintained that she does not wish to support any further police investigations.

The actions of the officers directly involved in these early investigations have been thoroughly reviewed. Much of the language of the report may be technical and difficult to follow to the lay reader; but necessary for GMP and the IPCC to ensure the issues were properly understood and to identify any misconduct or learning for those involved.

The actions of one Detective Chief Inspector, two Detective Inspectors, a Detective Sergeant and a number of Detective Constables were reviewed in relation to this part of the Professional Standards Branch aspect of the enquiry.
Notices of misconduct were served on the DCI, two DI's and the DS. The outcomes for Officer's 6 and 9 are covered in more detail later in this report.

The Decision of the Rochdale Senior Leadership team - Part two

Following the CPS decision to take no further action into the 2008 offences, the Sunrise multi agency CSE team continued to work with the victims referred to in this report and many others who came forward in 2010.

This leads to the focus of the second part of the PSB report.

In April 2010, the PPIU (Public Protection Investigation Unit) Detective Inspector made representations to the Rochdale Senior Leadership Team (SLT) for more resources to deal with the growing investigation into CSE, which she rightly identified had now become critical.

The PSB investigation reviewed in detail the decisions of the Rochdale SLT and their response to the concerns raised by the PPIU Detective Inspector.

The PSB reviewed the actions of the Chief Superintendent (Divisional Commander); a Superintendent and two Detective Chief Inspectors. Notices of misconduct were served on three of those officers, however the PSB has not found a case to answer for misconduct, although learning has been identified and addressed by management action.

Although the criminal investigation into CSE in Rochdale continued during this period, it did not gather sufficient pace or attract the resources it needed until December 2010, when Assistant Chief Constable Sweeney highlighted the issues to the GMP Command Team.

Significant investigative resources were then made available to support the investigation. It was at this point that a referral was sent to the IPCC by GMP regarding the potential failures in the previous investigation. The IPCC declared that the investigation into whether there was a case to answer for misconduct for any serving GMP officers was to be 'Supervised'.

The term 'Supervised' meant that GMP were required to submit terms of reference to the IPCC which had to be broad enough in scope to facilitate the investigation being able to address any potential failings.

Introduction to the GMP Professional Standards Branch investigation report titled Operation Span

In December 2010 ACC Sweeney commissioned an internal review into the investigation of CSE in Rochdale. The purpose of this review was to maximise the investigative opportunities for officers leading the investigation through appropriate specialist support and share the learning from the investigation.

The first GMP PSB investigation report lacked sufficient rigour and the IPCC rightly rejected it.

Revised terms of reference were produced by the Professional Standards Branch in March 2012 which included the specific requirement to examine the role played by the Senior Leadership Team at Rochdale and highlight the wider organisational learning.

The IPCC are now satisfied that the later terms of reference for the investigation have been met.

A total of five victims were involved in the latter criminal investigation of 2010 titled Operation Span which concluded at trial in May 2012 with the convictions of nine men from Rochdale.

The names, convictions and sentences of these men are a matter of public record.

The PSB investigation focuses in the main on the initial police response and investigation into the allegations made by Child 1 and Child 2 from 2008 even though Child 2 has never engaged with police.

Child 5 did not engage with the police in 2008/9 but when revisited as part of the 2010 criminal investigation where additional support could be provided, became a witness in the successful 2012 trial.

The abuse against Child 3, Child 4 and Child 6 came to light much later and became the catalyst of the 2010 criminal investigation that resulted in convictions at trial in 2012.

Alongside Operation Span, there are a number of other criminal investigations in various stages of maturity which are linked to offences of CSE in Rochdale.

In effect, the latter Operation Span criminal investigation of 2010 reopened the 2008 investigation involving Child 1. This was due to further offences being reported by different victims against the same suspects and in similar circumstances.

The investigation was only capable of bringing about convictions by examining those cases that had the best prospects of success based on a variety of factors in consultation with the CPS. At the height of the investigation 50 detectives were deployed to support the investigative effort and support the victims alongside professionals from partner agencies.

Investigation outcomes and learning for individual officers and agencies

In reaching the recommendations and outcomes contained within the PSB report the senior investigator has, where necessary, highlighted the role played by both the police service and those partner agencies including the CPS, who share responsibility for access to and progress through the criminal justice system.

It is widely accepted that the investigation titled 'Operation Span' has exposed failings across all agencies in the response to the challenges associated with Child Sexual Exploitation.

What occurred in Rochdale has taken place and is sadly continuing to take place elsewhere in the country as all agencies who are involved in safeguarding are working to improve their understanding and approach to Child Sexual Exploitation.

A great deal of work has been undertaken by GMP and other agencies across Greater Manchester to address the issues associated with this insidious crime since matters came to light in 2008. The investigating officer's report highlights in detail what GMP has done and is continuing to do to minimise the threat posed to the most vulnerable in communities.

It is necessary to highlight some of the failings that have emerged as a result of this investigation specifically. These include:

I. The lack of understanding of the complexity surrounding Child Sexual Exploitation by all agencies. The police were in 2008, in the main, the enforcement agency operating in a broader environment of social care. Information sharing and collaborative working was challenging to all agencies in Rochdale at that time.

II. The role of police officers is changing through necessity to become more vigilant to the signs and triggers of vulnerability and to look at a family from a whole agency response rather than what may be presented to them in isolation following a call for help or a missing from home report.

III. Information sharing across different agencies that operate on different IT systems with differing priorities undermines safeguarding.

IV. The need to focus more professionally on investigating the crime rather than investigating the victim due to their complex lifestyles and/or vulnerability. There

has been too great an emphasis on examining the credibility of the victim by the decision making agencies within the criminal justice system rather than the complexity of this type of offending.

V. Specifically for GMP, a strong target driven culture that was focussed predominantly upon Serious Acquisitive Crime and other targets. At best this was distracting for senior leaders and a barrier to skilled resources being channelled into threat/risk and harm.

VI. The skill set required to manage CSE investigations is very different to traditional reactive CID investigation. Victims present with complex lifestyles, often refuse to engage with agencies including police and perceive their abusers to be their saviours.

VII. Developing trust and rapport with vulnerable victims requires considerable investment in time, specialist interviewing skills and the knowledge and understanding to know when and how to draw in appropriate support from health and other key agencies.

VIII. The 'churn' of staff at Rochdale, particularly in the Inspecting ranks meant that leadership and proper ownership of this issue could not be maintained. There was little in the way of effective handover between staff.

It is therefore set against this backdrop that the question of misconduct is considered for individuals.

By way of example:

The failings by Officer 9 are procedural in nature and even if all relevant police databases and crime reports had been kept up to date, the investigating officer is not persuaded that the victims in this case would necessarily have been better served.
The requirement to keep police databases accurately up to date, whilst important, was not in isolation likely to protect victims.

Officer 9 was overwhelmed by the task before him. He worked extremely hard to secure evidence, make arrests and place compelling evidence before specially trained CPS lawyers.

He was not sufficiently supported by his line management who he approached for help.

When that help was not forthcoming he persevered in an attempt to prosecute known offenders and disrupt others. GMP's assessment of this is that this attempt at 'disrupting offenders (supported by his line manager) was borne out of desperation due to the scale of the problem.

Officer 9 involved himself in complex investigative work that required the skills of a suitably qualified and experienced Senior Investigating Officer (SIO) with the appropriate authority to draw in other specialists. He had no real investigative background in dealing with serious sexual offences and even if he had, he needed to have been part of a much bigger and better coordinated team under skilled leadership in order to have been more successful.

Officer 9 for example did not have sufficient access authority for some of the databases in use at the time (FSI) and therefore cannot be held responsible for failing to keep all of them up to date.

His perseverance in trying to secure forensic evidence in one of the cases whilst clumsy in terms of procedure and perhaps insensitive to the feelings of victims was commendable in trying to do the right thing, which was to identify perpetrators and prevent harm to existing and future victims.

Although Officer 9 was unsuccessful in his endeavours in this regard, specialist forensic staff later secured a conviction as a direct result of his earlier actions. It would therefore be inappropriate to punish someone who acted in good faith, secured evidence which resulted in convictions and positives outcomes, but lacked support and training.

In conclusion, Officer 9 highlighted the scale of the investigation to his line manager and others including the Sexual Crime Unit and was not sufficiently supported.

Officer 6

There is a compelling case to answer for Misconduct for this officer as identified in the Investigating Officers report.

Officer 6's culpability extends to:

a. Failure to produce any meaningful investigative strategy to support the investigation and Officer 9.

b. No record keeping of investigative strategy meetings and poor governance/follow up around actions and tasks.

c. Choosing not to properly update or alert his supervision or any other member of the senior leadership team on the Rochdale Division of the scale of the harm to victims and the complexity of the investigation. The reason given that his supervision was also carrying a large workload is not acceptable. This demonstrated a particularly poor victim focus.

d. No effective handover or briefing regarding workload between peers.

e. Failing to record sufficient rationale for decision making.

It is acknowledged that Officer 6 did try and coordinate subject matter experts to better understand the scale of the abuse and identify an analyst to support the investigation, but overall this officer's governance of the whole investigation was extremely poor.

In conclusion, Officer 6 would have been required to attend a formal Misconduct process had he not lawfully retired during the investigation at the conclusion of his 30 years' service.

The report highlights the outcomes for seven officers who were served with misconduct notices and concludes by highlighting lessons learned and some of the work GMP has done and is continuing to do to improve the service to victims who are subject to this appalling criminality.