

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

Part One

An assurance review of Operation Augusta

Malcolm Newsam CBE and Gary Ridgway
December 2019

EMBARGOED UNTIL 10.00AM, TUESDAY JANUARY 14, 2020

This anonymised report has been produced independently by Imprana Ltd and GKR Partnerships Ltd at the request of the Police and Crime Commissioner for Greater Manchester. The contents represent the opinion and views of the authors based on the information provided to them by the interviewees and the documents provided to them by Greater Manchester Combined Authority, Greater Manchester Police and Manchester City Council. Imprana Ltd and GKR Partnerships Ltd do not express an opinion as to the accuracy or completeness of the information provided, Imprana Ltd and GKR Partnerships Ltd have based this report on the information received or obtained, on the basis that such information is accurate and, where it is represented to Imprana Ltd and GKR Partnerships Ltd as such, is complete. The Police and Crime Commissioner has taken his own legal advice that the contents of this report do not infringe the personal rights of any individuals or employees and the Police and Crime Commissioner's responsibilities under data protection legislation and any other relevant laws. For the avoidance of doubt, no responsibility or liability is or will be accepted by Imprana Ltd and GKR Partnerships in relation to the release of this report and any such liability is expressly disclaimed.

Contents

		Page
Chapter One	Key findings	6
Chapter Two	Introduction and the death of Victoria Agoglia	21
Chapter Three	Our methodology	30
Chapter Four	Operation Augusta – the scoping phase	39
Chapter Five	Operation Augusta – the investigative phase	46
Chapter Six	The children	72
Chapter Seven	Details of potential offenders and offences	100
Chapter Eight	Final words	108

Appendix A	Terms of reference	111
Appendix B	Context: Manchester City Council (provided by MCC)	118
Appendix C	Key personnel	121
Appendix D	Chronology of key events	123
Appendix E	Summary table of sample of children	127
Appendix F	Serious crime demand at the time of Operation Augusta (provided by GMP)	130
Appendix G	Timeline (provided by GMP)	133
Appendix H	Context and previous public apologies for failings in relation to CSE investigation resource issues in 2004/05 (provided by GMP)	137
Appendix I	CSE live investigations (provided by GMP)	143

BLANK PAGE

Chapter One

Key findings

- 1.1. In July 2017, the BBC broadcast *The Betrayed Girls*, a documentary about child sexual exploitation (CSE) within Greater Manchester. In September 2017, we were commissioned by the Mayor of Greater Manchester Andy Burnham, in his role as Police and Crime Commissioner, to undertake an independent assurance exercise to explore the current and potential future delivery model of the response to child sexual exploitation (CSE) across Greater Manchester. Our terms of reference are included in Appendix A. As part of the first workstream, a review of the decision to close down Operation Augusta (an investigation into CSE in South Manchester in 2004/05), we were required to access personal and sensitive data held by Greater Manchester Police (GMP) and Manchester City Council (MCC). We were given access to the information held by GMP in January 2018, and to all the relevant information held by Manchester City Council in October 2018.

- 1.2. Our terms of reference also require us to undertake an analysis of recent statements about child sexual exploitation in Greater Manchester and all published inquiries and reviews completed following the convictions of nine men for CSE in Rochdale in 2012. In November 2012, Sara Rowbotham, a manager of the Rochdale NHS Crisis Intervention Team (CIT), reported to the Home Affairs Select Committee that she had made around 103 referrals to the police in respect of young people being sexually exploited. Following the convictions, Rochdale Local Safeguarding Children Board undertook a serious case review (SCR)¹ into seven children. A multi-agency meeting considered 21 children who had been subject to child sexual exploitation and six of these were initially selected for review. The six subsequently became seven at the request of the probation service. The concern presented to the review team by Sara Rowbotham was that the

¹ When a child dies or is seriously harmed as a result of abuse or neglect, a serious case review may be conducted to identify ways that professionals and organisations can improve the way they work together to safeguard children and prevent similar incidents from occurring.

remaining 14 children received no input or support from either children's social care or the police although it was clear they had been subjected to significant harm.

- 1.3. The review team is therefore seeking assurance either that the children referred by the CIT were appropriately protected at the time or, if not, that there has subsequently been an appropriate response to any non-recent issues identified. Alongside this the review team is seeking assurance that the 14 children considered by the SCR panel did receive appropriate support in response to the concerns presented.

- 1.4. On 21 December 2017, we formally requested from Pennine Care NHS Foundation Trust a copy of the relevant referral information. Pennine Care released this information to the review team on 12 July 2018 and to Rochdale Borough Council in December 2018. Throughout this period, the review team has been seeking agreement to be given access to the social care files held by Rochdale Borough Council on the relevant young people. In March 2018, Greater Manchester Combined Authority (GMCA) provided to Rochdale Borough Council a written account of the review team's key lines of enquiry to support this request. In September 2018, a data processing agreement was provided to Rochdale Borough Council along the same lines agreed with both Manchester City Council and Greater Manchester Police. The data processing agreement has recently been signed and work is progressing on this phase of the review.

- 1.5. Given these delays, the Police and Crime Commissioner asked the review team to produce part one of our report, covering our findings on Operation Augusta. Our work on the other elements of the review continues and our final report covering those aspects will be produced in due course.

- 1.6. In this report we have quoted from the contemporaneous records held by Greater Manchester Police and Manchester City Council. Terms such as "child prostitution" and "pimp" are regularly used to describe child sexual exploitation. We have therefore utilised those terms when we are quoting from the records. Although no longer an acceptable description of child sexual exploitation, the term "child prostitution" was set out in the government inter-agency guide *Working together to safeguard children* (1999) and also in subsequent Department of Health publications in 2001

and 2002. We therefore imply no criticism of staff for using this term during this period and in fact the Manchester partnership took a progressive position in 2003 through the adoption of the term “child sexual exploitation”.

- 1.7. Operation Augusta was initiated following the death of Victoria Agoglia² when she was 15 years old. We detail the severe abuse and exploitation suffered by Victoria in Chapter Two. In summary, in the two years before her death, while in the care of Manchester City Council, Victoria Agoglia was repeatedly threatened, assaulted, returned to her residential unit intoxicated and in distress, gave information that she was involved in sexual exploitation, alleged rape and sexual assault requiring medical attention, and had several pregnancy scares. While we found evidence of multi-agency meetings, not one of these occasions resulted in a Section 47³ child protection investigation to protect Victoria from significant harm. Although Victoria was cared for by Manchester City Council, a man who had been previously identified as her so-called “pimp” was given permission to visit her in her accommodation three times a week. Two months prior to her death, Victoria had disclosed to both her social worker and a substance misuse worker that an older man was injecting her with heroin. She died in hospital on 29 September 2003, five days after a 50-year-old man injected her with heroin. In 2004, this man was cleared of manslaughter at Manchester Crown Court. He admitted two offences of injecting Victoria with heroin and was jailed for three and a half years.

- 1.8. In Chapter Three we will outline the content of our interview with Margaret Oliver, a retired detective who worked on Operation Augusta. In respect of the inquest into the death of Victoria, she expressed the view that she believed that social services knew they had failed Victoria as she was in their care. Although she had no evidence, Mrs Oliver suggested that social services tried to exclude the family from the inquest into the death

² Victoria’s full name was Victoria Louise Byrne Agoglia.

³ 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.

of Victoria to “protect their own backs”.

- 1.9. The coroner’s hearing was adjourned from 16 February 2004 until March 2007. The current coroner has declined a request by the review team to view the information provided to the inquest by Manchester City Council, but she did share a copy of the then coroner’s narrative verdict. The coroner recognised the multiple concerns, including sexual exploitation and sexual assault; however, in his summary he described Victoria as having a propensity “to provide sexual favours”. From our analysis of the social care files, this significantly underplays the coercion and control Victoria was subject to. On 30 July 2003, Victoria’s social worker informed her drugs worker that an older man was injecting her with heroin in return for favours. No formal action was taken to investigate this matter or prevent it occurring again. Within two months of this revelation, Victoria died. This was set out in the Part 8 review⁴ provided by the council to the inquest. We are unclear, therefore, how the coroner could have concluded that: “No inferences can be made that the events from the 24 September were reasonably foreseeable.” Furthermore, having considered both the harrowing experience of Victoria and that of many of her contemporaries in public care in Manchester in the review team’s sample, we cannot understand how the coroner felt able to conclude his remarks with the following statement: “It is absolutely essential also that the public remain confident about the quality of care and support afforded to children cared for within the child protection system.”
- 1.10. A close relative of Victoria Agoglia was reported in the media in 2014 as saying: “These men are still walking about. She needs to be put to rest and I hope if anyone is watching and they do know something, even if it's the smallest thing, to come forward so that social services will know there's a lot of people that still know they never helped these young girls.” Following this broadcast interview, the Greater Manchester Police Chief Constable at the time confirmed that he was "quite happy" to look at Victoria Agoglia’s

⁴ *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].”

case again. However, to this day, no investigation has taken place into the exploitation of Victoria Agoglia. Greater Manchester Police has subsequently informed the review team that the statement made by the former chief constable was not a commitment to review Victoria's case.

- 1.11. In February 2004, Greater Manchester Police launched Operation Augusta following the death of Victoria Agoglia. Victoria was believed to have been involved in "child prostitution" within the South Manchester area and elsewhere. As a result, care homes within the South Manchester area had been canvassed and a total of 11 children in care were identified as potentially being subject to sexual exploitation. Each child portrayed a profile similar to that of Victoria prior to her death. An early report⁵ that set out the objectives of the operation stated: "The current serious case review being conducted in respect of Victoria Agoglia places a commitment on Greater Manchester Police to ensure similar tragedies are prevented wherever possible and those charged with a child protection remit have done all they can to address identified shortfalls or deficiencies in previous cases."
- 1.12. We have set out our methodology in Chapter Three. This included interviewing several police officers who served on Operation Augusta. We also received written submissions from the senior investigating officer and two senior officers. A few officers did not make themselves available for interview for various reasons. We undertook an analysis of the information Greater Manchester Police held on Operation Augusta. We subsequently selected a sample of 25 of the children we had identified as potential victims from the police records and analysed the records held on them by Manchester City Council.
- 1.13. We have provided a detailed analysis of the scoping phase of Operation

⁵ A SAFCOM (situation, aims, factors, choices, options, monitoring) briefing report was submitted by a detective inspector in which it was explained that there appeared to be a genuine fear that "a group of Asian males from the C1/C2 Police Divisional areas" (the South Manchester divisions) were targeting vulnerable girls in residential care for sexual exploitation.

Augusta in Chapter Four. The conclusion is that this scoping phase delivered its objectives successfully. Detectives built up a compelling picture of the systematic exploitation of looked after children in the care system in the city of Manchester⁶. They reported that they had “*identified a total of at least 26⁷ girls under the age of 16 who are all in the care of Manchester Social Services and are believed to be at risk.*” . They expected to find more and believed at least 15 of these would cooperate with the police. Officers conducting the scoping exercise reported that there were “in the region of 97 persons of interest who had been identified as being involved in some way in the sexual exploitation of the victims”. While there was no national definition, they defined a person of interest as “a perpetrator, facilitator or an associate of either”. They noted that it should also be borne in mind that of the 97 persons of interest there might an element of duplication involved.

1.14. The scoping report described these persons of interest as predominantly Asian⁸ men working in the restaurant industry; the police officers appeared to have a good insight into how these men enticed young girls in the care system and ultimately abused them. The officers also believed they had made a significant link with the adults involved with Victoria Agoglia and the suspected perpetrators in South Manchester.

1.15. On receiving the final report of this scoping phase of the investigation, Greater Manchester Police allocated a major incident team to the investigation. We have provided a detailed analysis of the investigative phase in Chapter Five. We conclude that there is much in Operation Augusta to be commended. The decision to allocate a major incident team to the operation demonstrated a commitment at the highest level to tackle the sexual exploitation of children in Manchester. It was recognised from the outset that Operation Augusta needed to be a joint investigation with

⁶ Operation Augusta Final Report 13 May 2004

⁷ The 26 was later confirmed as 25 as the investigative team found two to be identical and these were merged (Indexers’ Policy document 16 September 2004)

⁸ We have replicated the use of the term Asian throughout this report as this was widely used within both the police and social care records at the time. Where the descriptions have been more specific, we have used those more precise terms.

Manchester City Council children's social care services. A gold command structure⁹ was put in place, and this included senior officers from the city council. At the first meeting in July 2004, it was agreed that a social worker would be incorporated into the team to assist with the interview process. Furthermore, Greater Manchester Police appointed an experienced and competent senior investigating officer (SIO) with a track record of leading similar operations. Additionally, the operation was not without its criminal justice successes – the evaluation report presented to the Manchester Safeguarding Children Board on 25 August 2005 reported that there had been a criminal justice outcome in respect of seven adults. One further adult was detained as an illegal immigrant.

- 1.16. However, there were fundamental flaws in how Operation Augusta was resourced, and this had a significant negative impact on the investigation strategy and the way in which it was ultimately terminated. Within a few weeks of the outset, the team was insufficiently resourced to meet the demands of the investigation and ownership of the operation was problematic. The evaluation report¹⁰ produced on the conclusion of the investigation highlighted the following concerns: there was no central responsibility for child sexual exploitation, issues were split between three Manchester divisions, resulting in dispute and conflict between three divisional commanders as to who should put resources into it, and this continued throughout the operation as staff changed. Difficulties were experienced in staffing the operation with a small team of staff, some of them part-time and most of them loaned from other areas.
- 1.17. The evidence suggests that the senior investigating officer began the operation with the intention of tackling the problems identified within the scoping phase – sexual exploitation throughout a wide area of a significant number of children in the care system by a predominantly Asian group of men largely working in the restaurant trade. A key indication of his intent was the entering of the potential 97 persons of interest identified by the

⁹ The generic command structure, which is nationally recognised, accepted and used by the police, other emergency services and partner agencies, is based on the gold, silver, bronze (GSB) hierarchy of command.

¹⁰ Operation Augusta evaluation report.

scoping phase as nominals and the 25 young people identified as designated victims onto the computer database (HOLMES¹¹) used to manage the operation. However, it soon became apparent that this would not be quickly achievable given the resources at the senior investigating officer's disposal, and this was even more evident in autumn 2004 given the slow progress made in interviewing the victims.

- 1.18. Fundamentally, we believe, from the evidence that we have seen, that the decision to close down Operation Augusta was driven by the decision by senior officers to remove the resources from the investigation rather than a sound understanding that all lines of enquiry had been successfully completed or exhausted. In April 2005, the SIO attended a meeting with the responsible senior officers, the detective chief superintendent and chief superintendent. According to the SIO policy log, the chief superintendent stated he was unable to put permanent staff into Operation Augusta and that the operation would finish on 1 July 2005. The review team requested a copy of the notes of this meeting but was advised by Greater Manchester Police that they could not be found. A gold group meeting was held at Manchester Town Hall on the same day. The review team has requested a copy of the minutes for that meeting but neither GMP nor Manchester City Council was able to provide a copy. However, the SIO policy book states that it was attended by senior officers from GMP and Manchester City Council with their respective communications officers. It is recorded: "Update of operation given. Press strategies discussed, and group informed of finishing date of operation namely 1/7/05." The SIO lists who was present but does not record that either the detective chief superintendent or the chief superintendent attended.
- 1.19. Finally, the investigation strategy placed too heavy a reliance on victims' willingness to make complaints. As resources and time ran out, activity became reduced to closing down the majority of the cases because the child declined to make a formal complaint. Critically, the problem that Operation Augusta had been set up to tackle, namely the sexual exploitation throughout a wide area of a significant number of children in the care system by predominantly Asian men, had not been addressed.

¹¹ HOLMES (Home Office Large Major Enquiry System) is a computerised system that provides administrative support for major investigations.

Very few of the relevant perpetrators were brought to justice and neither were their activities disrupted.

1.20. In Chapter Six we look in detail at the children who were considered by Operation Augusta. We selected a sample of 25 children and set three tests to consider in relation to the records held by Greater Manchester Police and Manchester City Council:

- Was there a significant probability from the information on the files that the child was being sexually exploited?
- Could the review team provide assurance that this abuse was appropriately addressed by either Greater Manchester Police or Manchester City Council?
- Were the risks the identified adults presented to children appropriately dealt with by either Greater Manchester Police or Manchester City Council?

1.21. The review team was supported in this exercise by Manchester City Council officers and the GMP Cold Case Review Team, who had undertaken a very conscientious and thorough review of the files. We established the following:

- There was clear evidence that professionals at the time were aware these young people were being sexually exploited, and that this was generally perpetrated by a group of older Asian men. There was significant information known at the time about their names, their locations and telephone numbers but the available evidence was not used to pursue offenders.
- Perpetrators appeared to be operating in “plain sight”, hanging around in cars outside care homes and foster homes and returning young people to their care addresses.
- A key concern was that the focus of the multi-agency strategy meetings was on agencies encouraging young people to protect themselves rather than providing protection for them. There was very little evidence from the social care files of the deployment of disruption strategies to protect the young people.

1.22. We have deliberately removed much of the specific detail in the descriptions that follow to ensure that the individuals who were children at the time cannot be identified. However, we believe it is important that this

report also captures the distressing experiences that these vulnerable children were subjected to.

- The age of the children, in our sample, who were being exploited, ranged from 12 to 16. Most complaints related to children aged 14 to 16. Children as young as 14 were reported to have “boyfriends” in their mid-20s and were said to be placing themselves at risk.
- Carers heard a child say that “they go to various houses with groups of Asian males aged 18 to 23 and have sex. She had been with a 23-year-old male the previous night and he introduced her to his brother ... The girls are allegedly forced to have sex with the men”.
- A child who was still very young reported that she had been restrained by a man in his mid-20s who then seriously assaulted her and committed an extremely serious and distressing sexual act.
- Care staff reported on one child that there was a network of Asian men and that it was likely that this was where the child was getting her money from. The social worker said that one of the men would have given her money and this led to her being sent to different establishments for sex.
- Carers reported to police that a child had provided information stating that she was being “pursued/threatened/coerced” into having sex by two men who were Asian. She was interviewed, declined to speak to police but did provide information about one man, giving his name and explaining that she was afraid.
- A child begged her carers to get her away from Manchester as she was too involved with Asian men. She disclosed that an Asian man known by his nickname “made her do things she didn't want to do”.
- A child described how she would go to flats with friends. There were lots of Asian men there and she would be given drink (vodka or similar) and drugs (cocaine). She described how she would “have sex with them without a fight” and “do whatever they wanted us to do”. She was generally paid a significant sum of money.

In conclusion, we found clear evidence in the social care files that the young people were not well served or protected by the statutory agencies.

1.23. Out of the 25 cases within the sample, we conclude that there was a

significant probability that 16 children were being sexually exploited, and the review team cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or the responsible local authority. Fifteen of these children were looked after by Manchester City Council and one by another local authority. In respect of the remaining nine children, we conclude that there was insufficient available information for the review team to form a view as to whether the children had experienced sexual exploitation or whether these concerns were appropriately addressed by either Greater Manchester Police or Manchester City Council/the relevant local authority.

- 1.24. In September 2004, the Part 8 review into the death of Victoria Agoglia had 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.**”
- 1.25. Although this was a key lesson learned from the death of Victoria Agoglia, we found a continued over-reliance by investigators in Operation Augusta on the cooperation of the child victims, despite the obvious coercion and control exhibited by the perpetrators. We do not believe this was the intention of the SIO from the outset, but clearly, given the limitations of the resources allocated to the operation, this became a key determinant in closing the operation down. Given the size and make-up of the team, winning the trust of the children and putting in place the required level of support to sustain their confidence was always bound to be a challenge. However, we do not understand why many of the men identified as significantly involved in the sexual exploitation of specific children were not formally designated as suspects by the SIO. This would have ensured that the investigation into their criminality would have been satisfactorily concluded prior to the closing down of the operation.
- 1.26. Furthermore, while we would accept that subsequent changes in legislation have enhanced the opportunities to tackle child sexual exploitation (CSE), we expected to see more evidence of attempts by the

operation to take disruptive action, utilising powers under PACE¹² to arrest and question suspects and search premises. We also found no examples of the operation working with the licensing authority to oppose the licences of the premises that had been identified as central to the identified exploitation. Clearly, the SIO recognised the need for these strategies when he referred to the “proactive phase” of Operation Augusta, and the decision not to allocate resources to that element of the operation fundamentally constrained its effectiveness in tackling the identified harm and risk to children presented by those adults.

- 1.27. In Chapter Seven we consider whether the risks the identified adults presented to children were appropriately dealt with by Greater Manchester Police or Manchester City Council. Relative to the original concerns, there were very few criminal justice outcomes emanating from Operation Augusta and, specifically, only two outcomes related to the original 25 children who formed the target group for the investigation as set out in the joint protocol. We independently identified the names of 68 individuals who could reasonably have been assumed to have been part of the cohort of the 97 individuals referred to in the scoping report as persons of interest. We also worked with Manchester City Council to identify if any of these adults were known to the council at the time, and whether the potential risks they presented to children had been actively considered. Many of these adults were known only by their first names, nicknames or by a common Asian name, but information about others contained sufficient detail to make them identifiable. In summary, our report concludes that although there was significant information held by both Manchester City Council and Greater Manchester Police on some individuals who potentially posed a risk to children, the review team can offer no assurance that appropriate action was taken to address this risk. The team found very little evidence of professionals considering the risk these perpetrators presented to their own children and the children they met throughout their daily activities.
- 1.28. Throughout our review we have shared our findings with Greater Manchester Police and Manchester City Council. Greater Manchester

¹² Police and Criminal Evidence Act 1984.

Police has confirmed the following additional information in respect of the potential perpetrators we sampled.

- Sexual offending 2005 and before: There are 19 nominals shown as offenders for sexual crimes during this time period, with varied outcomes.
- Sexual offending post-2005: There are eight nominals shown as offenders for sexual crimes during this time period, with varied outcomes. Two are currently serving custodial sentences for sexual offending against children.
- Intelligence linking nominal to CSE/sexual offending post-2005: There are eight nominals with intelligence logs of this nature.
- Links to other CSE investigations: There are three nominals linked to other major CSE operations.
- DBS checks¹³: There are five nominals who have applied for jobs requiring DBS checks.

1.29. The offences committed by the eight men since the closing down of Operation Augusta include: inciting a sexual act with a female under 16, rape of a female under 16, rape of a female over 16, sexual activity with a female under 16, control of a child for sexual exploitation, unlawful sexual activity and sexual assault. While it would be wrong to conclude that if Operation Augusta had been more successful it would have prevented further offending, it is of concern that a number of individuals known to Operation Augusta appear to have since been involved in some way with the sexual exploitation of children.

1.30. In summary, we have found through our analysis that although there was significant information held by both Manchester City Council and Greater Manchester Police on some individuals who potentially posed a risk to children, we can offer no assurance that appropriate action was taken to address this risk. We found very little evidence of professionals considering the risk these perpetrators presented to their own children and the

¹³ Disclosure checks (DBS checks): the Disclosure and Barring Service (DBS) carries out criminal record checks that result in DBS certificates being issued to individuals. Employers can then ask to see this certificate to ensure that they are recruiting suitable people into their organisation.

children they met throughout their daily activities. One of our interviewees explained to us: “They weren’t viewed as sex offenders per se, just a group of men of all ages, from one ethnicity taking advantage of kids from dysfunctional backgrounds. It could have overwhelmed child protection. There had to be a degree of pragmatism, the children also had to manage their own behaviour, the education issues were far greater than the enforcement issues.”

- 1.31. Our terms of reference require us to make recommendations that help guide the future direction of the Greater Manchester response to child sexual exploitation. As this report forms only the first part of our review, until such time as we can review the current provision, it would be inappropriate for us to make recommendations at this stage. We are also mindful that current practice has moved on considerably since 2005. Notwithstanding these points, our review has established that most of the children we have considered were failed by police and children’s services. The authorities knew that many were being subjected to the most profound abuse and exploitation but did not protect them from the perpetrators. This is a depressingly familiar picture and has been seen in many other towns and cities across the country. However, familiarity makes it no less painful for the survivors involved, and it should in no way detract from the need for them to be given the opportunity to ask that the crimes committed against them now be fully investigated. We would also apply the same expectation to the family of Victoria Agoglia, who have been asking for her abuse to be investigated since her tragic death in 2003.

- 1.32. Furthermore, the Mayor, as Police and Crime Commissioner, must consider with Greater Manchester Police and Manchester City Council how the people who appeared to present a risk to children in 2004 can now be brought to justice and any risk they still present to children mitigated. On receipt of our findings within this report, Greater Manchester Police (GMP) has accepted that there are several children for whom it is unable to find evidence that the investigations were progressed satisfactorily. GMP has informed the review team that it will now undertake multi-agency assessments on each of these cases, which may then lead to investigations and mitigation of any current risks. We would emphasise that any future approach needs to go beyond the investigation of individual complaints and address the exploitation of a significant number of children as recognised by Operation Augusta at the time. Anything less would risk repeating the mistakes of the past and not give the survivors the justice they deserve.

Chapter Two

Introduction

- 2.1. On 3 July 2017, the BBC broadcast *The Betrayed Girls*, a documentary about child sexual exploitation within Greater Manchester. Later that week, the Mayor of Greater Manchester made the following statement. “Sexual exploitation and abuse of children is utterly abhorrent and, in my view, must always face the full force of the law. The broadcast on Monday night raised a number of serious historical issues. I know that there have already been reviews and investigations in the past, but I want to be able to assure myself and, by extension, the public of Greater Manchester that everything possible has been done to protect children today and in the future and prevent any repeat. That is why I have asked Baroness Beverley Hughes, Deputy Mayor for Policing and Crime, to look at the issues raised in the programme, to ensure that the changes made have brought about the necessary improvements and report back to me with her findings.”

- 2.2. In July 2017, we were approached by Greater Manchester Combined Authority (GMCA) to undertake this review. Over the summer period, the terms of reference for the review were drafted and refined in consultation with the 10 local councils in Greater Manchester. These terms of reference are included as Appendix A to this report. The review was formally commenced on 29 September 2017, at the first meeting of the steering group chaired by Baroness Hughes. The steering group comprised senior officers from GMCA, Greater Manchester Police, Manchester City Council and Salford City Council. It was extended in May 2018 to include the chief executive of Rochdale Borough Council.

The death of Victoria Agoglia

- 2.3. Operation Augusta commenced following the death of Victoria Agoglia in September 2003 at the age of 15. She was brought into care at the request of her mother when she was eight years old. Following the death of her

mother, she was made subject to a care order in 1998. After a breakdown in her foster placement, there followed a pattern of regular placement moves.

- 2.4. By April 2002, when Victoria Agoglia was still 13, it was recognised that she was at risk due to concerns regarding truancy, drug taking, theft and what was termed at the time as “prostitution”. Residential care staff complained that Victoria’s “boyfriend”, who they described as her “pimp”, was supplying her with drugs on his visits to see her. This man was not a nominal in Operation Augusta, so we refer to him throughout this report as Nominal Q. Nominal Q was said to be in his mid-20s, but no attempts were made to verify his age. Between February and September 2002, Victoria Agoglia was reported as missing on at least 136 occasions. On almost all occasions on which she returned, she was thought to be under the influence of alcohol and drugs. Over the same period, on 16 occasions residential staff were aware that Victoria was concerned for her safety because of threats and incidents from inside or outside the residential unit. All this information was made known to the police and social services.
- 2.5. Following a period within a secure unit, Victoria quickly resumed contact with Nominal Q and this relationship appears from the reports held by Manchester City Council to have been condoned by social services. Although she had been placed within a secure unit because of the risks he presented to her, he was subsequently allowed to visit her placement on a supervised basis. No attempts appear to have been made to establish his identity or background, or to validate his age or address, by either Manchester social services or Greater Manchester Police. In March 2003, Victoria was taken by Nominal Q to the home of one of his relatives. She was later collected by residential staff and reported that she had been raped. The following day, Victoria was medically examined by a forensic medical examiner, but the doctor was not made aware of the sexual exploitation and drug abuse. Victoria had several further placement moves but concerns continued in respect of her “prostitution” and drug taking.
- 2.6. In July 2003, Victoria stated that she used heroin daily. At the end of that month, she was moved to another residential unit in Greater Manchester. On 30 July, Victoria’s social worker informed her drugs worker that she was being injected with heroin by an older man. It is difficult to understand why this information was not immediately relayed to the police and why the

threat of significant harm was not addressed. Victoria told her drugs worker the same thing a week later. She agreed with the drugs worker that she would in future smoke heroin and not have it injected. Within two months, Victoria visited the home of an Asian man who was 50 years old. He injected her with heroin, and she died in hospital on 29 September 2003, five days later. In 2004, this man was cleared of manslaughter at Manchester Crown Court. He admitted two offences of injecting Victoria with a noxious substance and was jailed for three and a half years.

- 2.7. 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”¹⁴. While we found evidence of some multi-agency meetings, not one of these occasions resulted in a Section 47¹⁵ child protection investigation to protect her from significant harm.
- 2.8. The report of the Part 8 review panel¹⁶ in respect of Victoria Agoglia was completed in September 2004. It concluded that her extreme level of vulnerability was exacerbated by contact with dangerous adults, drug misuse and involvement in sexual exploitation. These factors contributed to her death because they all further increased her vulnerability and exacerbated risk-taking behaviour. While not disagreeing with these observations, we would go further. Manchester City Council had parental responsibility for Victoria throughout this difficult period and due to poor professional practice and an absence of the most basic statutory child

¹⁴ *The report of the Part 8 review panel in respect of Victoria Byrne*, City of Manchester Area Child Protection Committee, September 2004.

¹⁵ 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.

¹⁶ *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.”

protection processes failed to protect her.

2.9. The Part 8 review contained two specific recommendations relevant to our work.

- 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.”

We will return to the importance of these recommendations when we consider in more detail how the children in Operation Augusta were dealt with.

2.10. The coroner’s hearing was adjourned from 16 February 2004 until March 2007. The narrative verdict was reported in the media¹⁷ at the time. The coroner concluded:

“Whilst the Local Authority and other agencies could and should have anticipated Victoria’s propensity to abscond (and return), consume alcohol, abuse drugs, mix with inappropriate individuals and provide sexual favours this knowledge and these acts would not in my view amount to a real and immediate risk to life. No

¹⁷ Manchester Evening News, 13 August 2007.

inferences can be made that the events from the 24 September were reasonably foreseeable. Victoria's death was therefore neither the result of a breach of the Authority's protective duty pursuant to Article 2 and notwithstanding Victoria's dependency not by reason of a gross failure on the part of the Authority to meet her needs, nor indeed by reason of any failure that would have had a significant bearing on her death. There was no breach of the Authority's protective duties under Article 2. There is no evidence of a gross failure to meet Victoria's needs that would have had a significant bearing on her death.

"The verdict is therefore a narrative one viz Victoria Louise Byrne Agoglia died of opiate toxicity in circumstances where she was a vulnerable young person and following her unlawful administration of heroin."

- 2.11. It is not the role of the review team to challenge how the coroner came to this conclusion. However, the information we have considered leaves us in no doubt that Victoria Agoglia was exposed to the most profound harm, at least from the age of 13. Her exposure to sexual exploitation by adult males was known to police and social services and, despite the risk of significant harm caused by the men who were sexually exploiting her, statutory child protection procedures, which should have been deployed to protect her, were not utilised and the strategies put in place to protect Victoria were wholly inadequate. Furthermore, it was known to both her social worker and her drugs worker that Victoria was being injected with heroin by an older man, and we have seen no evidence that this risk to her life was appropriately escalated and dealt with through a police and social services Section 47 investigation.
- 2.12. In March 2018, the review team formally requested from Manchester City Council access to the reports provided by the council to the inquest into the death of Victoria Agoglia. This request became subject to the legal arguments in respect of access to personal data referred to in Chapter One and was therefore originally included in the data processing agreement with Manchester City Council. However, in October 2018, Manchester City Council informed GMCA that it had been instructed by the coroner not to share any information from the coronial hearing. Therefore, on 18 October, GMCA wrote to the coroner asking for her early confirmation that she had no objection to Manchester City Council sharing information of which the review team assumed Manchester City Council was the data controller. The coroner responded on 19 October requesting more information about the

review team and the purpose of the review. She also was of the opinion that the documents requested were produced for the purpose of a court investigation and were therefore court documents. The additional information requested was provided to the coroner on 30 October 2018.

2.13. GMCA received a final response from the coroner on 28 December 2018, declining the request by the review team to access the information requested. The Coroner cited several factors to support her decision not to release the information to the review team.

- “The review team were not, nor could they ever be considered to have been, a properly interested person for the purposes of the Inquest. However, the Court has a discretion and may provide any document or copy of any document to any person who in the opinion of the Coroner is a proper person to have possession of it.”
- “In considering this request the Court has taken into account the fact that the death of Victoria Byrne¹⁸ occurred on the 29th September 2003, over 15 years prior to this request. At the time of her death she was not subject to Operation Augusta, this being established after her death.”
- “The only information requested by the review team are statements provided to the Court by one of the properly interested persons, Manchester City Council.”
- “There is no recording of the Inquest hearing and the Court cannot confirm the evidence provided by the witnesses in Court as opposed to the content of their written statements.”
- “The publication of the review goes some way to dissuading the Court in disclosing the requested documents, given the time which has elapsed and the potential risk of relying on documents which are not the evidence given by the individuals.”
- “It is clear this was a sensitive and emotive Inquest involving the tragic death of a young girl. This in the Court’s view elevates the need to ensure accurate information could be provided. This is not possible. In addition, the Court is not prepared to release information pertaining to only one properly interested person.”
- “The Court notes the review team have identified, ‘very specific

¹⁸ Victoria’s full name was Victoria Louise Byrne Agoglia.

concerns in respect of the care of Victoria Byrne and are seeking clarification as to whether these were made known to the Coroner at the time'. If the review team have such concerns then the correct process would be to notify the Court of them and for the Court to consider whether such information should be considered fresh evidence and whether an application should be made to the Attorney General for a fresh Inquest."

- "For these reasons the Court does not permit access to the requested documents. The Court has no objections to the Coroner's narrative verdict being disclosed, there is a full clear typed, record of this document. A copy of this is enclosed."

- 2.14. We have reviewed the narrative verdict and remain concerned as to how the coroner at the inquest reached the conclusions he did, given the information the review team has since considered. The coroner recognised the multiple concerns identified within the Part 8 review, including sexual exploitation and sexual assault; however, in his summary he described Victoria as having a propensity "to provide sexual favours". This significantly underplays the coercion and control Victoria was subject to. The coroner quoted the counsel representing Manchester City Council as saying that the test was "whether Manchester City Council knew or ought to have known of facts which gave rise to a real and immediate risk to life – not merely wellbeing or welfare from the criminal acts of a third party".
- 2.15. We have confirmed that on 30 July 2003 Victoria informed her social worker that she was being injected by an older man with heroin. She told her drugs worker the same thing a week later. No action was taken to formally investigate this matter or prevent it occurring again. Within two months of this revelation she died.
- 2.16. The Part 8 review report that Manchester City Council provided to the inquest stated: "On 30.07.03, VB's social worker informed her drugs worker that an older man injected her with heroin 'for favours'." Given the information known to Manchester City Council, it is difficult to understand how the coroner concluded that: "No inferences can be made that the events from the 24 September were reasonably foreseeable."
- 2.17. Furthermore, having considered both the harrowing experience in public

care in Manchester of Victoria and of many of her contemporaries in our sample, we cannot understand how the coroner felt able to conclude his remarks with the following statement: "It is absolutely essential also that the public remain confident about the quality of care and support afforded to children cared for within the child protection system."

- 2.18. As we will show in Chapter Six, we cannot offer any assurance that the majority of the children in the care of Manchester City Council in our sample were adequately protected from child sexual exploitation and that these risks were appropriately dealt with by both Greater Manchester Police and Manchester City Council.
- 2.19. The current coroner has suggested in her letter that the correct process is for the review team to share its concerns with the coroner and for the coroner's court to consider whether such information should be viewed as fresh evidence and whether an application should be made to the Attorney General for a fresh inquest. We have therefore written to the coroner providing details of the information we have considered, with a copy of our report for her consideration.
- 2.20. Furthermore, we have found no evidence that there was an investigation into the men who sexually exploited Victoria Agoglia. A close relative of Victoria was reported in the media in October 2014 as saying: "These men are still walking about. She needs to be put to rest and I hope if anyone is watching and they do know something, even if it's the smallest thing, to come forward so that social services will know there's a lot of people that still know they never helped these young girls."
- 2.21. In the same October 2014 media broadcast and online news item, Greater Manchester's chief constable at the time gave a commitment that he was "quite happy" to look at Victoria Agoglia's case again. The review team has been in contact with the relative quoted and she has confirmed that she has heard nothing in respect of the review of Victoria's case. In August 2018, the current chief constable of Greater Manchester Police informed the review team of the following: "It is reported at the end of the article that [the former chief constable] 'told ITV News that there was the potential for old cases to be reopened and added that he is "quite happy" to look at Victoria Agoglia's case again'. I can confirm that this suggestion

by [the former chief constable] was just that and not a commitment to review this case. There is a need for Greater Manchester Police to re-engage with [Victoria's relative] directly and the best and most appropriate course for that to happen is through our appointed Family Liaison Officers."

- 2.22. On 10 September 2019, after we sent him a summary of this report, the review team received an email response from the former Greater Manchester chief constable who spoke to the media in October 2014. His email said:

"The contact I had since leaving GMP about this particular ITV interview was from the Chief Constable's PA and I was under the impression that this was as a result of an enquiry from the TV company and did not know that it was a part of this review.

"In all the hundreds of interviews I gave as chief constable and subsequently it is difficult to remember one particular question and my response. My recollection is that as Victoria was a teenager from Rochdale, I believed that this particular case was covered by the review and follow up investigations into CSE which were being carried out at the time. My response indicated that I was open to review any case including this one and that I believed that the television company or the family had new evidence or representations to make to me or to the review. I cannot recall who was the detective who would have been with me at the time of the interview but again I would have believed that they would have ensured that the matter was followed up. I am very sorry that Victoria's family have not had justice in this case.

"I had no reason to be defensive about this case. I was very open at the time about the failings of GMP in these cases and the failings in the wider system. I put very considerable resources into the investigation of CSE and the review of past cases at a time of overall declining budgets."

- 2.23. We will return to this matter in Chapter Eight.

Chapter Three

Our methodology

- 3.1. In February 2004, following the death of Victoria Agoglia, Greater Manchester Police launched Operation Augusta. Victoria was believed to have been involved in “child prostitution” within the South Manchester area and elsewhere. As a result, care homes within the South Manchester area had been canvassed and a total of 11 children in care were identified as potentially being subject to sexual exploitation. Each child portrayed a profile similar to that of Victoria prior to her death. Operation Augusta was initially a scoping exercise and it identified 26 potential victims of child sexual exploitation (CSE) and potentially 97 persons of interest. A person of interest is defined by the authors of the report as someone identified as being involved in some way in the sexual exploitation of the victims. This may be as a perpetrator, a facilitator or an associate of either of these. A major investigation team was set up in June 2004 and additional resources allocated. Operation Augusta was formally closed on 1 July 2005 after a command meeting with the head of Greater Manchester Police (GMP) ‘V’ CID Command and the divisional commander of A-C Divisions.

- 3.2. The operation’s senior investigating officer (SIO) has informed the review team that he believed that Operation Augusta managed to deliver and complete an agreed task with a very small and limited number of resources over a short timescale. This was achieved despite some officers not having the requisite skills, training, experience or full-time capability. The entire investigation team received commendations from the chief superintendent and was nominated for a force excellence award.

- 3.3. Our terms of reference require us to consider the decision to close down Operation Augusta in July 2005. Margaret Oliver, a detective on the Augusta team, has gone into the public domain to express concern that Operation Augusta was closed prematurely:

“And don’t believe any of this rubbish that police have learned from their mistakes. I worked on an almost identical operation in 2004, Operation Augusta, which had identified dozens of young victims and dozens of suspects. It was a virtual carbon copy of Rochdale, men of largely Pakistani heritage were abusing vulnerable white

girls, in Hulme, and around Rusholme. I was on that job for a year and a half. It was a huge investigation.

“My husband Norman became ill and sadly passed away. I had to take time off and by the time I came back three months later the job had literally died a death. I was totally incredulous. It just didn’t make sense. It was as if it had never happened. The girls had told me what had happened. I’d gained their trust. I’d given them my word that GMP would take their allegations forward and that they should trust us.

“We’d found locations where the abuse had happened, vehicles used to transport the victims and had identified many serial sex offenders.

“We also had social workers telling us they’d been trying to get the police to take this problem seriously for years. But not one offender was arrested or charged. I couldn’t believe it. It was as if none of it had ever happened. Nobody was ever able to explain to me why the case had been dropped.”¹⁹

In Chapter Seven, we will discuss in detail the criminal justice outcomes for Operation Augusta, which did include several convictions. We have also established that other adults were arrested and charged.

Mrs Oliver also spoke at length to the review team and expressed the following concerns about Operation Augusta:

- She explained that the death of Victoria Agoglia had acted as a trigger and the start of Operation Augusta. She stated that Victoria’s story still devastated her and should have been prevented had the protective agencies done the job they were set up to do. She believed that the agencies tasked with protecting the vulnerable failed to do so. This forms a key finding in our review as set out in Chapter Two and subsequently in this report.
- She now believed that the initial Operation Augusta was set up because Greater Manchester Police was expecting a public reaction in respect of an anticipated Channel 4 documentary on CSE in Keighley, West Yorkshire, called *Edge of the City*. This was particularly sensitive in the context of the death of Victoria in similar circumstances to those portrayed in Keighley. We have

¹⁹ ITV interview, 18 May 2017.

established that this documentary was a consideration of the gold command, and in our judgement appears to be one factor in the decision to initiate Operation Augusta. Mrs Oliver believed the Augusta team was not required to research Victoria Agoglia, although she had since spoken to a close relative of Victoria who believed that in 2014 the chief constable had agreed to reopen the case. Mrs Oliver believed the overdose that killed Victoria Agoglia was administered by the Asian abusers. She expressed the view that she believed that social services knew they had failed Victoria as she was in their care. Although she had no evidence, Mrs Oliver believed that social services tried to exclude the family from the inquest into the death of Victoria to “protect their own backs”.

- She said: “It was surrounded in secrecy which makes them feel something was not quite right. The family were kept in the dark, they were not allowed to see Victoria’s letter, and there was a concerted effort to conceal the truth. The way it was played to them was that Victoria was in the care of Social Services and they had no legal rights.”
- Mrs Oliver believed that the death of Victoria Agoglia had acted as a catalyst and that it was for this reason that the decision was made by the Operation Augusta team to put her photograph and the letter she had written on the front of the final report. The scoping team believed that this could have happened to any of the other girls on the list. We have since discovered that the letter on the front of the report was written by another child²⁰. Mrs Oliver reported being given a list from social services of approximately 27 young people. The young people listed were all in the care of social services and potential victims of CSE. She believed the social workers were relieved that something was

²⁰ We have confirmed that the letter included in the final report had the name of the author redacted. This redacted version of the letter appears to be identical to the one published by the media in 2014. The review team located the un-redacted version following a search prompted by an extract of the letter appearing in a report in relation to a different child. Mrs Oliver informed the review team that the letter in question came to the Operation Augusta enquiry team, and that it was presented to the detective inspector as Victoria’s letter. He then brought it to the enquiry team as such. She also informed the review team that the decision to include the letter at the front of the Augusta report was taken by the DI/DCI in the full belief by everyone on the enquiry that it was Victoria’s letter. Detective Inspector ‘A’ informed the review team in his written response to the summary report that that he did not recall the Augusta report claiming that the letter on the front of the final report was written by Victoria, and that from the outset the scoping report used the letter, which was written by another victim of abuse, to reinforce the emotional impact and reality of the effects of such abuse on young vulnerable children.

finally being done as they had been flagging incidents of grooming and “sex parties” to the police for a long time and did not know what else to do. Mrs Oliver commented that Manchester City Council’s child protection units were only responsible for the investigation in instances where children were being abused by perpetrators who had care, custody or control of their victims. She believed equally that GMP’s Criminal Investigation Department (CID) was not equipped at the time to deal with CSE as it did not have a joint agency approach or access to standalone child protection databases. She believed this led to many young people who were being exploited falling through the gap, as no one agency had ownership or responsibility for investigating this type of sexual crime. Our analysis of this is set out in detail in Chapter Six.

- Mrs Oliver described the Augusta team’s intelligence as endless, with the details of 97 potential offenders²¹, including associated vehicle registration numbers and street names. All records were kept on cards in a paper-based system but nonetheless links between offenders were becoming apparent. Many young people independently connected numerous offenders and the names reported by social workers often overlapped. Mrs Oliver stated that they firmly believed that this was a very organised group of offenders whereby the younger men were tasked with picking up the young people and befriending them before passing the children on to be abused at “sex parties” by older, predominantly Pakistani, men. Our analysis of this is set out in detail in Chapters Four, Five and Seven.
- Mrs Oliver recounted presenting a report at the conclusion of the scoping phase of Operation Augusta to Detective Chief Superintendent ‘A’,²² and this subsequently led to the force’s tasking and coordinating group allocating a force major incident team to the investigation. We cover this in Chapter Four.
- Mrs Oliver also recounted an incident when she took a young person on drives to identify where the abuse had occurred. On one occasion the child identified a restaurant and on another a

²¹ As we have explained in Chapter One (1.12), the scoping team identified “in the region of 97 persons of interest who had been identified as being involved in some way in the sexual exploitation of the victims”. While there was no national definition, the team defined a person of interest as “a perpetrator, facilitator or an associate of either”.

²² We have anonymised the names of key personnel throughout this report. Appendix C contains a description of their roles.

suspected perpetrator was identified in a car. Mrs Oliver took the registration details and conducted a police computer check when back at the office. This identified that the vehicle was linked to a GMP officer. She explained that there must have been a flag on the system as she got a call straightaway delving into why she made the check and was directed not to go anywhere near the suspect as he was subject to an investigation. A year later the officer was dismissed²³.

- Mrs Oliver explained that in late March 2005 her husband's illness deteriorated and she took time off work to look after him. She did, however, leave in the confident knowledge that finally the issues were being tackled, the abuse was being addressed, and children protected. However, in September 2005, Mrs Oliver returned to work to find the team was on another investigation altogether. She described to us that it was as if Operation Augusta had just disappeared as if it had never even existed, none of the serious sexual offending had been addressed, and no one prosecuted. Mrs Oliver was unable to recall the exact conversation, but she was unable to get any real answers as to why the investigation had finished before it had started. The only information she received was that some of the younger perpetrators had been warned about picking up young people under the Child Abduction Act 1984. However, her strong view was that the offending uncovered by Operation Augusta was organised, systematic child abuse on a massive scale and this was allowed to go unchecked. We have established that there were some criminal justice outcomes for Operation Augusta and deal with our judgement on the effectiveness of Augusta in Chapter Seven.
- Mrs Oliver speculated in her interview that the premature closure of Operation Augusta had been precipitated by the 7 July 2005 bombing in London. We explain in more detail in Chapter Five that on 22 April the SIO attended a meeting with a detective chief superintendent and a chief superintendent. According to the SIO policy log, the chief superintendent stated he was unable to put permanent staff into Operation Augusta and that the operation would finish on 1 July 2005. We have therefore discounted any link between the ending of this operation and the London bombing.

²³ The Chief Constable of Greater Manchester Police clarified for the review team the position in relation to the dismissed police officer, confirming that he was dismissed for offences not related to child sexual exploitation.

- Mrs Oliver also speculated that another factor was that performance indicators at the time focused solely on acquisitive crime (for material gain, such as burglary). Senior officers were rewarded based on their success in addressing this. She said: “CSE was still a hidden crime, so why open that box if they didn’t have to?” There is some evidence for this assertion. GMP informed the review team that the 2004/05 annual report by Sir Ronnie Flanagan, Her Majesty’s Chief Inspector of Constabulary (HMIC), was similar to previous years, with a heavy focus on performance-driven targets based on the Government’s priority offences: vehicle crime, domestic burglary and robbery. The emphasis was on not only reducing these crime types but also increasing detection rates. HMIC’s baseline assessment of Greater Manchester Police in 2005 showed positive results for investigating crime and there was nothing in the report about child sexual exploitation. The Greater Manchester Chief Constable’s annual reports for 2004/05 and 2005/06 echoed the language of the Home Secretary’s national policing plan and the HMIC annual reports that the reduction and detection of serious acquisitive crime offences was the priority.

3.4. In reviewing Operation Augusta, we examined the following documentation:

- A senior officer’s SAFCOM (situation, aims, factors, choices, options, monitoring) briefing on CSE, South Manchester
- An IIRMAC (information, intention, risk assessment, method, administration, communication) briefing by Detective Inspector A
- Child sexual exploitation in South Manchester: Brief summary of findings, dated 14 April 2004
- Senior investigating officer (SIO) policy book (February 2004 to May 2004)
- A second child sexual exploitation final report, dated 13 May 2004, which was submitted to force tasking by the detective inspector following a scoping exercise
- The second SIO’s policy book (June 2004 to May 2005)
- The Operation Augusta HOLMES account
- Gold group meeting minutes from 22 April 2005, 1 July 2004 and 23 September 2004
- Joint operation – child sexual exploitation report, Manchester City Council, 31 July 2005

- Operation evaluation report, Greater Manchester Police, 25 August 2005
- Operation Augusta joint protocol, agreed by Greater Manchester Police and Manchester City Council in December 2004
- Manchester City Council social care files on a sample of the potential victims we identified from our review of the HOLMES account
- Manchester area child protection child sexual exploitation procedures, 2005.

3.5. We also interviewed the following police officers involved with Operation Augusta:

- Detective Constable A (retired)
- Strategic interview advisor (retired)
- Detective Constable B (retired)
- Police Constable A (serving officer, GMP)
- Detective Sergeant A (retired).

3.6. Greater Manchester Police also invited for interview the following officers who had left the force. They did not make themselves available for interview for various reasons but agreed to provide a written response:

- Detective Superintendent A, SIO responsible for the investigation phase (written response received)
- Detective Superintendent B, head of public protection (written response received)
- Chief Superintendent A (written response received)
- Detective Chief Superintendent A (no response received and now retired)²⁴.

²⁴ We were informed by GMP that it had taken documents to Detective Chief Superintendent A to help refresh his memory and supplied him with the review team's list of written questions. We were subsequently informed that Detective Chief Superintendent A could not recall any of the detail and would not be able to assist.

- 3.7. Detective Inspector A, the SIO of the scoping phase, had several positive telephone discussions with the review team but we did not receive a response to our request to interview him. He supplied some written comments to the review team on receipt of a summary of our findings.
- 3.8. 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. Greater Manchester Police also approached five further officers who either declined to be interviewed or were not contactable.
- 3.9. During our review of the HOLMES account, we considered the circumstances of a sample of 25 children, and to ensure the robustness of the exercise, every action raised, document, message and multi-agency report was analysed for each child. Following this detailed analysis, we reviewed the information held by Manchester City Council on the social care files.
- 3.10. On 26 September 2018, following our review of the data held by Manchester City Council, we asked the council to contact three former employees to give them the opportunity to meet with the review team. We provided the council with an explanatory letter, the terms of reference and a confidentiality agreement to send to each of them. These were:
- Team manager A (embedded social worker)
 - Team manager B (embedded social worker)
 - Senior manager 1²⁵.

²⁵ On receiving a summary of this report, senior manager 1 explained in an email to the review team: "I replied to a letter from [Manchester City Council employee] and spoke to her twice on the telephone. I told her that my starting position was to engage with anything that led to the greater protection of children. I did ask to see terms of reference for the work and that I would be allowed access to records as we were referring to events up to 15 or 16 years ago. I did not hear back about whether I could engage with the assurance exercise on the basis I outlined to [Manchester City Council employee]."

We received notification from Manchester City Council on 29 October 2018 that it had not received any response indicating these individuals would be prepared to be interviewed.

Chapter Four

Operation Augusta – the scoping phase

4.1. At the commencement of Operation Augusta, children’s homes within the South Manchester area were canvassed by the Augusta team, which identified a total of 11 children in care as being potentially subject to sexual exploitation. The police officers believed that each child presented a profile similar to that of Victoria Agoglia prior to her death, with frequent reports of going missing and having access to alcohol and drugs in exchange for sexual activity with adults. A SAFCOM (situation, aims, factors, choices, options, monitoring) briefing report²⁶ was submitted by Detective Inspector A in which it was explained that there appeared to be a genuine fear that a group of Asian²⁷ men were targeting vulnerable girls in residential care for sexual exploitation. The aims of the operation were summarised as follows:

- Secure the protection of any child victim identified
- Identify offenders
- Secure evidence against offenders
- Prevent further offences and provide reassurance to the public
- Work in a multi-disciplinary partnership to address the needs of the victim and reduce crime.

4.2. The report stated: “The current serious case review being conducted in respect of Victoria Agoglia places a commitment on Greater Manchester Police to ensure similar tragedies are prevented wherever possible and those charged with a child protection remit have done all they can to address identified shortfalls or deficiencies in previous cases.”

²⁶ Although undated, this report was written in advance of the commencement of the operation on 16 February 2004.

²⁷ The term “Asian” was generally utilised in both the contemporaneous reports and in our interviews. Where there is a more specific description of ethnic origin, we have repeated that.

- 4.3. The report recommended the establishment of an ad hoc dedicated investigation team, comprising detectives across all four sub-divisions and with the investigative and child interview skills to deal with both victim and offender. This was agreed by senior officers and the scoping phase of Operation Augusta was commenced on 16 February 2004.
- 4.4. Detective Inspector A prepared an operational briefing²⁸ in which it was explained that the intention of the order was “to scope the perceived situation found within the South Manchester Area with a view to providing an informed platform for which appropriate resources can be directed at the level of criminality found (should this be the case) against identified target individuals or groups of individuals”. The detective inspector posed several questions to be answered:
- Is there a common thread that links some or all of the case profiles examined?
 - If yes, what is the thread, can it be evidenced?
 - What is the motivation for the children going missing?
 - What levels of criminality are found?
 - Are offenders able to be identified?
 - If so, can evidence be secured against them?
 - Is there any indication that the criminality is organised, whether through association, location or direction?
- 4.5. The detective inspector stated in the operational briefing: “There is a public expectation that children irrespective of whether they reside in care or not should be protected and liability for this remains with the Police and Social services despite evidence that some children may be compliant in these acts of exploitation.”

²⁸ This IIRMAC briefing is undated but refers to both the SAFCOM report and the commencement of the “scoping task” as of Monday 16 February. It is referred to in DI A’s policy log on 5 March 2004. We have concluded that it was most probably created shortly before the commencement of the operation.

- 4.6. The resources originally requested in the SAFCOM briefing were not secured and the scoping exercise commenced with Detective Inspector A as the senior investigating officer (SIO), three detective constables and a field intelligence officer. The task of the dedicated officers was to research information on the children, including to re-examine the missing from home reports, examine records held in the care homes, interview key persons with relevant information, and work with social services as required. "Each case profile of children will be examined with the child being approached and interviewed when it is felt appropriate by dedicated team members....any disclosure will not be probed but arrangements will be made to secure evidence/ intelligence on a video statement in according with 'Achieving Best Evidence'."²⁹
- 4.7. The scoping element of Operation Augusta was undertaken between February 2004 and May 2004. It quickly became apparent to the team that there were far more than the original 11 children referred to in the SAFCOM briefing. On 14 April 2004, an interim report³⁰ was prepared by one of the detectives on the team and signed by three additional detectives. One of our interviewees, Detective Constable B, confirmed this was a jointly compiled report for the SIO.
- 4.8. This summary report stated the following:
- Victoria Agoglia had a "boyfriend/pimp" and it was accepted he was introducing Victoria to Asian men for the purposes of having sex for money. This same suspect was also associating with another female identified as being at risk of sexual exploitation.
 - At this stage the team had identified 23 victims and they could prove that 10 had links or relationships with this suspect.
 - There were repeated references by various victims to a red Mercedes being used in the procurement of the victims, and intelligence linked at least four identified victims to this vehicle.

²⁹ IIRMAC briefing.

³⁰ Child sexual exploitation in South Manchester: Brief summary of findings, 14 April 2004.

- Another suspect, believed to be the main contact involved with sexual exploitation of children in care, had been identified. He was believed to be a manager of an identified establishment in South Manchester and have links to a town outside of Manchester. This man was known to be an associate of the first suspect, and it was believed his establishment was used as a location for sexual exploitation.
- At least 10 of the identified victims referred to being taken to an establishment or a flat above a named takeaway nearby for the purpose of having sex with Asian men. The report stated: “We would hypothesise that the Asian males are linked by means of the network of take-aways operating throughout a wide area.”
- One young woman agreed to speak to her social worker after she was informed of the purpose of the enquiry. During this discussion she gave a brief overview of the situation relating to the sexual exploitation of children as she knew it. She stated that a 24-year-old Asian man was instrumental in procuring girls in care to have sex with Asian men, offering them £50 incentives to do so. The report also referred to the social care file stating that this young woman and another resident were working as prostitutes for Asian men in a massage parlour. It is also stated that the Asian proprietor of the massage parlour had visited the children’s home.

4.9. At the end of the scoping exercise, three detectives produced a report for briefing senior officers, *Operation Augusta final report 13 May 2004*. Attached to the front of the report was a photograph of Victoria Agoglia and a letter entitled *Things I have done in the past* written by a 13-year-old victim. This was subsequently published in the media in 2014 and attributed to Victoria Agoglia. During our analysis of the original police records we identified that this letter was in fact written by another identified victim and not by Victoria. This does not make the letter any less poignant.

4.10. The report listed 26 young women identified as victims. The age range of victims ran from 11 (the youngest) to 17 (the oldest), with the majority being 14 and 15 years old. All the girls were in the care of Manchester City Council. The team identified five common characteristics of the victims they had researched and concluded the following:

- All the victims had lived in one of the care homes in the south of the city and were in the care of Manchester social services.

- Consequently, there were many associations between the various victims as the children moved through the care system.
- The victims came from dysfunctional backgrounds and had often been subjected to physical and sexual abuse prior to being taken into care.
- Every one of the victims was persistently missing from home.
- The majority of victims were non-attenders at school.

4.11. The scoping team established that in many cases the victims initially viewed their abusers as boyfriends, and in the early stages were at the very least compliant with the requests of their abusers. The team had received reports of victims attending ‘parties’ with as many as 20 Asian men, when £50 incentives were offered to the child to perform sexual acts. The report stated that the evidence and intelligence throughout this scoping exercise showed that the level of criminality ranged from assault, harassment, abduction and indecent assault, to rape and manslaughter. Of the 26³¹ victims identified, the team believed that 15 were willing to speak to the police. The team also noted in the region of 97 persons of interest who had been identified as being involved in some way in the sexual exploitation of the victims. The team defined a person of interest as a “perpetrator, facilitator or an associate of either”, and noted that it should also be borne in mind that of these 97 persons of interest there might be an element of duplication involved. Intelligence identified that offenders were predominantly employed in or used the Asian restaurant and takeaway trade, and identified several premises in South Manchester. Intelligence suggested that offenders were targeting the care homes within the City of Manchester area. The children were befriended as soon as they arrived and were seen by their abusers as easy pickings. This was exacerbated by the fact that offenders understood that a specific children’s home in Manchester was used as an emergency placement unit for children entering the care system and this maintained a steady supply of victims.

4.12. The report concluded by answering the questions set by Detective

³¹ The 26 later was confirmed as 25 as the investigative team subsequently identified a duplication.

Inspector A in the IIRMAC briefing paper.

<p>Is there a common thread that links some or all of the case profiles examined, and if so can it be evidenced?</p>	<p>“Yes, all victims are young white females in the care of the local authority who display similar lifestyles and behaviour patterns to Victoria Agoglia. The perpetrators are almost exclusively Asian adult males many of whom are associated via the Asian restaurant trade.”</p>
<p>What is the motivation for the children going missing?</p>	<p>“Anecdotal evidence suggests that in the early stages the children are tempted by the attention paid to them by manipulative Asian males and the attraction of small gifts.”</p>
<p>What levels of criminality are found?</p>	<p>“The evidence and intelligence gathered throughout this scoping exercise shows that levels of criminality range from S47 assault, harassment, abduction, indecent assault, rape, to manslaughter.”</p>
<p>Are offenders able to be identified?</p>	<p>“Yes. There is now a considerable database which contains the details of individuals believed to be involved in the above offences. This incorporates their personal details telephone numbers and vehicle registration numbers.”</p>
<p>If so, can evidence be secured against them?</p>	<p>“This will only become clear as this scoping exercise develops into the investigative stage.”</p>
<p>Is there any indication that the criminality is organised, whether through association, location or direction?</p>	<p>“Yes, although only containing a relatively small amount of the intelligence gathering, the report and chart compiled by the analyst at the FIB³² clearly show links between suspected offenders and a number of locations.”</p>

³² Force Intelligence Bureau.

Summary

- 4.13. The initial scoping phase had delivered its objectives successfully. From the presenting problem of 11 girls in the care of Manchester City Council going missing, the team had built up a compelling picture of systematic exploitation of looked after children in the care system in Manchester. The team had identified 25 victims but expected to find more and believed at least 15 would cooperate with the police. The team collected a strong intelligence picture on the suspects, identifying up to potentially 97 persons of interest, including how they operated. These were predominantly Asian men working in the restaurant industry, and the team had a good insight into how they enticed young girls in the care system and ultimately abused them. The team also believed it had made a significant link with the adults involved with Victoria Agoglia and the suspected perpetrators in South Manchester. We have established that the investigation was therefore considering sexual exploitation of children predominantly from early 2002 to the conclusion of the investigative stage of Operation Augusta in July 2005.
- 4.14. On receiving the final report, the GMP Tasking and Coordinating Group met and decided the matter should be investigated using Force Major Incident Team (FMIT) resources with Force Family Support Unit (FSU) and divisional detectives headed by Detective Superintendent A as the new senior investigating officer (SIO). On 14 May 2004, a HOLMES account was set up and FMIT major incident room (MIR) staff began converting the paper management system into the electronic record. During this period, social services identified 10 young people who would be willing to be interviewed by the police.
- 4.15. Detective Inspector A informed the review team that he was not part of the continued investigation, although he did recall giving Detective Superintendent A and his deputy a full briefing on the scoping investigation he had completed.

Chapter Five

Operation Augusta – the investigative phase

Set-up phase: June to September 2004

- 5.1. On 7 June 2004, a new SIO (Detective Superintendent A) was appointed, and he commenced his policy book on 10 June 2004. He was a detective superintendent in GMP's Force Major Incident Team (FMIT) and in charge of several dedicated units investigating serious and major crime. While working on Operation Augusta, he also retained responsibility as the SIO for a complex murder investigation involving an organised crime gang who had shot and murdered a man at his home address. The SIO had previously led an investigation into a "child sex worker" who had been brutally murdered. She had regularly gone missing from home and became involved in the sex trade during her teenage years.

- 5.2. In his written response to the review team, the SIO informed us that he believed that child sexual exploitation (CSE) in 2004 was still largely misunderstood by policing. There were no benchmarks, policies or clear guidance on which to base an investigation. GMP had previously completed Operation Cleopatra, an investigation into non-recent sexual offences, but these were not of the same type and nature as those Operation Augusta was asked to investigate, namely involving missing from care home victims exploited predominantly by adult Asian men. Operation Cleopatra had grown into an enquiry that was a lot larger than first planned, and it was against this backdrop, the SIO informed us, that he considered the scale, scope, timescales and capacity he would require for Operation Augusta.

- 5.3. The SIO confirmed that he was aware of the many sensitive community issues around policing the South Manchester Division.
 - The profile of potential offenders highlighted under the scoping for Operation Augusta were predominantly adult Asian men from local minority ethnic communities in the area covered by South Manchester Division.
 - He also confirmed he was aware of the impending Channel 4 TV

programme *Edge of the City*, due to be rescheduled, about a similar problem in West Yorkshire. It was thought this could potentially raise media and political interest in any similar problem occurring in Manchester, particularly as it involved accusations of grooming schoolchildren. We have established that this documentary was initially expected to be broadcast in May 2004 but was subsequently postponed until August 2004.

- He also informed the review team that GMP had recently dealt with an unrelated case involving Kurdish people in the South Manchester Division area (Operation Zoological) that had created community tensions and Augusta was to examine accusations against another minority group. However, Detective Superintendent A was categorical that any concerns about creating further community tensions did not influence any of his investigative decisions, but the impact clearly had to be considered by the gold command group.

5.4. On 10 June 2004, the SIO had an initial meeting with Augusta team members and it was agreed to prioritise entering the existing paper records onto the computer system. On 22 June, the SIO visited Merseyside Police as this force had been identified as a site of good practice.

5.5. A gold command meeting was held at Manchester Town Hall on 1 July 2004, and this included the city council's Director of Children and Families Services and her assistant director. Greater Manchester Police was represented by the head of public protection, the deputy SIO at the time, and a detective inspector from the Force Family Support Unit. The meeting confirmed that 25 children, the subject of the original scoping document, were identified as possibly being at risk of exploitation. The investigation remained focused on these cases, although it was expected they might not be the only incidents in the GMP area. The investigation had identified 10 of them for further research as being likely to have evidence to offer to take the investigation forward. These children were to be interviewed to see if they had any information of significance, whether they were alleging any criminal offences, and whether they would support any prosecutions. A meeting was arranged for 5 July 2004 to formulate a strategy for these interviews and it was agreed that the council would provide a dedicated social worker to assist with the interview process.

5.6. On our behalf, GMP has approached Detective Superintendent B, who oversaw public protection during Operation Augusta. He has been

recorded as an attendee at the gold command meetings. He gave a written response to the review team. He stated his role as detective superintendent in charge of public protection was not the role it is now: "At the time I was in charge of a small team of case conference attendees, sexual offences management unit staff and abusive images unit staff. Public protection units were based on territorial divisions and were line managed by divisional DCIs and Superintendents. I had no line management responsibility for them." Detective Superintendent B stated he was unable to recall in his response any specific details in respect of Operation Augusta. Detective Constable A informed the review team that she had numerous face-to-face meetings with Detective Superintendent B about Operation Augusta and, as head of the GMP Child Protection Unit, he was part of the force tasking group involved in the decision to appoint a major incident team to the operation. As we were unable to interview Detective Superintendent B, we could not reconcile these two statements.

- 5.7. Subsequently, Manchester City Council nominated a social worker to act as the coordinator with children's social care. She was later replaced by another social worker who worked as a quality assurance officer in Manchester children's services. This second social worker produced a report on Operation Augusta³³ at the end of the operation.

- 5.8. On 12 July 2004, the SIO attended a meeting at GMP headquarters to discuss communications. This meeting acknowledged that the enquiry was sensitive due to the involvement of Asian men. The communications lead was asked to consider the Channel 4 documentary on West Yorkshire that might go forward in case this caused problems for Augusta. Concerns were expressed about the risk of proactive tactics or the incitement of racial hatred. There were also concerns expressed about the damaged relations following Operation Zoological.

- 5.9. In his written statement to the review team, the SIO commented that at this time GMP probably was not accustomed to assembling joint multi-agency enquiry teams to investigate Augusta-type offences. It was more

³³ Joint operation – child sexual exploitation report, Manchester City Council, 31 July 2005.

geared towards mounting murder investigations and tackling gun and gang crime, as that was what it had the biggest need for.

- 5.10. The Augusta team experienced immediate difficulties³⁴ in resourcing the operation. Greater Manchester Police has shared with the review team the difficult context in which these resourcing decisions were taken. Two long-running murders were being investigated by the two major incident teams (MITs) that were permanently based in the City of Manchester district. One was a racially motivated murder and the second the murder of a child. Each investigation ran for over 18 months, during the whole period of Operation Augusta, and undoubtedly drained the force of resources that might otherwise have been available to the Augusta SIO. The resource issues are explained in more detail in Appendix F.
- 5.11. Initially, the SIO had planned to utilise one of his own dedicated MITs based at Wythenshawe for the enquiry. However, on 18 July 2004, a person was shot and subsequently died and the FMIT resource coordinator re-allocated the Augusta team to this murder investigation. The SIO informed the review team that: “The staff recruited onto Operation Augusta mainly came from the South Manchester Division and were not all fully trained detectives (what is now known as PIP2)³⁵. He counted himself fortunate to have Detective Sergeant A assigned from the Force Family

³⁴ Operation Augusta evaluation report, 25 August 2005.

³⁵ The Professionalising Investigation Programme (PIP) was introduced in 2003. According to Association of Chief Police Officers (ACPO) 2003 guidance on professionalising investigation, PIP provides a structured development programme to embed and maintain investigative skills for police officers and police staff. It aims to deliver the capability to conduct professional investigations at all levels within the police service and in other sectors of law enforcement.

PIP provides consistent registration, examination, training, workplace assessment and accreditation to a national standard at each level:

PIP 1 – priority and volume crime investigations

PIP 2 – serious and complex investigations

PIP 3 – major investigations

PIP 4 – strategic management of highly complex investigations.

Support Unit as a full-time appointed case officer. He also had to replace his deputy SIO at an early stage (in October, due to the new murder enquiry) with a part-time deputy SIO from C Division.

5.12. Detective Sergeant A informed the review team that he had commenced on Operation Augusta in September 2004, but he did not lose any of his existing headquarters responsibilities; his view was that the team was poorly resourced. In the early days he met with Detective Constable A and Detective Constable B and his work began by going around the Manchester divisions to see where the team could be located. "It was like no one wanted us and it was concerning for me, but I was aware there was an issue that needed responding to. We eventually secured a space in Wythenshawe, across from MIT, the aim was to try to work closely with them to get it onto Holmes."

5.13. By 16 September the total team comprised the following:

SIO	Leader of the team
Dep SIO	Deputy leader, not appointed
DS A	Enquiry supervisor/ reader
DC A	Enquiries/exhibits ³⁶
DC B	Enquiries
DC C	Enquiries

³⁶ The Operation Augusta indexing policy (dated 16 September 2004) records the following: "Enquiries/Exhibits DC A (when HOLMES course completed. Until then-maintained in orange book MIR/21)." Detective Constable A has informed the review team that she did not maintain the exhibits during the course of the operation.

DS B	HOLMES manager
DS C	Receiver/action management
DS D	Receiver/action management
Ms A	Analyst

5.14. In addition, there were three indexers and a typist. The team was subsequently supplemented by three seconded constables. Their role initially was to respond to missing from home reports.

5.15. The evaluation report produced in August 2005 outlined the problems in staffing the team³⁷:

- The staff recruited onto Operation Augusta came mainly from the South Manchester Division and were not all fully trained detectives, comprising a detective inspector, detective sergeant and three detective constables, working alongside three police constables.
- Responsibility for the operation was split between three Manchester divisions, leading to disputes and conflicts between the three divisional commanders as to who would provide the resources.
- The Force Major Incident Team was unable to commit long-term resources other than the SIO (who had other responsibilities), and there was a heavy reliance on staff from South Manchester Family Support Unit, who would only conduct interviews with potential victims on overtime.

³⁷ Operation Augusta evaluation report, 25 August 2005.

5.16. The operation's indexing policy was set out in a document dated 16 September 2004. This stated that the receivers would receive all documentation from the enquiry teams for registration and marking-up for inclusion in the database indexes. Detective Sergeant A took responsibility for marking-up for actions to be raised when documentation was initially submitted. He was also required to monitor:

- allocated action management, ensuring those allocated were pertinent to current main lines to progress the enquiry
- that actions were being actively pursued and submitted promptly
- that if an allocated action was unable to be progressed it would be reviewed for partial resulting, re-queuing or referring.

The SIO would be forwarded actions and documentation of importance prior to it being filed. Detective Sergeant A was responsible for such decisions, otherwise he would have the authority to file. Detective Sergeant A explained to the review team that he had not received any HOLMES training for this operation and, while having the authority to forward and file actions in certain circumstances, he did not have the relevant skills to undertake specific roles within the HOLMES system.

5.17. While it was agreed that the operation would utilise HOLMES, the SIO pointed out to the review team that this necessitated staff and indexers being available to function effectively. They relied on the staff who were engaged on processing the new murder investigation in a 'double hatting' type approach. The HOLMES receiver for example, a key role in which to manage HOLMES, was Detective Sergeant B assisted by Detective Sergeant D. However, both had also been assigned to the new murder enquiry. As noted above, Detective Sergeant A explained to the review team that he had not received any HOLMES training for this operation and did not regard himself as having the relevant skills associated with the HOLMES system. Detective Constables A and C were sent on HOLMES courses during the enquiry to try to alleviate this problem (particularly with disclosure responsibilities in mind). The SIO concluded by saying that: "Although we did put Augusta on HOLMES, this was very much a 'light touch' version."³⁸

³⁸ There are three nationally accepted levels of indexing on HOLMES: 'full', 'intermediate' and 'minimum'. The reference to 'light touch' refers to minimal indexing. There is an indexing policy for Operation Augusta that confirms that it was run on minimum indexing.

- 5.18. Detective Sergeant A went further in his interview with the review team and stated that they struggled to get information onto HOLMES as the operation was not being taken seriously by the indexers. “Getting it onto HOLMES we struggled, and it wasn’t taken seriously. The [Wythenshawe] Syndicate were resentful of the fact that they were helping us, and it wasn’t a murder, that we were seeking to safeguard victims, find perpetrators. There was clearly a lot of anxiety, and it felt uncomfortable, they were resentful of the report and didn’t like DI A³⁹. When I met him, I wondered why, he was a professional person interested in getting the best outcome.”
- 5.19. Detective Sergeant A had no doubt that the detectives, including the SIO, wanted the investigation to be successful and for children to be safeguarded, and that the local authority wanted a successful outcome. However, the team struggled from the outset. “There was a lot of ambiguity and confusion. I don’t think the relevant syndicate saw that they had a role in the operation. The other police officers who were seconded were not from a child protection background. It wasn’t that they were unskilled, but I had to put a lot of effort into educating them about multi-agency working. We had regular briefing meetings every morning and [the SIO] gave regular update meetings covering progress, how performance was and the management of it, how to record things etc. Apart from that it seemed like good will, notwithstanding it felt as though we were an annoying add-on to the Wythenshawe Syndicate.”
- 5.20. Detective Constable B confirmed this approach. He informed us: “The [SIO] left us to it. [DS A] was meticulous. The team researched missing from homes every day. [The SIO] knew of Cleopatra and wanted to put tight constraints on the operation so it didn’t balloon out of control. We would get phone calls, missing from homes, we would feed the email/memo through to [the SIO] and he would review them and decide whether we would take it on board or not. [DS A] then allocated people to speak to.”

This should not be used to imply criticism. This level of indexing is the norm for major investigations. Full indexing would only be utilised on ‘Category A’ murders.

³⁹ Detective Inspector A was the first SIO and author of the SAFCOM report.

- 5.21. Further delays were experienced in getting a full-time member of social services co-opted onto the enquiry team. When the first social worker (team manager A) arrived, there were challenges in arranging her access to computer equipment and the GMP network. Notwithstanding this, the SIO informed the review team that he believed that, though small in scope, the operation proved a success. He stated that it was ahead of its time in terms of the processes developed involving joint working. It brought together two agencies using 'working together' principles to tackle a problem that was relatively unknown as to scale, complexity and seriousness. This view was shared by Detective Sergeant A, who told us that he thought that: "Operation Augusta had turned out to be ground-breaking in approach by pragmatically applying 'working together' principles. We had looked elsewhere for good practice to replicate, including Operation Shield in Merseyside and Operation Parsonage in West Yorkshire. The message was the same: the key to success was gaining victim trust as these were young people who came from chaotic lifestyles with a general mistrust for authority."
- 5.22. On 9 September 2004, a meeting to discuss the role of the embedded social worker was called. This included the SIO, Detective Sergeant A, Detective Constable B, and a senior manager from Manchester Children and Families Services. Detective Constable A and team manager A gave their apologies. The main item on the agenda was to clarify the roles of police and social services for the interviewing of potential witnesses/victims and the role of the embedded social worker. Concern had been expressed that the embedded social worker wished to be involved in all interviews. This would lead potentially to up to four interviewers (the investigating police officer, the child's key worker, the embedded social worker and the strategic interview advisor). It was resolved that the joint planning phase for the interview would decide who needed to be present and that normally only two interviewers would be required – namely a police officer and social services representative. It was also agreed that once the accommodation for the operation had been arranged, the embedded social worker would be co-located with the team.
- 5.23. It was during this meeting that the SIO was asked by the social services manager why the enquiries were restricted to the 25 named young people contained within the source report and asked about additional witnesses who might become available. The SIO "fully explained his rationale for the terms of reference being limited to the 25, but added it was always at the SIO's discretion to include others who may be valuable to the enquiry. He

then outlined the suggestion that it may be useful for Augusta staff to interview returning MFH's (Missing from Home) as soon as they turn up again. This may be a valuable opportunity to obtain uncontaminated first-hand accounts or intelligence⁴⁰. Our opinion is that this is indicative of the SIO's intention at the time to ensure that the operation captured current reports of child sexual exploitation as well as investigating the less recent reports relating to the 25 children.

- 5.24. This approach is corroborated by Police Constable A, who told the review that the role of the uniformed constables was primarily to interview the children who had been reported as missing from home. "We tried to build a relationship with the young person, so they would make a complaint. Some of them would tell you the stuff but wouldn't make a complaint, in these instances there was not much we could do except keep in contact and involve other services to provide support, try and get a safety net around the child. If they still didn't speak and the safety net was in place, we would have to close it and hope that at some point in future they might feel ready to speak. We would have contact with the young person over months and months." On 25 October 2004 the SIO noted in his policy book that daily checks were being made for any missing from home cases so that staff could attend and investigate.
- 5.25. Detective Constable B was less positive about the approach and told the review team: "After the tasking meeting, we didn't look too much, we looked at the offenders we had, not a lot of new intelligence came in, and we couldn't develop it. There wasn't a huge degree of penetration in the Asian community."
- 5.26. The SIO informed the review team: "The whole focus of Operation Augusta was to be victim centric. The original report by DI A mentioned 26 victims and we later added another 5." The review team has, however, established that there were 42 designated victims on the HOLMES account (one of whom had died).

⁴⁰ Minutes of meeting held on 9 September 2004.

- 5.27. In his written response to the review team, the SIO commented: “In agreement with the Gold strategic multi-agency group, the terms of reference were kept deliberately tight and focused on a precise number of victims due to the scale of the task and resources available. I had concerns not only from our small team getting quickly swamped by a rising number of potential number of victims and offenders, but also that subsequent new reports could feasibly get allocated to the Augusta team. In which case we would have had not only to investigate these but also manage associated safeguarding risks with a very small number of staff. This can be compared to current times and Operation Stovewood in Rotherham that has rapidly grown into a huge complex enquiry involving over 200 full time officers and 1500+ victims.” This is echoed by Detective Constable B in his comment that the SIO knew of Operation Cleopatra and wanted to put tight constraints on the operation, so it did not “balloon out of control”.
- 5.28. Detective Sergeant A informed the review team that his approach was not to wait for a formal complaint from the child. “We adopted a proactive approach, looking at the incidents coming in in relation to the victims, not just missing’s but other codes which signalled vulnerability. We were always looking for opportunities which would generate evidence without a statement, so that we were always on the front foot. That’s what happened with [victim name], we had the evidence which negated her going to court. I strongly refute any suggestion that we needed a complaint, I promoted a proactive approach from day one.” However, in our analysis of HOLMES we have found several examples of cases not being progressed because there was no formal complaint from the child⁴¹.
- 5.29. On 14 September, the SIO identified 10 potential victims who would be prioritised by the team. All but one of these young people were within the original cohort of 25. He shortly thereafter added two further children who were regularly going missing from care and there were indications they were being sexually exploited. One was from the original cohort. We were unable to read the handwritten entry on the second. On 25 October, the SIO recorded that he was reviewing the lines of enquiry and potential proactive options.

⁴¹ GMP pointed the review team to the HMIC national thematic crime data integrity inspection in 2014. This expressed concern about the under-reporting of crimes.

- 5.30. On 23 September 2004, a gold command meeting⁴² was held. Seven individuals were listed as being present and three individuals gave apologies. The minutes did not identify who was chairing the meeting and/or acting as gold commander. There were two officers of superintendent rank present; one was the SIO and the other Detective Superintendent B, who was in command of public protection. The review team also noted that Detective Chief Superintendent A gave his apologies for that meeting. That officer has retired from the police and did not respond to a set of questions we sent him. The minutes recorded that Detective Superintendent B provided an update on progress. This officer has provided a written response to the review team and has stated: "I do not recall much about operation Augusta, so it is likely I was not involved in the operation especially in the management of it as it was run by the other half of headquarters CID namely the major incident team."

⁴² Gold meeting minutes, 23 September 2004.

Mid-term phase: October to December 2004

- 5.31. On 23 November 2004, the SIO stated in his strategy review that good progress was being made given that there had been long-term extractions of two members of his team. He stated that arranging interviews with the 26 potential victims had been slow as the joint protocol agreed by the gold group required lengthy research, planning and strategy meetings between joint agencies prior to any approach being made. He was not optimistic that the enquiry would be completed by Christmas. He noted that B Division was keen to complete as soon as possible to get staff back and that the force tasking group would be aware that he needed more time. On 7 December 2004, he recorded that two victims from the original list of 26 had now been video interviewed and provided evidence that supported charges against two men for child abduction and incitement to commit indecent acts. He also stated: "Arrangements are ongoing to interview remaining victims and are at various stages of progression."
- 5.32. We have reviewed a document called *Operation Augusta joint protocol*. The protocol had no date, but it appeared to have been formally agreed between GMP and Manchester City Council in December 2004.
- 5.33. The Operation Augusta joint protocol set out two primary objectives:
1. "For GMP and Manchester Children and Families Social Care to work together in order to identify and wherever possible prosecute people concerned in the exploitation of young people in the Greater Manchester Area, for commercial sex or other illegal sexual activities, particularly children under the age of 18 years.
 2. "For GMP and Manchester Children and Families Social Care to work together in order to review procedures and introduce such measures that ensure the risk of child sexual exploitation to vulnerable children under 18 years of age is significantly reduced."

5.34. In terms of its investigative strategy, the protocol stated:

- “The investigation is to be limited to concentrating on criminal offences revealed in conducted interviews and enquiries with the 25 named victims specifically highlighted within the ‘source document’ [final report from DI A].”
- “Any interview of the victims will follow a strategy meeting coordinated by the Manchester Children, Families and Social Care Team Leader.”
- “The identification and interview of other potential victims or witnesses that might aid the investigation remains at the discretion of the Senior investigating Officer.”

5.35. The Operation Augusta HOLMES account had 428 actions, 783 documents, 76 statements and 226 exhibits recorded. The review team spent five days considering a significant proportion of the information held in the account on both adults who were either designated suspects or nominals, and young people either recorded as designated victims or nominals. The HOLMES account did not have a category for ‘persons of interest’⁴³ but the review team identified 68 nominals who could reasonably be assumed to have been among the potential 97 persons of interest referred to in the earlier scoping report. The HOLMES account had 42 designated victims (including the deceased Victoria Agoglia) and five designated suspects. While we are sympathetic to the SIO’s view that the team was insufficiently resourced to undertake a large-scale investigation, we do believe that, in the initial stages at least, this is indicative of an aspiration to meet the challenges set out in the scoping phase to tackle the sexual exploitation throughout a wide area of a significant number of children in the care system and investigate the potential 97 persons of interest. We can see evidence that the SIO intended to commence with the 26 victims identified in the final report and maintain a focus on these. Nonetheless, the formal inclusion of the potential 97 persons of interest and the ultimate inclusion of 41 designated victims on the HOLMES account does point to a more ambitious intention. This is completely in line with the concerns expressed by the officers who completed the final scoping report and the concerns expressed by Manchester City Council social care staff.

⁴³ The report author defined a person of interest as a perpetrator, a facilitator or an associate of either.

- 5.36. In his written submission to the review, the SIO stated: "Mention is made in [DI A's] source document (para. 5.1) of the nominal index indicating 'in the region of 97 persons of interest' with 'maybe some duplication'. As I recall, the officer's assessment of the intelligence sitting behind the enquiry relied heavily on speculation. Once I had assumed command of the investigation I started with a fresh perspective and focused on victims and information obtained by my own team that we could rely upon as being accurate gleaned from their accounts rather than being speculative. We focused on reliable and tangible evidence gathering from victims/witnesses and created suspects based on what we could prove and verify."
- 5.37. This is supported by Detective Sergeant A, who informed us in a similar vein: "I was aware [DI A's] report extended to more than 26 victims and similar for POI (persons of interest), aware of refined number of victims was likelihood, but they weren't firm lines of enquiry which we could develop. I might be wrong but from what I recall the information was all historic and outdated intelligence that we couldn't develop and run with. Our starting point were 26 names you could work with, which could be potentially lines of enquiry, but we were not given things on a plate. There was intelligence regarding names that could be involved in the network, a lot of references to curry houses. They did have CCTV cameras and other hotspots identified in the report that we tried to develop without success."
- 5.38. We are not persuaded by this assertion. The work we have undertaken on the HOLMES account points to at least 68 adults potentially posing a threat to children and our review of the HOLMES account and Manchester City Council social care files has not provided sufficient assurance that the degree of risk these individuals presented was responded to appropriately. We will return to this issue in some detail, later in this report.
- 5.39. The joint protocol also clearly anticipated the deployment of a range of proactive tactics beyond the interviewing of potential victims. These included:
- "To formulate suitable activities for gathering intelligence or information that would assist in the formulation of proactive activities to assist and complement the investigation.
 - "Create target profiling in respect of individuals, locations and premises.

- “Utilise the collation and analysis of all sources of intelligence including any Telecommunication interrogation.
- “Consideration of static or mobile surveillance in compliance with the Regulation of investigatory Powers Act 2000.
- “Establish mechanism for early intervention and interview of young people who return to residencies after a period of being reported missing... to capture high quality intelligence and preserve forensic or other useful evidence where appropriate.”

5.40. The SIO informed the review team that the operation had considered proactive as well as reactive tactics. He surmised that these probably would have been in the form of surveillance around chosen hotspots and premises believed to be of significance, adding “I don’t think we had sufficient resources to undertake this sort of activity”. The review would agree with the SIO’s view on resources, although we did find one entry in HOLMES in relation to a drugs warrant being executed at a takeaway where CSE was suspected. GMP has also identified a further two search warrants conducted during the operation and another search following an arrest. The review team found one HOLMES action for enquiries to identify a suspected perpetrator, which was updated in April 2005 as “pending proactive phase of operation”. This action was subsequently closed in July 2005 as “no resources available for proactive operations”.

5.41. Detective Sergeant A informed us that the Augusta team tried to educate residential staff on how to disrupt offenders by monitoring telephone calls to young people and informing the potential abusers of the age of the child and the fact that they were looked after. This strategy was designed to capture the evidence to act under the Child Abduction Act legislation and to disrupt offenders. The review team has seen examples of this guidance document, which was apparently provided to all residential establishments.

5.42. The SIO recorded in his policy book that: “On 2 December 2004 a Gold meeting was held at Manchester town hall attended by the SIO, staff from the FSU and senior managers from Manchester City Council Children, Families and social care department. Apologies were tendered by the GMP press officer.” He did not mention anyone above the rank of chief inspector. It is, therefore, not clear from that policy book entry who was acting as gold commander. We have searched the HOLMES account and

asked both GMP and MCC for the minutes of this meeting, but no one has been able to provide the review team with this information.

- 5.43. On 7 December the SIO noted in his policy book that Manchester social services had committed to another six months and he strongly recommended that the investigation continued into next year. The SIO informed the review team that a major resourcing issue was that the seconded staff had been provided on short-term agreements. Some were also moving posts or taking up acting duties that posed problems around the consistent and long-term staffing of the Augusta team. The SIO noted in his policy log that the operation would not be concluded by the end of December and the GMP Tasking and Coordinating Group would need to decide whether the force would similarly support it into the New Year. On 14 December, he reported that the embedded social worker (team manager A) had been replaced by team manager B with immediate effect.
- 5.44. On 22 December 2004, one suspect (Suspect 5) was charged with child abduction. The child in question was not a designated victim on the HOLMES account nor one of the 25 children identified within the scoping phase.

Final phase: January to July 2005

- 5.45. On 5 January 2005, a further suspect was arrested for offences against a child. Although this child was a designated victim on HOLMES, she had not been identified during the scoping phase and did not form part of the SIO's original target group. On 27 January the SIO met with Manchester Children and Families Services senior management to discuss phase two of Augusta, which was designed to prevent and detect similar offences. This meeting was described as 'Operation Augusta phase two – The way forward'.
- 5.46. On 31 January 2005, a detective superintendent from the Force Major Incident Team conducted a full investigative assessment with the SIO (as was the norm for all investigations FMIT was involved in). This was to ensure all lines of enquiry had been pursued properly. The review team requested the record of this review and was informed by GMP that the only record of the review was that recorded by the SIO in his policy book. This stated: "The SIO gave an outline of the major lines of enquiry and strategies adopted to aid the assessment process." The SIO has informed the review team that there was nothing arising from that review that would suggest any issues.
- 5.47. In early 2005, Suspect 5 pleaded guilty to abduction offences against a child. On 11 March 2005, the SIO updated his policy log. He summarised that two suspects⁴⁴ had been charged, six of the 27 identified victims were still left to be progressed, and all the others had either made witness statements or had no evidence or complaint.

⁴⁴ We discuss the criminal justice outcomes arising from Operation Augusta in chapter seven

5.48. On 21 March 2005, the SIO met with the deputy SIO and Detective Sergeant A and agreed to add three new victims to the investigation. These were:

- a child regularly reported as missing from a residential unit
- a child who had made an allegation of rape
- a child who, though not in care, had disclosed to a nurse she was being contacted by Asian men, plied with alcohol and having sex.

5.49. On 6 April 2005, the SIO had a meeting with Operation Augusta staff. At this meeting he received updates on current enquiries and some potential victims who had been “refused”. The SIO outlined his reasons for not accepting these enquiries. This was mainly that he wished to complete all the enquiries relating to the existing victims list, of which there were still six outstanding. He also explained that there was an “important command meeting on 22 April 2005, followed by a Gold meeting. This would be when the future plans for Operation Augusta and timescales would be discussed”.

5.50. On 22 April, the SIO attended a meeting with Detective Chief Superintendent A and Chief Superintendent A. According to the SIO policy log, Chief Superintendent A stated he was unable to put permanent staff into Operation Augusta and that the operation would finish on 1 July 2005. The review team requested a copy of the notes of the meeting between Detective Chief Superintendent A, Chief Superintendent A and the SIO and was advised by GMP that they could not be found.

5.51. Greater Manchester Police approached Chief Superintendent A on behalf of the review team. In his written response, he informed us that:

- In late 2004/05, because of police reorganisation, he became the commander for the new Manchester Metropolitan Division.
- Large investigations were controlled by the serious crime division, not the local police areas.
- He had no recollection of Operation Augusta and could not assist further.

- 5.52. Chief Superintendent A was the divisional commander supporting the investigation by providing staff resources. The review team notes that the original decision by the force tasking meeting was to allocate a major incident team to the Augusta investigation, supported by divisional staff. We have been unable to clarify who was the gold commander for Operation Augusta; however, it would have been likely to have been an officer of at least chief superintendent or assistant chief constable rank.
- 5.53. The SIO policy log recorded that later that day (22 April 2005) a gold group meeting was held at Manchester Town Hall. The review team requested a copy of the minutes for that meeting but neither GMP nor Manchester City Council was able to provide a copy. The SIO policy book stated that it was attended by senior officers from GMP and Manchester City Council with their respective communications officers. It is recorded: "Update of operation given. Press strategies discussed, and group informed of finishing date of operation namely 1/7/05." The SIO listed who was present but did not record that either of the senior police officers attended⁴⁵.
- 5.54. It is our view that it is highly improbable that a decision to close an investigation of this type, with the potential risk to children and public confidence in police and social care services, would be made below the rank of chief superintendent or assistant chief constable.
- 5.55. The SIO made no further entries in his policy book after the Augusta team meeting on 8 April 2005. The subsequent entries, few in number, were in a different handwriting and the SIO informed the review team that these were completed by the deputy SIO, who appeared to have been given the task to review unallocated actions. The pages we viewed mentioned various reasons why enquiries concerning three potential victims were either to be progressed or closed.
- 5.56. The SIO conceded that staff were a little disappointed when the operation
-

⁴⁵ SIO policy book entry 71, page 3.

was ended, “but this was the decision of the Gold Group”. Detective Constable B was more defensive: “Look at it from our perspective we didn’t get the resources to deal with the job. There was an educational issue – Asian males didn’t understand that it was wrong, and the girls were not quite there. They were difficult groups to deal with. We can’t enforce our way out of the problem.” Detective Sergeant A informed us that the Augusta team made sure that there were not any cases outstanding or victims who were at risk, and that this was coordinated from a multi-agency perspective by the embedded social worker in the team. “My recollection is that she and I had to be confident that there was no ongoing risk prior to closing them down.”

- 5.57. Another member of the team, however, did express some concerns. “Yes, I felt the operation closed down too soon in my personal opinion. I was surprised as we were starting to get names and build up an intelligence picture of certain males. We’d just had our first successful arrest and charge. It felt like we were starting to make headway, thinking there was going to be a benefit to the investigation, a light at end of tunnel and then it closed down.”
- 5.58. The evaluation report⁴⁶ written by Detective Sergeant A in August 2005 explained that of the 25 potential victims identified by the scoping exercise, no evidence of child sexual exploitation (CSE) was substantiated in relation to 21. This was said to be because either the potential victims did not engage with the police or independent evidence was not identified. Two of them made allegations of relevant offences but with insufficient evidence to act. Two engaged with police and the offenders were arrested and charged with relevant offences. During the operation, the SIO exercised his discretion in respect of six new potential victims: four were identified because of enquiries by staff working on Augusta, one was referred from South Manchester CID and one referred by South Manchester Family Support Unit. Of these six, there was insufficient evidence in respect of three children, but arrests were made in relation to the other three.

⁴⁶ Operation Augusta evaluation report, 25 August 2005.

5.59. The evaluation report also stated that the operation was responsible for the arrest of five offenders; four of these were Asian and one was white. (However, we have identified that on HOLMES one of the suspects is referred to as of Tunisian origin and not Asian). The evaluation report listed the offenders:

- One was convicted of four counts of child abduction and received a community rehabilitation order.
- One (at the time of writing the report) was charged with several serious sexual offences against a girl under 16.
- One was remanded into custody for serious sexual offences against girls aged 14 and 15 living outside the Manchester city area.
- One was remanded on bail and charged with child abduction of a 14-year-old known to Manchester social services.
- One was remanded on conditional bail charged with rape of a 16-year-old known to Manchester social services.
- In addition, two offenders were officially warned under the Child Abduction Act – one, a woman, had detained a 12-year-old looked after child; the other, an Asian man, had removed and detained a 15-year-old child known to Manchester social services.

5.60. The SIO informed the review team: “Nonetheless, a phase II operation was considered for longer term and is referenced in my policy log from February 2005 onwards. Also noted (entry 67) is a restructure of the Force’s Family Support Unit being scheduled. It was recommended in the post Augusta report these types of vulnerable victims and cases could be incorporated into the role and responsibilities of the new unit. As I recall a new multi-agency ‘PROTECT’ team dedicated to tackling CSEA (Child Sexual Exploitation and Abuse) in Manchester was later established.”

5.61. However, having reviewed the entries in the policy log, we believe this was overly optimistic in respect of responding to and mitigating the risks faced by the children at the time, and instead referred to a strategic intent to learn the lessons of Operation Augusta for future years. We have seen no evidence that the young people identified as victims were in any way formally handed over to other sections in GMP – even though in some instances significant relationships had been built up with the officers on the operation.

Summary

5.62. We believe that there is much in Operation Augusta to be commended:

- Greater Manchester Police responded positively to the known threat of child sexual exploitation by setting up a dedicated team of officers to scope the size and nature of the problem. Within a few months, the scoping exercise presented a compelling picture of sexual exploitation of children in care in South Manchester. As we shall demonstrate in more detail later, this abuse had been known and understood by police, residential workers and social care staff for several years, but the death of Victoria Agoglia had served to bring this into sharp focus.
- The decision to allocate a major incident team to the operation by the GMP Tasking and Coordinating Group demonstrated a commitment at the highest level to tackle these crimes. Several of our interviewees suggested that this was also prompted by concerns in respect of the pending broadcast by Channel 4 of the documentary on Keighley. We have also found several contemporaneous references to senior staff tracking the progress of that programme and its reputational impact once it was eventually broadcast. Notwithstanding some of this broader context, the decision by the GMP Tasking and Coordinating Group to move the operation to the investigative stage evidences a determination to address the issues identified by the scoping exercise.
- It was recognised from the outset that Operation Augusta needed to be a joint investigation with children's social care. A gold command structure was put in place and this included the Manchester Director of Children and Families Services and the assistant director. At the first meeting in July 2004 it was agreed that a social worker would be incorporated into the team to assist with the interview processes. The joint protocol with children's social care was formally agreed in December 2004, but it is clear that this was being discussed by the SIO with senior officers in Manchester City Council at the commencement of the operation. Manchester City Council put in place two highly regarded managers in succession. The joint nature of this investigation has been described to the review team as

“groundbreaking”⁴⁷ and it is fair to say that joint agency investigations were less the norm than they have become in more recent years.

- Greater Manchester Police appointed an experienced and competent senior investigating officer with a track record of leading similar operations. We have no doubt the force’s intention in appointing him was to ensure the operation had the best possible outcome. We have also been impressed by all the staff we have met who worked on the Augusta operation. They evidenced their commitment to ensure the right outcomes for children were achieved wherever possible and the records indicate they approached this task with the required energy and rigour.
- The operation was not without its criminal justice successes – seven offenders were apprehended and we analyse them further in Chapter Seven. We will also evidence where there were examples of a proactive approach, particularly by the police constables on the team. This was beginning to achieve results despite the reluctance of the victims to engage with the police.

5.63. However, we also believe that there were some fundamental flaws in how Operation Augusta was resourced, and this had a significant negative impact on the investigation strategy and how it was ultimately terminated.

- Within a few weeks, the team was insufficiently resourced to meet the demands of the investigation. Although there had been a commitment to staff the operation from both the Force Major Incident Team (FMIT) and Family Support Unit, this was immediately problematic. The dedicated MIT was almost immediately re-allocated to a murder investigation. The staff subsequently recruited onto the team were not detectives fully trained in working on serious and complex investigations. The SIO was not working on the operation full time, the deputy SIO was replaced in October by a part-time SIO, and the seconded detective sergeant maintained his additional headquarters functions during his time on Augusta. Once the FMIT resources were withdrawn there was a heavy reliance on the South

⁴⁷ The SIO told the review team in his written submission 12: “Operation Augusta turned out to be groundbreaking in approach by pragmatically applying ‘working together’ principles.”

Manchester Family Support Unit, which would only conduct interviews with potential child victims on overtime.

- Ownership of the operation was problematic. There was no central responsibility for child sexual exploitation, and this resulted in problems in locating a base. Also, issues were split between three Manchester divisions resulting in dispute and conflict between three divisional commanders as to who should put resources into it, and this continued throughout the operation as staff changed. The SIO's policy log had several references to the difficulties presented by staffing the operation with a small team of staff, some of them part-time and most of them loaned from other areas.
- Although it was agreed the operation would utilise HOLMES, the team was dependent on the support of the Wythenshawe major incident team to input this. Detectives on the team informed us that this led to delays and resentment.
- The evidence suggests that the SIO began the operation with the intention of tackling the problems identified within the scoping phase. A key indication of his intent was the entering of the potentially 97 persons of interest identified by the scoping phase, and the 25 identified victims, onto the HOLMES database. It quickly became apparent that this would not be quickly achievable given the resources at his disposal and this would have been even more evident by the autumn, given the slow progress made in interviewing the victims.
- Fundamentally, we believe, from what we have seen, that the decision to close Operation Augusta was driven by the decision by senior officers to remove the resources from the investigation rather than a confident understanding that all lines of enquiry had been successfully completed or exhausted.
- The investigation strategy placed too heavy a reliance on the victims' willingness to make a complaint. The process was set out as early as July in a memorandum from team manager A to her line manager. She explained: "It was agreed that there would be a two-stage approach to an initial shortlist of 10 of 26 young people within this operation. First stage being a tentative enquiry to establish if the young person had any concerns and if so were they willing to speak to the Police and SSD on a formal basis or an intelligence basis. The second stage would be to progress to ABE interview for forensic purposes." As resources and time ran out, the laudable intention to investigate the sexual exploitation of a significant number of looked after children became reduced to closing down the majority of the cases because the child refused to make a complaint. Sadly, a

significant recommendation⁴⁸ set out in the Part 8 review was not followed and the mistakes evidenced in the tragic death of Victoria Agoglia were repeated.

- Critically, the problem that Operation Augusta had been set up to tackle, namely the sexual exploitation throughout a wide area of a significant number of children in the care of Manchester City Council by a group of Asian men, had not been addressed, very few of the relevant perpetrators were brought to justice and neither were their activities disrupted.

⁴⁸Recommendation 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.

Chapter Six

The children

- 6.1. Our role as a review team was not to undertake a reinvestigation of Operation Augusta but required us to consider the reason for Operation Augusta being closed down, the level of safeguarding and protection afforded to the victims, and the action taken in relation to the suspected perpetrators.
- 6.2. We therefore set three tests to consider in relation to the records held by Greater Manchester Police and Manchester City 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 Manchester City Council? In this regard we judged the response in line with the Manchester Area Child Protection Committee procedures that were in place at the time.⁴⁹
 - Were the risks the identified adults presented to children appropriately dealt with by either Greater Manchester Police or Manchester City Council?
- 6.3. The numbers of potential victims identified by Operation Augusta grew significantly during the investigation:
- The SAFCOM report originally identified 11 potential victims.

⁴⁹ "If the outcome of the assessment determines that a child is actually, or is likely, to suffer significant harm due to child sexual exploitation a Section 47 strategy discussion/meeting should be held....If the section 47 Strategy Discussion/ Meeting determines there is actual or a likelihood that a child is suffering significant harm due to Child Sexual Exploitation then formal child protection procedures must be initiated." *Manchester Area Child Protection Committee child sexual exploitation procedures, 2004.*

- By May 2004, the final report of the scoping phase⁵⁰ had identified an additional 15 potential victims, making in total 26 victims and potentially 97 persons of interest.
- An indexing policy document dated 16 September 2004 noted that all the potential victims were allocated a victim number. V1 was noted as the deceased subject of a separate investigation/conviction. V14 was marked as MASTER of V23, and V23 marked as a subsidiary of V14. This therefore reduced the potential victims to 25.
- The evaluation report stated that in addition to the initial 25 potential victims, the SIO added six potential new victims, a further two victims were identified as the result of enquiries following arrests, and a ninth added, being a victim of abduction for which an offender had been warned, “bringing the total of young people dealt with by the operation to thirty-four⁵¹”.
- The report written by the quality assurance officer from Manchester City Council listed the 34 potential victims⁵²
- In our examination of the HOLMES account we identified that there were, in fact, 41 nominals assigned with a victim number. We compared these 41 with the potential victims listed in the quality assurance officer’s report and established that six of the 34 young people were not allocated a victim number on the HOLMES account. There are, therefore, an additional 13 young people that the investigation team designated with victim numbers that are neither referred to in the evaluation report of May 2005 nor the report by the council quality assurance officer in July 2005.
- Furthermore, on examining the HOLMES account and sampling the nominal records, we were able to identify an additional 10 names of children who had been put forward by professionals or other children as potential victims.
- In summary, adding the 41 designated victims to the additional six identified in the quality assurance report along with these 10 makes a total of at least 57 children identified as potential victims of child sexual exploitation. We do not believe this is the definitive total.

⁵⁰ Operation Augusta final report, 13 May 2004.

⁵¹ Operation Augusta evaluation report, 25 August 2005.

⁵² Joint operation – child sexual exploitation report, Manchester City Council, 31 July 2005.

- 6.4. During our review of the HOLMES account, we considered the circumstances of 25 children, and to ensure the robustness of the exercise, every action raised, document, message and multi-agency report was analysed for each child.
- 6.5. Following this detailed analysis, we reviewed the information held by Manchester City Council on the social care files. The sample of 25 children we selected was as follows:

Sample A	Children 1 to 9 were all listed in the original SAFCOM report.
Sample B	Children 10 to 18 were from the children added as designated victims who were not originally included in the SAFCOM document.
Sample C	Children 19 to 25 were nominals not officially designated as victims but identified by the review team as being children who could be potential victims of CSE.

- 6.6. The detailed information in respect of each of their cases is set out later in this chapter. We were supported in this exercise by Manchester City Council officers, who had undertaken a very conscientious and thorough review of the files. Our conclusions, without exception, concurred with the findings of that review. The records showed that from 2002 onwards there were multi-agency meetings to consider the concerns presented by child sexual exploitation (CSE). These meetings were originally termed 'child

prostitution meetings⁵³, but by mid-2003 they were called CSE strategy meetings. The term “child prostitution” was set out in the *Working together* guidance (1999 update) and in subsequent Department of Health publications in 2001 and 2002. We therefore imply no criticism of staff for using this term during this period and, in fact, the Manchester partnership took a progressive position in 2003 by using the term child sexual exploitation.

6.7. We established the following:

- There was clear evidence that professionals at the time were aware the young people were being sexually exploited and that this was perpetrated by a group of older Asian men. There was significant information known at the time about these men’s names, their locations and telephone numbers, but the available evidence was not used to pursue offenders.
- Perpetrators appeared to be operating in ‘plain sight’, hanging around in cars outside care homes and foster homes and returning young people to their care addresses.
- A key concern was that the focus of the strategy meetings was on agencies encouraging young people to protect themselves rather than providing protection for them. There was very little evidence from the social care files of the deployment of disruption strategies to protect the young people.

6.8. We have deliberately removed much of the specific detail in the descriptions that follow to ensure that the individuals who were children at the time cannot be identified. However, we believe it is important that this report also captures the distressing experiences that these vulnerable children were subjected to.

⁵³ The term ‘child prostitution’ is regularly used within the GMP and MCC records of the time to describe child sexual exploitation. We have therefore utilised that term when we are quoting from the records. The term child prostitution was set out in the government inter-agency guide *Working together to safeguard children* (1999) and also in subsequent Department of Health publications in 2001 and 2002. We therefore imply no criticism of staff for using this term during this period and in fact the Manchester partnership took a progressive position in 2003 through the use of the term ‘child sexual exploitation.’

- The age of the children, in our sample, who were being exploited ranged from 12 to 16. Most complaints related to children aged 14 to 16. Children as young as 14 were reported to have “boyfriends” in their mid-20s and were said to be placing themselves at risk.
- A child was heard to tell carers that she would “go to various houses with groups of Asian males aged 18 to 23 and have sex. She had been with a 23-year-old male the previous night and he introduced her to his brother The girls are allegedly forced to have sex with the men”.
- A child who was still very young reported that she had been restrained by a man in his mid-20s who then seriously assaulted her and committed an extremely serious and distressing sexual act.
- Care staff reported on one child that there was a network of Asian men and it was likely that this was where the child was getting her money from. The social worker said that one of the men would have given the girl money and this led on to her being sent to different establishments for sex.
- Carers reported to police that a child had provided information stating that she was being “pursued/threatened/coerced” into having sex by two men, who were Asian. She was interviewed, declined to speak to police, but did provide information giving one man’s name and explaining that she was afraid.
- A child begged her carers to get her away from Manchester as she was too involved with Asian men. She disclosed that an Asian man known by his nickname “made her do things she didn't want to do”.
- A child described how she would go to flats with friends. At the flats she would be given drink (vodka or similar) and drugs (cocaine) and there were lots of Asian men in the flats. She described how she would “have sex with them without a fight” and “do whatever they wanted us to do”. She was generally paid a significant sum of money.

In conclusion, we found clear evidence on the social care files that the young people were not well served or protected by the statutory agencies.

Children listed in the SAFCOM report

- 6.9. The cases of nine of the 11 children referred to in the SAFCOM report were examined, including that of Victoria Agoglia. All these children were looked after; one child may have been looked after by another local authority as there are no significant records on the Manchester system. **We have concluded that there is a significant probability that all but one of these children had been sexually exploited. We cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council or, in the case of Child 3, the responsible local authority.**

Victoria Agoglia

- 6.10. Victoria Agoglia's history is outlined in more detail earlier in this report. Victoria was repeatedly threatened, assaulted, returned intoxicated and in distress, gave information that she was involved in sexual exploitation, alleged rape and sexual assault, required medical attention, became involved in the criminal justice system and had several pregnancy scares. Not one of these occasions resulted in a Section 47 investigation or a thorough assessment of what was required to protect her from harm. The review team's judgement is that there was a significant probability that Victoria Agoglia had been sexually exploited and we cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council.

Child 2

- 6.11. Child 2 was a female child, adopted onto Operation Augusta. It was reported that she was "having sex for drugs". Child 2 was returned to live at home in 2004 and regularly went missing. She was linked to a nominal on the HOLMES account. His full name and date of birth was known, and he was of Asian heritage. He was in his early 20s. He was not classified as a suspect on HOLMES and was never arrested. A strategy discussion was held in 2005. It was decided that the police were not to approach her as she was described as having contempt for the police, and as such her social worker would attempt to contact her. A month later a telephone call was made by a member of the Augusta team to the social worker, who explained she had not managed to contact Child 2. The social worker later left a message to say Child 2 had moved and she did not know her address. By the

summer there had not been any contact from Child 2 and her address remained unknown. A decision was put on HOLMES that she “is no longer considered a victim and filed pending her making contact”. This was two days before the end of the operation. The review team’s judgement is that there was a significant probability that Child 2 was being sexually exploited and we cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council.

Child 3

- 6.12. Child 3 was a male child looked after in a residential unit. The residential home believed he was a suspected drug user and connected with the gay community. They were concerned he was staying with an adult who was having a negative impact on him. Although the boy’s name was registered on the Manchester City Council children’s system there was no other information or trace of his files. He may well have been looked after by another local authority. There was no record of multi-agency meetings and no associates listed on the HOLMES account. There was a note on HOLMES indicating “victim researched – no further action required”, and in April 2005 a further note said “not deemed relevant to enquiry by joint protocol and enquiry”. The review team’s judgement is that there was insufficient information on the files we viewed to form a judgement as to whether Child 3 was being sexually exploited. However, we have been presented with no information to suggest this was actively considered. We are unable, therefore, to offer any assurance that these concerns were appropriately addressed by either Greater Manchester Police or the responsible local authority.

Child 4

- 6.13. Child 4 was a female child accommodated by Manchester City Council when adopted onto the Augusta investigation. She had several residential placements. The statutory reviews outlined issues of sexual exploitation and what were described as behaviours that put herself at risk. The HOLMES account identified significant links with at least eight men who were entered as nominals on the HOLMES account. One was a man known

by his full name, address, mobile telephone number and date of birth. There were lots of recorded instances where he displayed behaviour consistent with exploiting female residents of the residential unit. He was given several warnings by police for his behaviour but was not shown as a suspect on HOLMES or as being arrested. A different girl stated that this man introduced her to Asian men for sex and indecently assaulted her. A “child prostitution” strategy meeting held in July 2002, on Victoria Agoglia, also recorded that this man had introduced her to two Asian men for the purpose of exploitation. There was a record on the HOLMES account that described him being warned not to associate with Child 4, but he continued to buy her alcohol and bring it to her in the unit. Staff believed he also provided cannabis to some of the residents.

- 6.14. The review team also had sight of an undated typed document that listed five male associates with their addresses and dates of birth. One of these was the man referred to above. “[He] is believed to be at least a ‘facilitator’ who introduces children to Asian men for sex although a social worker has stated to [Detective Constable B] that he was believed to have been caught having sex with Victoria Agoglia prior to her death. No record of anything recorded by Police.” It was also stated that Child 4 was an associate of three of the other children in our sample.
- 6.15. In our work with Manchester City Council it was unable to locate any Section 47 discussions or joint investigations. However, successive CSE strategy meetings in 2003 and 2004 reported significant concerns in respect of sexual exploitation. One strategy meeting recorded that “child sexual exploitation is suspected with another young person [name] whom Child 4 has been associating with”. She was reported to have a “boyfriend” in his late 20s. By spring 2004, the review outlined that “[Child 4] developed a small network of interested males that are currently seeking [Child 4]’s attention”. She was described as “placing herself in a position of being sexually exploited”. Subsequently, a planning meeting was held between Operation Augusta detectives and social services. Child 4 was believed to be willing to speak to the police.
- 6.16. An action was raised by the SIO to “fully research [Child 4] interview after liaising with Manchester children families and social care and ascertain whether she is a victim of CSE”. A detective visited Child 4 and during this visit, Child 4 started to disclose some concerns about CSE. The detective

stopped the conversation as it needed to be subject to an ABE⁵⁴ interview. The detective agreed to come back “in a couple of weeks”. A strategy meeting was held subsequently, and a detective recorded the social worker as stating that Child 4 was “somewhat unreliable and was prone to fabricate facts”. The review team identified five further entries where an officer tried to liaise with the social worker. The handwriting varied so we have assumed that more than one officer had attempted this. The fifth entry stated: “[Child 4] not engaging with SSD and unable to engage with [Child 4] at all.” There was a handwritten note on the paper with an action date in mid-2005: “As discussed, Officers report is badly worded. The subject did meet the threshold for investigation by Augusta. The investigation has revealed no evidence of CSE.” The review team’s judgement is that there was a significant probability that Child 4 was being sexually exploited and we cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council.

Child 5

- 6.17. Child 5 was a female child placed in residential care in Manchester. She was the subject of several CSE strategy meetings between 2002 and 2004. In 2002, she alleged that she was sexually assaulted by an adult male. Greater Manchester Police also recorded her as a victim of two sexual offences. The minutes of a CSE strategy meeting in 2003 stated that [Child 5] “has been persistent in leaving the unit at night and going to a house in the local area. The house is owned by [Name]. This man is rumored to be involved in putting children on to the streets for prostitution. [Child 5] receives telephone calls late at night and during the early hours of the morning. She then insists on leaving the unit immediately... [Child 5] has returned to the unit with cigarettes sweets, crisps although she does not appear to be in receipt of large amounts of money”. The meeting also heard that a member of the residential staff had visited the home of this man and saw two or three Asian men there. They offered information that activities were taking place with Child 5 of a sexual nature. They said they

⁵⁴ Achieving Best Evidence. The principles of Achieving Best Evidence (ABE) are set out in the Youth Justice and Criminal Evidence Act 1999 (YJCE).

knew Child 5 and she was performing sexual acts on men. Local police officers warned this man on several occasions but were not convinced he was exploiting the girls. The prevailing view was that he was being used by the girls and Asian men. Despite these continued concerns, no CSE strategy meetings were held after mid-2004. The HOLMES account contained the following action, “fully research [Child 5], interview after liaising with Manchester Children, Families and Social Care and ascertain whether she is a victim of CSE”.

- 6.18. Child 5 provided a video interview alleging indecent assault against an adult male. She also stated that he introduced her to Asian men for sex. In mid-2005 there was a statement put on HOLMES that it was reasonable to believe that Child 5 had been exploited by at least two individuals, but no further action would be taken as she was not credible as a prosecution witness. The review team’s judgement is that there was a significant probability that Child 5 was being sexually exploited and we cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council.

Child 6

- 6.19. Child 6 was a female looked after child. The HOLMES account recorded that she had disclosed to her residential worker that she was going to addresses in Manchester “with up to 20 males” and would then perform oral sex in exchange for drugs. Child 6 was linked to numerous suspected perpetrators on the HOLMES account. One of these was a man whose name and address was known. He had been arrested by another police force in relation to abduction. He was described as a drug dealer who threatened her and was believed by her carers to be procuring her for sexual activities with adult males. This man had previously been arrested for the abduction of another child, but that case was not taken forward as the child declined to cooperate with the police.
- 6.20. In our review of the files held by Manchester City Council, we found substantial concerns in respect of the sexual exploitation of Child 6 yet there was no evidence of a formal Section 47 investigation. It was reported at a CSE meeting that she had been heard to describe being forced to have sex with Asian men. A detective sergeant present at the meeting was

reported as saying that if [Child 6] was willing to prosecute the police would investigate it. He added that “there have been similar meetings to this about other young girls in the area targeted by the same Asian males and there is currently an ongoing police operation in respect of the concerns”.

- 6.21. In 2003, Child 6 made a witness statement in which she explicitly said that this man had planned to abduct her. She insisted he did not know her age but did know she was in care. She stated she had not had sex with him. The statement was taken following the arrest of an Asian man and a woman for abduction. The content of the statement led to the man eventually being released without charge.
- 6.22. At the subsequent CSE meeting it was stated that her needs were now being met and the detective sergeant would enquire if the police had enough information to warn the man that if Child 6 was found in his company then he could be arrested.
- 6.23. The investigative phase of Operation Augusta commenced nine months later. A report on HOLMES stated that Child 6 appeared more settled in her placement and had stated she did not want to be visited by police officers or engage with the Augusta investigation. The report stated: “I respectfully suggest that she does not meet the threshold for further investigation by Operation Augusta at this stage and request all matters relating to her be filed pending any further information coming to light. [Named social worker] is aware of this course of action and has been furnished with Operation Augusta contact information, which she will retain and forward to her if required. This matter has been discussed fully with [named senior social care manager] who has been party to all information and fully supports the action.”
- 6.24. An entry was put on the HOLMES account by Detective Sergeant A on behalf of the SIO: “[Child 6] has refused to engage with police.”
- 6.25. The review team’s judgement is that there was a significant probability that Child 6 was being sexually exploited and we cannot offer any assurance

that this was appropriately addressed by either Greater Manchester Police or Manchester City Council. Significant concerns were not pursued with the required rigour to protect her from exploitation when it first came to the attention of the agencies and it is not apparent from either the Manchester City Council or GMP records that sufficient attempts were made to engage with her and win her trust subsequently.

Child 7

- 6.26. Child 7 was a female looked after child in residential care. CSE meetings in 2003 catalogued numerous instances of her going missing, returning with alcohol and drugs, and being vulnerable to sexual exploitation. There were several CSE meeting records on the Manchester City Council files but no evidence of a Section 47 strategy discussion or an intervention that effectively protected her. The professionals viewed this behaviour as a choice made by Child 7. The residential manager was reported as saying “[Child 7] is being exploited but said that this is exploitation that she is willing party to”, adding “there is no sense of coercion”.
- 6.27. Child 7 was moved out of Manchester and settled well into her new placement. There was a reference on Child 7’s paper file held by Manchester City Council that read: “There is an ACPC action plan for child sexual exploitation in the area of prevention.” It continued: “There is currently a joint investigation with GMP and CFSC⁵⁵ in relation to [Child 7] and [team manager A] is seconded to take forward the prosecution side with GMP.”
- 6.28. A report on the HOLMES account described the concerns about Child 7 being involved in “prostitution” but stated that over the previous 12 months she had “transformed herself” and now had a steady boyfriend. The report stated that this girl had led a “promiscuous lifestyle” but that there was no evidence that she had been a prostitute. The

⁵⁵ Manchester City Council Children and Families Social Care.

recommendation was that she be “removed from the investigation”. No nominals were directly linked to her on the HOLMES account as potential perpetrators and there was no record on HOLMES that she was ever directly approached and asked whether she wanted to engage with the investigation.

- 6.29. The review team’s judgement is that there was a significant probability that Child 7 was being sexually exploited and we cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council. Significant concerns were not pursued with the required rigour to protect her from exploitation in 2003 and it is not apparent from either the HOLMES or GMP records as to what attempts were made to engage her as part of Operation Augusta and win her trust subsequently.

Child 8

- 6.30. Child 8 was a female child in care placed with a residential unit. There was significant evidence on the files held by Manchester City Council that she was experiencing sexual exploitation and was regularly reported as missing. Child 8 made several complaints of a sexual nature to the police, including one of rape, and there were significant concerns that she was befriending younger residents and introducing them to exploitation. An incident report at the residential unit stated that Child 8 had described being taken to a house with another child where they drank alcohol. Child 8 described subsequently being raped. The police interviewed the other child, who reported that Child 8 “consented” and was given money. Another incident report referred to Child 8 being physically and sexually assaulted by a man in his mid-20s. In the same month, carers reported to the police that young people were buying alcohol and possibly drugs at a named local shop. Later it was stated that the owner of the shop gave alcohol in exchange for sexual favours and other young people had said that one of those involved was Child 8. A CSE meeting concluded that there were concerns that Child 8 was sexually vulnerable and was being sexually exploited, and listed several examples, including rape.
- 6.31. There was no evidence on the Manchester City Council file that a Section 47 investigation was commenced, or child protection procedures followed

in respect of any of these concerns. Child 8 had previously been involved in a case (as a victim) that had collapsed. Augusta staff formally interviewed Child 8. A decision was made that it was not in her best interest to have a second interview but to give her an opportunity to write things down. She was described as “going off the rails” following the video interview.

- 6.32. The review team’s judgement is that there was a significant probability that Child 8 was being sexually exploited and we cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council. Significant concerns were not pursued with the required rigour to protect her from exploitation when these concerns came to light, and more support through the interview and criminal justice process might have resulted in a better outcome.

Child 9

- 6.33. Child 9 was a female looked after child. She was placed in a residential unit and was brought into Operation Augusta following concerns raised at a CSE strategy meeting. Although there were substantial concerns of significant harm, there was no evidence found on the file of a Section 47 investigation, child protection procedures or any joint investigation.
- 6.34. At a “child prostitution” strategy meeting in 2002, it was reported by the social worker that Child 9 was being given money for sex with multiple men. By 2003, a CSE strategy meeting had identified the name of a man who was believed to be her “pimp”. It was also believed that he took any money Child 9 had received for sex. It was recommended from the meeting that the police pursue details of this man regarding living off immoral earnings. Child 9 provided a video interview in which she named a number of Asian men who sexually exploited her.
- 6.35. A further CSE strategy review meeting was held. While there was a reference to the previous allegations, no progress had been made on the police enquiries from the last meeting. The social worker reported that cars were still driving past the unit, but Child 9 was not engaging with them.

- 6.36. On the HOLMES account Child 9 was linked to numerous potential suspects. She disclosed rape by a named offender. She was allocated to divisional staff and a named offender was charged with assault (actual bodily harm) and indecent assault. This was mentioned at the September 2004 gold group meeting as the children's services senior manager queried why it was not being dealt with by Augusta staff. In early 2005, Child 9 gave a video interview concerning a rape allegation against one of the men. He is described in a diary kept by Child 9 as being her boyfriend but the rape allegation against him was not progressed. Crown Prosecution Service (CPS) advice stated that the case was to be discontinued because it was not in her interest to be subject to cross-examination when the "likelihood of conviction is slim" and if the case proceeded to trial this would "alert the public to this ongoing sensitive operation" (Augusta). The barrister concluded, "as a consequence I am of the opinion that it would not be in the public interest for the case to continue".
- 6.37. An entry on HOLMES summarised the various investigations. The report stated: "[Child 9] is not a credible witness for operation Augusta because of the discontinuance of the case against [name] and the reasons outlined earlier. This is the basis of counsel's advice."
- 6.38. The review team's judgement is that there was a significant probability that Child 9 was being sexually exploited and we cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council. There was insufficient regard for her vulnerability and the coercion she was experiencing at the hands of the man who was variously described as her pimp or boyfriend. Furthermore, the specific advice offered by counsel in respect of one offence was used to close the other serious lines of enquiry. Significant concerns were not pursued with the required rigour to protect her from exploitation and more support through the interview and criminal justice process might have resulted in a better outcome.

Children formally designated as victims who were not named in the SAFCOM document

- 6.39. We reviewed nine additional children officially designated as victims on the HOLMES Augusta account. Eight of these children were looked after by Manchester City Council and one by another local authority. **In seven of these cases, we have concluded that there was a significant probability that the children were being sexually exploited and we cannot offer any assurance in these cases that this was appropriately addressed by either Greater Manchester Police or Manchester City Council/the other local authority. In two of these cases we have concluded that we cannot form a view as to whether the children had experienced sexual exploitation or form a judgement as to whether these concerns were appropriately addressed by either Greater Manchester Police or Manchester City Council.**

Child 10

- 6.40. Child 10 was a female looked after child. Multi-agency CSE meetings were held in 2003 and 2004 prior to the investigative phase of Operation Augusta. There was a clear view that she was being sexually exploited but that the police needed a complaint from the child. Despite these concerns there was no evidence of a Section 47 investigation or child protection procedures being followed. Child 10 was linked on the HOLMES account to an Asian man. In 2004, she was found at his home address following her going missing. She later disclosed that she was pregnant by the same man. He had allegedly threatened the girl's family and the social worker described Child 10 as "young" and "naive" for her age.
- 6.41. An action on HOLMES set out the following: "Fully research [Child 10], interview after liaising with Manchester children families and social care and ascertain whether she is a victim of CSE." A report on HOLMES stated that Child 10 denied being sexually exploited. This report stated that Child 10 no longer reached the threshold for Operation Augusta. There was a handwritten entry on the paper copy that said "file" and an initial, which appeared to be by Detective Sergeant A.

- 6.42. The review team saw a copy of the Family Support Unit (FSU) investigation into Child 10 that occurred towards the end of Operation Augusta. A referral was made by a Manchester social worker. “[Child 10] has been subject of previous CSE meetings. She was taken to [another city] by friends of her mother’s boyfriend. She returned to [redacted] children home with a new mobile and [significant] cash. She has since received numerous telephone calls and then visits from gentlemen and hangs about on street corner.” The referral was filed as “no further police action required by the detective sergeant”. A strategy discussion was subsequently held and it was recorded that there were sufficient indicators to establish Child 10 was vulnerable to sexual exploitation but “is refusing to cooperate with any police investigation and make any complaint and the FSU detective sergeant therefore told the meeting there was little or nothing police could do under the circumstances and this was accepted at the meeting”.
- 6.43. The review team’s judgement is that there was a significant probability that Child 10 was being sexually exploited and we cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council.

Child 11

- 6.44. Child 11 was a female looked after child placed in a residential unit. The file recorded that she had numerous changes of placement. “Child prostitution” strategy meetings were held in 2002 and 2003. The minutes on file for 2002 referred to residential staff being concerned about the number of looked after children linked to Asian men in the Rusholme area and felt there was a strategy needed to deal with this. Child 11 went missing numerous times in a 15-month period. There were several meetings held about this child in respect of CSE, although Manchester City Council was unable to locate details of all these. There was no record of any investigation under Section 47 or the use of child protection procedures on the file. The focus was on staff setting boundaries to keep the child safe but there was little evidence on the file of action to protect Child 11 or of police action. In 2003, social services reported to the police that they believed that Child 11 was being groomed by two older residents. Following this, Child 11 had been seen with a succession of Asian men, many considerably older than her. Previously, Child 11 would receive phone calls during the night, get dressed and leave the unit for short

periods before returning, often with money and gifts. A meeting was held by social services and it was recorded that Child 11 had told her key worker the name of her “boyfriend”, his occupation and the address of his employer. He was in his mid-20s. Staff reported to the police that this Asian man had come to the unit, and they provided to the police his contact telephone number, a description of the car he was driving and its registration number. We found an action on HOLMES to trace and interview this man, and he appeared as a nominal in HOLMES. However, we have not located any evidence that this man was either traced or interviewed.

- 6.45. Residential staff reported to police that Child 11 was being sexually exploited by Asian men and provided a written note to that effect. In 2004 the area police officer confirmed the identity of one of these men and that he “has been verbally warned to stay away from the females, although no offences have been revealed. At this stage there is no evidence linking [name] to any offences this may well change when the female residents of the residential unit are interviewed”.
- 6.46. There were records on HOLMES that officers visited Child 11. It was recorded that she informed officers there was nothing she wished to discuss and refused to hand over her mobile for examination. In 2005 the record stated she had “spoken openly” and “appears to acknowledge she has been sexually exploited but declines to make a complaint”. Later in 2005, it was recorded that as she had declined to speak to police it was requested that the action be filed.
- 6.47. The review team’s judgement is that there was a significant probability that Child 11 was being sexually exploited and we cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council. Significant concerns were not pursued with the required rigour to protect her from exploitation when the abuse commenced, and more support might have resulted in a better outcome.

Child 12

- 6.48. Child 12 was looked after by another local authority. She was brought into Operation Augusta as she told staff while in Manchester homes that she was friendly with another child in our sample.
- 6.49. Child 12 provided a statement to police describing how she was a prostitute for a period. She described sex with multiple men and was using significant amounts of heroin a day. In late 2004, Child 12 was seen by Operation Augusta and she stated, unprompted, that she was not sexually exploited herself and did not know the identities of the Asian men and that she had not been with any Asian men. In 2005 it was agreed with the social care senior manager to take no further action.
- 6.50. The review team's judgement is that there was a significant probability that Child 12 was being sexually exploited. An opportunity was missed earlier to thoroughly investigate the statement she gave. We cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or the responsible local authority.

Child 13

- 6.51. Child 13, while in care, was believed to be associating with a gang of Asian men. The gang began to call at the home during the night. She was brought into Operation Augusta when she disclosed serious sexual exploitation to her social worker. In addition, a man described by Child 13 as a perpetrator had arrived at the residential unit asking for Child 13. He was known by his first name and residential staff passed his car registration number to the police. Child 13 was moved to a unit outside of the city shortly thereafter. At this point her behaviour worsened and she regularly went missing, spending time in Manchester with an Asian man. From 2003 to 2005 there was no evidence on the social care file of a Section 47 investigation or child protection procedures being followed.
- 6.52. The HOLMES account listed several potential perpetrators associating with Child 13. In 2004, Child 13 was interviewed by Augusta staff and made an allegation of serious sexual offences against a designated suspect in Operation Augusta. The review team understands from our interview with

the detective who dealt with Child 13 that the man was subsequently found guilty of several counts of less serious offences. In 2004, Child 13 was interviewed by Augusta staff and made an allegation of abduction and rape against a designated suspect in Operation Augusta. This man was initially charged with these offences. The review team understands from our interview with the detective who dealt with Child 13 that the man was subsequently found guilty of several counts of unlawful sexual intercourse with a child under 16 and abduction. He was sentenced to 15 months' imprisonment. Actions in relation to other suspects linked to Child 13 appeared to have been referred on HOLMES, pending the outcome of this case. Although this man was convicted of offences involving Child 13, there were actions pending in respect of research of other potential offenders; it is not clear why these actions were not progressed.

- 6.53. Due to Child 13's repeated episodes of missing from home, an initial child exploitation meeting was held, which concluded that she should be placed on a child protection plan. At the subsequent review it was reported that Child 13 continued to abscond, and her "boyfriend" had now been identified as a middle-aged man.
- 6.54. The review team's judgement is that there was a significant probability that Child 13 was being sexually exploited and there was evidence of the use of child protection procedures. While one of the perpetrators was subsequently convicted, we remain concerned that the majority of Child 13's abusers were not apprehended. We cannot, therefore, offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council.

Child 14

- 6.55. Child 14 was a male looked after child who regularly went missing and there were strong indications he was being exploited by older men. Staff had collated information that that he was returning with money and goods, and references from other young people that he was being prostituted by Asian and gay men. Although the HOLMES account recorded CSE meetings in 2002, 2003 and 2004, we were only able to locate a record of meetings in 2002. These set out significant concerns in respect of him being picked up in cars, going missing for long periods, and returning with money.

- 6.56. According to the HOLMES account in 2004, the residential unit reported he was working in an establishment linked to the sex industry. Two months later, the manager of the residential unit confirmed Child 14 was a “male prostitute” and it was believed he was acting as a “pimp” for the girl residents. In 2005, a record on HOLMES stated: “Filed victim does not fit remit of operation.” GMP was unable to provide evidence that this victim was passed to another agency or investigation team for the concerns raised to be addressed.
- 6.57. The review team’s judgement is that there was a significant probability that Child 14 was being sexually exploited. We cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council.

Child 15

- 6.58. Child 15 was a female looked after child. There was no evidence on the Manchester City Council files of her vulnerability to child sexual exploitation. There was a note on the HOLMES account in 2004 that social care had agreed to approach Child 15 on behalf of the police. In late 2004, she provided a statement in which she gave an explicit account of the sexual exploitation of her and other children. She also gave a graphic account of two named individuals who attempted to sexually abuse her before she and another child (not part of the Augusta investigation) ran away.
- 6.59. In a second statement Child 15 described rape by two men; one was a nominal in the Augusta account. The latter nominal was identified by his full name, address and date of birth. Child 15 also named other girls involved in “sex parties” in this statement. The Crown Prosecution Service later advised no further action due to the delay in reporting, the lack of supporting evidence and no realistic prospect of conviction. GMP was unable to provide an explanation of why the individuals mentioned were not arrested and why the decision to take no further action was made without this taking place. Child 15 also informed the police in 2004 that she had been sexually assaulted by an unknown assailant. Operation Augusta detectives interviewed several occupants of the property where this had occurred but were unable to identify the perpetrator.

- 6.60. There is a record on the HOLMES account: “Although the victim has now been video interviewed on three occasions ... she has failed to provide any formal information concerning the circumstances of this crime and is unlikely to do so. She has provided evidential information relative to abduction and rape by [designated suspect] crimes ... in view of the lack of further information there was/is no evidence to suspect any individual particularly. I therefore ask that this crime stands but is filed pending any further information.”
- 6.61. The review team’s judgement is that there was a significant probability that Child 15 was being sexually exploited. We cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council.

Child 16

- 6.62. Child 16 had periods of being looked after following concerns in respect of the care offered by her parent. There were no recorded concerns regarding child sexual exploitation on the social care file and there was a note on the HOLMES account that there had been no multi-agency CSE meetings held. It appeared from a report on HOLMES that she had been included on Operation Augusta as she was a child who regularly went missing.
- 6.63. In 2005, Child 16 gave a video interview in which she described an incident where she and another child had been with a designated suspect. No disclosures were made. It was recommended that no further action be taken by the Augusta team. This decision was supported by a social care manager.
- 6.64. The review team’s judgement is that we cannot form a view as to whether Child 16 had experienced sexual exploitation. She had associated with known suspects of child sexual exploitation and was at risk of significant harm. However, as there was little on the social care record the review team is unable to form a judgement as to whether these concerns were appropriately addressed by Greater Manchester Police and Manchester City Council.

Child 17

- 6.65. Child 17 was a female looked after child. There was no record of CSE meetings on the social care file. In early 2004 she went to an address with another child in our sample. While there, a man attempted to indecently assault her. She became distressed and left. There were no identified concerns in respect of child sexual exploitation on the social care file. No outcomes were recorded on the HOLMES account.
- 6.66. The review team's judgement is that we cannot form a view as to whether Child 17 had experienced sexual exploitation. However, there is evidence that Child 17 was associating with a victim of sexual exploitation. Given the limited information on the social care record, the review team is not able to form a judgement as to whether these concerns were appropriately addressed by Greater Manchester Police and Manchester City Council.

Child 18

- 6.67. Child 18 was a female child in care. A fellow resident had said that Child 18 had been raped by a young Asian man. Child 18 denied this but did say she had been sexually assaulted by the man. Two CSE strategy meetings were held in 2002 although the police sent their apologies to both. High levels of concern were reported by the residential unit. The meeting heard that Child 18 was regularly going missing with two other girls, returning with money, jewelry and clothes, and there were concerns she was working in a massage parlour. She was said to be associating with two named Asian men. These men were suspected of contacting girls and recruiting them to involve other young girls in "prostitution".
- 6.68. There was also information on the HOLMES account that the "boyfriend" of another resident had wanted Child 18 to work at an establishment linked to the sex industry. This report was made by the unit manager in early 2004. There was also a report in the same month where it was recorded that a fellow resident had told staff that Child 18 went to "sex parties" with her and this involved Asian men. Furthermore, the resident said that Child 18 was working with her for two brothers with Asian surnames and both

were being given drink and drugs.

- 6.69. A resident subsequently gave a statement to this effect in 2005. She described how they went to an identified flat and were given a significant amount of money to have sex with Asian men. HOLMES did not contain any potential perpetrator information linked to Child 18 and there was no outcome recorded. This child was not formally identified by the Augusta investigation as a victim and although intelligence on this victim was known by the Augusta team there was no evidence of the case being passed to another investigation or district to progress. The review team's judgement is that there was a significant probability that Child 18 was being sexually exploited. We cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council.

Children identified during the review team's examination of the HOLMES account as potential victims of CSE

- 6.70. We reviewed seven children who were marked as nominals on the HOLMES account but had not been officially designated as victims. Two of these children were the responsibility of Manchester City Council. One child was not in care and was unknown to Manchester City Council. There were no detailed records on the remaining four children, and they might have been the responsibility of another local authority. **We have concluded that in this sample of seven children that there was a significant probability that one of the children was being sexually exploited, and we cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council/another local authority. In six of these cases we have concluded that we cannot form a view as to whether the children had experienced sexual exploitation or whether these concerns were appropriately addressed by either Greater Manchester Police or Manchester City Council/the relevant local authority.**

Child 19

- 6.71. Child 19 was a male looked after child. He was the subject of a child sexual exploitation meeting and a “child prostitution” meeting in 2001. A copy of the latter meeting was located on the social care file. Concerns were expressed that Child 19 was frequenting the ‘gay village’ in Manchester. He mentioned a man by his first name who gave him drinks and sometimes drugs, and also mentioned the bar the man worked in. The meeting concluded that Child 19 was at very serious risk of “prostitution” and exposure to drugs. Child 19 was moved to an alternative placement and there were no further references to CSE on the file. Child 19 was included in Operation Augusta as a child who staff were concerned about as being vulnerable to CSE. There were no further entries on HOLMES for this child. GMP was unable to provide evidence that this victim was passed to another agency or investigation team in order for the concerns raised to be addressed.
- 6.72. The review team’s judgement is that there was a significant probability that Child 19 had been sexually exploited. We cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or Manchester City Council.

Child 20

- 6.73. Child 20 was a female looked after child in a residential unit. In 2004, the manager of the residential unit stated that they believed she might be being sexually exploited. Another resident stated she believed Child 20 went to a flat with three Asian men known by nicknames only. A report on HOLMES in 2005 stated that the manager of the residential unit “strongly suspects” she was being sexually exploited. Child 20 was shown in the HOLMES account as an associate of the three Asian men known by nicknames only, but these were not given nominal numbers.
- 6.74. A report stated that Operation Augusta was not progressing this line of enquiry (action was to research her as a possible victim) as the resident who gave the initial information no longer wished to engage with the investigation. There was no record of this child on the Manchester City Council system, so she might well have been looked after by another local authority. Given the limited information, the review team is unable to form a judgement as to whether Child 20 was being sexually exploited or

whether this was appropriately addressed by Greater Manchester Police and the responsible local authority.

Child 21

- 6.75. Child 21 was listed as an individual subject to CSE meetings. A note on HOLMES in 2004 referred to her as a potential victim. There was nothing else recorded on HOLMES of relevance. She was known to Manchester City Council and there was a record of a CSE meeting in mid-2002 in which concerns were expressed that she had been seen on the streets working as a sex worker. The meeting established that Child 21 was a child from another district in Greater Manchester and the matter was referred to that local authority. Given the limited information, the review team is unable to form a judgement as to whether Child 21 was being sexually exploited or whether this was appropriately addressed by Greater Manchester Police and the responsible local authority.

Child 22

- 6.76. Child 22 was a female looked after child. She was an associate of another resident, who was also part of our sample. This resident described serious sexual exploitation ("sex parties" involving multiple Asian men). There was an action on HOLMES to research Child 22 as a potential victim. This was closed in 2005 as the resident who had provided the information no longer wanted to engage with the investigation. There was no record of Child 22 on the Manchester City Council system and she might well have been looked after by another local authority. Given the limited information, the review team is unable to form a judgement as to whether Child 22 was being sexually exploited or whether this was appropriately addressed by Greater Manchester Police and the responsible local authority.

Child 23

- 6.77. Child 23 was a female looked after child. She lived in several different placements during her time in care. She was reported to be more settled in

her final placement prior to leaving care. No concerns were identified through a review of the social care file and no CSE strategy meetings were located.

- 6.78. We were unable to find the originating document or incident that led to her being recorded as a nominal on HOLMES. However, there was an action on HOLMES to research her as a potential victim. This action was closed in 2005 as the resident who had provided the information no longer wanted to engage with the investigation. Given the limited information, the review team is unable to form a judgement as to whether Child 23 was being sexually exploited or whether this was appropriately addressed by Greater Manchester Police and Manchester City Council.

Child 24

- 6.79. Child 24 was a female child looked after in a residential unit. In 2004, she was named on HOLMES as a potential victim of CSE. There was no recorded action or outcome for this child. Manchester City Council had no record of her on its system and she might well have been looked after by another local authority. Given the limited information, the review team is unable to form a judgement as to whether Child 24 was being sexually exploited or whether this was appropriately addressed by Greater Manchester Police and the relevant local authority.

Child 25

- 6.80. Child 25 was a female resident of a residential unit. She was recorded in 2004 on the HOLMES account as a potential victim of CSE. No actions or outcomes were reported on HOLMES. Manchester City Council had no record of her on its system and she might well have been looked after by another local authority. Given the limited information, the review team is unable to form a judgement as to whether Child 25 was being sexually exploited or whether this was appropriately addressed by Greater Manchester Police and the relevant local authority.

Summary

- 6.81. Out of the 25 cases within our sample, we have concluded that there was a significant probability that 16 children were being sexually exploited and we cannot offer any assurance that this was appropriately addressed by either Greater Manchester Police or the responsible local authority. In respect of the remaining nine children, we have concluded that given the insufficient available information, we cannot form a view as to whether the children had experienced sexual exploitation or whether these concerns were appropriately addressed by either Greater Manchester Police or Manchester City Council or the relevant local authority. These findings are set out in the table in Appendix E.
- 6.82. We also cannot offer assurance that the risks the identified adults presented to children were appropriately dealt with by either Greater Manchester Police or Manchester City Council. We look at this in more detail in the next chapter.

Chapter Seven

Details of potential offenders and offences

- 7.1. In this section, we consider in more detail whether the risks the identified adults presented to children were appropriately dealt with by either Greater Manchester Police or Manchester City Council.
- 7.2. The numbers of potential suspects investigated by Operation Augusta has been difficult to establish.
- The operation's final report stated that approximately 97 persons of interest had been identified. Although all these persons of interest were entered onto the HOLMES account as nominals, they were neither input as persons of interest nor as suspects.
 - The SIO only formally designated five individuals as suspects. In our analysis of the HOLMES account, it was therefore not possible to trace the potentially 97 persons of interest mentioned in the May 2004 document by referring to a category. It was therefore necessary for the review team to identify those individuals from reading the documents and action results on the HOLMES account.

Details of offenders and offences noted in the evaluation report on Augusta

- 7.3. The evaluation report named seven offenders. These had all either been warned, charged or convicted. In addition, an eighth adult was named who was identified as an illegal immigrant during the investigation.
- **Outcome 1** – This individual was designated Suspect 5. He was charged and found guilty of four counts of abduction in relation to a child (Nominal 280). This child was not a designated victim

within Operation Augusta. However, we have established that an Augusta police constable visited a children's home regularly to try to engage with Nominal 280. He obtained statements from four members of staff describing how Suspect 5 would seek to take Nominal 280 from the premises against their wishes. He confirmed that Nominal 280 would not cooperate with him. He arrested Suspect 5 in autumn 2004 for child abduction and in interview Suspect 5 admitted going to the home to see Nominal 280 but stated he did not realise he was doing anything wrong. Suspect 5 received a community rehabilitation order for three years.

- **Outcome 2** – This individual was not a designated suspect. The offender was acting as a bogus taxi driver and a child in care reported that he had raped her. This child was one of the three designated victims added on 21 March 2005. He was charged with two accounts of inciting a female under 16 to engage in sexual acts. The two victims cited in the evaluation report did not have designated victim status within Operation Augusta and were from outside the Manchester area. The individual was a known sex offender and it was reported that he had offered the two victims money for a sexual act. Subsequently, the suspect was arrested and charged for a crime of rape against the original complainant. Detective Constable B informed the review team: "He was grooming kids, the demographics didn't fit as it was a prosperous middle-class area, and they were well to do kids. They weren't from the original tranche of children that were in children's homes. What had a massive input was the offending target group were predominantly Asian males and we were told to try and get other ethnicities." The offender identified in Outcome 2 was not of Asian heritage. He was sentenced to 30 months' imprisonment with a sex offender's notice.
- **Outcome 3** – This individual was designated Suspect 4 and was charged with 13 charges (including abduction, unlawful sexual intercourse, sexual assault and inciting to engage in sexual activity) in total against three young people; two were designated victims on the HOLMES account and the third was a child from outside the Manchester area who was subsequently added as a complainant (not a designated victim on the HOLMES account). Detective Constable B has confirmed the work that the Augusta team undertook with a designated victim to achieve Suspect 4's conviction. He was sentenced to 15 months' imprisonment with a sexual offences prevention order.
- **Outcome 4** – This individual was not a designated suspect. He was originally investigated for Section 18 assault on a designated victim. This child was added as a designated victim on 21 March 2005. He was dealt with by an officer on Operation Augusta and

subsequently charged with one count of abduction. He pleaded not guilty and no evidence was offered by the prosecution.

- **Outcome 5** – This individual was not a designated suspect. The alleged offence was against the designated victim who had also made the disclosure in Outcome 2. This was also dealt with by Augusta officers and he was charged with rape. He was discharged by the crown court.
- **Outcome 6** – This individual was not a designated suspect. He received a formal warning under the Child Abduction Act 1984 from an Augusta officer in respect of a complainant (not a designated victim on the HOLMES account). Following concerns relayed by a designated victim that this child (the complainant) was involved with this individual, an Augusta police constable visited the child, who would not engage with her. However, the child's grandmother had witnessed the child getting into the individual's car. The police constable subsequently used that information to give him an abduction warning. The last entry on the report stated, "in light of [the child] making no disclosures I respectfully request that [the child] does not fall within the scope of operation Augusta".
- **Outcome 7** – This individual was given a formal warning under the Child Abduction Act 1984 in respect of a designated victim.
- **Outcome 8** – This individual was identified as an illegal immigrant. He was not a designated suspect and no victims were identified against him.

7.4. In addition, two men were arrested and interviewed for offences of abduction against two children. One child was a designated victim and one was not. The Crown Prosecution Service (CPS) took the decision not to instigate proceedings. Four other men were named by one child, a designated victim. One denied the two alleged assaults and, following counsel's advice, the case was withdrawn. The child also made an allegation of indecent assault by two men and reported she had been raped by a third. The offenders were identified and arrested but denied the offences. On CPS advice, no further action was taken. One further man was warned in relation to his conduct with a designated victim. Another man admitted detaining a child (who was not a designated victim) but proceedings were not taken against him.

7.5. As can be seen from the eight outcomes above, there were very few

positive criminal justice outcomes emanating from Operation Augusta. Specifically, only two outcomes⁵⁶ related to the original 25 children who formed the target group for the investigation as set out in the joint protocol. The final report produced by the scoping phase had described, in our opinion, serious child sexual exploitation and our own work has supported this assessment. In this regard, Operation Augusta was unsuccessful in meeting the objectives set out in the scoping report and the joint protocol agreed between Greater Manchester Police and Manchester City Council.

Analysis of potential perpetrators by the review team

7.6. The review team established that every individual included in the original scoping exercise card index was subsequently given a nominal number and entered onto the HOLMES account. During the examination of material held on HOLMES we independently identified the names of 68 individuals who we could reasonably assume had been part of the cohort of the potentially 97 individuals referred to in the May 2004 document. Our findings were as follows.

7.7. Three of the five men shown as formal suspects by the SIO were selected randomly and considered.

- One had no evidence offered just prior to trial following advice from the Crown Prosecution Service. He had been arrested by divisional CID in 2004 prior to the investigative phase of Operation Augusta. The case was discontinued in April 2005.
- One is Outcome 3 and was dealt with by Augusta detectives.
- The third one was dealt with by divisional CID and the investigation pre-dates the investigative phase of Augusta. A trial date was originally set for late spring 2004. This was adjourned

⁵⁶ Outcomes 3 and 7.

and there were no further details on HOLMES.

7.8. Six of the 10 men identified as either being arrested during the investigation or being clearly of interest through the intelligence charts, or mentioned by other young people, were selected randomly and considered. In three cases, files were presented to the Crown Prosecution Service and charging advice was provided to the Augusta team, and in the remaining three cases:

- One was closed on the basis that “nothing further to be gained”.
- One was closed as “not relevant to current enquiry”.
- One was closed as the defence at the start of the trial produced a report that the victim “lies and makes up stories”. On this basis the case was withdrawn due to credibility and delay in reporting by the victim.

7.9. We considered in more detail 12 of the 68 individuals identified as potentially being among the possible 97 persons of interest. None of these was pursued within the investigation and therefore the information in relation to them was limited. They are summarised below:

- In one case there is no information other than that the individual (a woman) owned the car that allegedly followed a victim.
- Three were not pursued following a decision not to engage further with victims. One man was mentioned previously in respect of the abduction and alleged sexual exploitation of a child in our sample. Another was a man who the same child disclosed she was forced to have sex with. The action on HOLMES in April 2005 was “no further action as not progressing [child’s name]”. Another man was also linked to this child and the case was discontinued for the same reason.
- One man was not pursued pending the victim making a complaint. This related to an allegation that he had threatened and coerced a child in our sample into having sex with him.
- One man was not pursued pending a “proactive phase” of the operation. This man was alleged to be sexually exploiting a child in our sample. In April 2005 it was noted on HOLMES, “pending pro-active phase of operation”. In July 2005 it was reported, “no resources available for proactive operations”.
- Two were not pursued due to the potential credibility issues of a

victim (a child in our sample). One of these men was known by a nickname and his telephone number. The child alleged he was driving girls around on behalf of a pimp. The second man was known by his nickname and it was reported that he was involved in the sexual exploitation of this child.

- One man was not pursued as he was said to be unknown, although his first name and the restaurant where he worked were known. A designated victim had alleged he was present at “sex parties”.
- One man was not pursued as not being within the remit of the investigation. He was described as an associate of a male looked after child.
- Two men were not pursued for reasons not clear on HOLMES. The first man had been alleged to have raped a child in our sample. This man was recorded as “no further action” as the child was not interviewed. The other nominal made a child in our sample pregnant.

7.10. We believe that in the case of nine of these individuals there was sufficient information on HOLMES to indicate that they might be involved in the sexual exploitation of children.

7.11. We worked with Manchester City Council to identify if these 68 adults were known to the council at the time and whether the potential risk these adults presented to children had been actively considered. Many of them were known only by their first names or nicknames or by a common Asian name, but other records contained sufficient detail to make them identifiable.

7.12. It was not possible in 23 cases to trace the individual named due to the lack of specificity or detail. In 32 cases there was sufficient detail to identify the individuals, but we found no trace of them on the Manchester City Council records⁵⁷. Fourteen of the nominals were recorded as known.

⁵⁷ MiCare.

- Six of these had a flag on the record that indicated there were child protection concerns. The review team was not permitted to view the details in respect of these adults but was informed by Manchester City Council that the data referred specifically to notifications in respect of the release of an individual who had been identified as a 'risk to children offender'. These notifications were more recent and not within the timescale of Operation Augusta.
- There was no significant information on the remaining eight individuals, although several had been at the centre of significant concerns during Operation Augusta.

7.13. Throughout our review we have shared our findings with Greater Manchester Police and Manchester City Council. Greater Manchester Police has confirmed the following additional information in respect of the potential perpetrators we sampled:

- Sexual offending 2005 and before: There were 19 nominals shown as offenders for sexual crimes during this time period, with varied outcomes.
- Sexual offending post-2005: There were eight nominals shown as offenders for sexual crimes during this time period, with varied outcomes. Two are currently serving custodial sentences for sexual offending against children.
- Intelligence linking nominal to CSE/sexual offending post-2005: There were eight nominals with intelligence logs of this nature.
- Links to other CSE investigations: There were three nominals linked to major CSE operations.
- DBS⁵⁸ checks: There were five nominals who had applied for jobs requiring DBS checks.
- The offences committed by the eight men since the closing down of Operation Augusta include: incite a sexual act with a female under 16, rape of a female under 16, rape of a female over 16, sexual activity with a female under 16, control of a child for sexual exploitation, unlawful sexual activity and sexual assault.

⁵⁸ The Disclosure and Barring Service (DBS) was established in 2012 and carries out the functions previously undertaken by the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA).

7.14. In summary, although there was significant information held by both Manchester City Council and Greater Manchester Police on individuals who potentially posed a risk to children, we can offer no assurance that appropriate action was taken to address the risks they presented to children. Throughout our analysis of both the police and the social care files we found very little evidence of professionals considering the risk these perpetrators presented to their own children and the children they met throughout their daily activities. One of our interviewees explained to us: “They weren’t viewed as sex offenders per se, just a group of men of all ages, from one ethnicity taking advantage of kids from dysfunctional backgrounds. It could have overwhelmed child protection. There had to be a degree of pragmatism, the children also had to manage their own behaviour, the education issues were far greater than the enforcement issues.”

Chapter Eight

Final words

- 8.1. As set out in our section on the children (Chapter Six), there was significant information held by both Manchester City Council and Greater Manchester Police on individuals who potentially posed a risk to children, but we can offer no assurance that appropriate action was taken to address the risks they presented to children. There were very few criminal justice outcomes resulting from Operation Augusta. Fundamentally, Operation Augusta failed to meet the original objective of tackling the widespread and serious sexual exploitation of looked after children.

- 8.2. In September 2004, the Part 8 review into the death of Victoria Agoglia 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.**”

- 8.3. Although this recommendation was a key lesson learned from the death of Victoria Agoglia, we have found a continued over-reliance by investigators in Operation Augusta on the cooperation of the child victims despite the obvious coercion and control exhibited by their perpetrators. We do not believe this was the intention of the SIO from the outset, but clearly, given the limitations of the resources allocated to the operation, this became a key determinant in closing the operation down. Given the size and make-up of the team, winning the trust of the children and putting in place the required level of support to sustain their confidence was always bound to be a challenge. Notwithstanding these impediments, we would have expected more proactive disruption of the perpetrators. We do not understand why many of the men identified as significantly involved in the sexual exploitation of specific children were not formally designated as suspects by the SIO. This would have ensured that the investigation into their criminality would have been satisfactorily concluded prior to the conclusion of the operation. Furthermore, while we would accept that

subsequent changes in legislation have enhanced the additional opportunities to tackle child sexual exploitation, we would have expected to see more evidence of attempts by the operation to take disruptive action, utilising powers under PACE⁵⁹ (the Police and Criminal Evidence Act 1984) to arrest, question and search premises. We also found no examples of working with the licensing authority to oppose the licences of the premises that had been identified as central to the exploitation.

- 8.4. Our terms of reference require us to make recommendations that help guide the future direction of the Greater Manchester response to child sexual exploitation. As this report forms only the first part of our review, until such time as we can review the current provision, it would be inappropriate for us to make recommendations at this stage. We are also mindful that current practice has moved on considerably since 2005. Notwithstanding these points, our review has established that most of the children we have considered were failed by police and children's services. The authorities knew that many were being subjected to the most profound abuse and exploitation but did not protect them from their perpetrators. This is a depressingly familiar picture and has been seen in many other towns and cities across the country. However, familiarity makes it no less painful for the survivors involved and it should in no way detract from the need for them to be given the opportunity to ask that the crimes committed against them now be fully investigated. We would also apply the same expectation to the family of Victoria Agoglia, who have been asking for her abuse to be investigated since her tragic death in 2003.
- 8.5. Furthermore, the Mayor in his role as Police and Crime Commissioner must consider with Greater Manchester Police and Manchester City Council how the people who appeared to present a risk to children in 2004 can now be brought to justice and any risk they still present to children mitigated. On receipt of our findings within this report, Greater Manchester Police has accepted that there are several children for whom it is unable to find evidence that the investigations were progressed satisfactorily. GMP has

⁵⁹ The Police and Criminal Evidence Act 1984 governs the major part of police powers of investigation, including arrest, detention, interrogation, entry and search of premises, personal search and the taking of samples.

informed the review team that it will now undertake multi-agency assessments on each of these cases, which may then lead to investigations and mitigate any current risks. **We would emphasise that any future approach needs to go beyond the investigation of individual complaints and address the sexual exploitation throughout a wide area of a significant number of children in the care system as recognised by Operation Augusta at the time. Anything less would risk repeating the mistakes of the past and not give the survivors the justice they deserve.**

Appendix A

Terms of reference

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 to child sexual exploitation (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.

Child sexual exploitation 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 2015/16 review of services for children in Greater Manchester undertaken by 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 to 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 meet the demands placed upon 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 child care 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 10 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 the 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.

Appendix B

Context: Manchester City Council

Manchester City Council asked the review team to include the following chronology.

We recognise that some of this report relates to serious and unacceptable historic failings within social work practice during the period it covers.

Awareness and understanding of child sexual exploitation (CSE) has improved significantly since the early 2000s and Operation Augusta, with fundamental changes to how this issue is tackled in Manchester.

Partly in response to findings surrounding the tragic death of Victoria Agolia, the joint Protect team was set up with GMP in 2006 to respond to the issue of child sexual exploitation and work with young people at risk of, or victims of, CSE. At the time this was a nationally pioneering partnership to tackle an issue that was widely unrecognised and unacknowledged.

Manchester Safeguarding Children Board – which brings together a number of social and health care agencies and the voluntary sector to ensure a joined-up approach to safeguarding – was established in 2006.

In recognition that residential care works for some children but most do better in a family setting, in 2011 the council embarked upon a programme to reduce the number and size of children's homes in a move to improve the quality of care, support and supervision for our looked after young people.

Building on the success of the Protect team, and recognising that those who seek to exploit our children do not recognise geographical boundaries, and to continually improve our response to CSE, in 2012/13 Manchester City Council, together with the other nine Greater Manchester local authorities, established Project Phoenix to strengthen standards of practice, multi-agency arrangements and cross-boundary cooperation.

A review of Manchester's Protect team in summer 2016 led to a redesign of services, with a strengthened focus on partnerships and

improved links with neighbourhood services. Following this exercise, for further reassurance a joint review was undertaken to evaluate the team's approach and impact, and to ensure appropriate actions were being taken in all cases where there were concerns children were being exploited.

When Ofsted's inspection in 2014 found that Manchester's children's services were 'inadequate' (a previous inspection in 2010 had found them to be 'adequate'), a comprehensive plan was developed to strengthen arrangements. £10.5m has been invested in recruiting 121 social workers, including additional managers to strengthen and improve management support, guidance and oversight.

Our Manchester, Our Children: Manchester's children and young people's plan 2016-2020 recognises safeguarding young people from issues including child sexual exploitation as one of the city's absolute key priorities.

In December 2017, Ofsted's most recent inspection (at the time of writing) of Manchester's children's services found that strong partnership work between Manchester City Council and GMP was having a positive impact on vulnerable children, including those at risk of sexual exploitation.

The Ofsted report said: "Strong partnership work between the local authority and the police, at both strategic and operational levels, is having a positive impact on vulnerable children. This includes children at risk of or experiencing sexual exploitation ... Work with these children and their families is increasingly effective, with examples of good assessments and targeted work to reduce risks. Responses for children at risk of exploitation are increasingly effective ... The multi-agency Protect team provides intensive work with children at higher risk of exploitation and also coordinates the successful disruption of the adults seeking to exploit them."

Taking lessons previously learned, as well as drawing on local and national research, the Manchester Complex Safeguarding Hub was established in 2018, with a focus on protecting vulnerable people in the city from sexual and other forms of exploitation. The hub brings together adult and children's services and a range of partners. It works with nationally recognised experts to proactively protect children from all forms of exploitation.

As part of the collaborative work across Greater Manchester children's services, in October 2018 Manchester City Council was the first local authority in Greater Manchester to adopt the

Achieving Change Together (ACT) model, which focuses on a more collaborative approach to working with vulnerable young people to reduce their risks and enable them to feel more supported as well as protected. This approach has been pioneered in Wigan and Rochdale, where it has been independently evaluated and found to have a significant and beneficial impact for children and young people at risk of or being exploited.

Safeguarding young people in the city is a key priority for the council, and while there have been demonstrable improvements by Manchester City Council and its partners in identifying and effectively responding to the exploitation of children, there can never be any room for complacency. In line with our overall ambition to ensure this ongoing improvement process results in excellent services for children in our city, Manchester Safeguarding Children Board has agreed to a Local Government Association independent peer review/challenge. This review, taking place in 2019, includes national experts and considers current practice against the best national standards.

Appendix C

Key personnel

Chief Superintendent A	The divisional commander for South Manchester division and in late 2004/early 2005 commander for the new Manchester Metropolitan division
Detective Chief Superintendent A	Head of V CID command
Detective Superintendent A	SIO for the investigative phase of Operation Augusta
Detective Superintendent B	Head of Public Protection
Detective Inspector A	SIO of the scoping phase of Augusta
Detective Sergeant A	Detective sergeant on Operation Augusta
Detective Constable A	Detective constable on Operation Augusta
Detective Constable B	Detective constable on Operation Augusta

Police Constable A	Constable seconded to Operation Augusta
Team manager A	Embedded social worker on Operation Augusta
Team manager B	Embedded social worker on Operation Augusta
Senior manager 1	Director of Children and Families Services, Manchester City Council

Appendix D

Chronology of key events

29 September 2003	Victoria Agoglia died
16 February 2004	The inquest into Victoria's death was opened and adjourned until March 2007
2004	An individual was cleared of manslaughter at Manchester Crown Court. He admitted two offences of injecting the victim with a noxious substance and was jailed for three and a half years
16 February 2004	Scoping phase of Operation Augusta commenced
14 April 2004	The interim report on Operation Augusta was produced – <i>Child sexual exploitation in South Manchester: Brief summary of findings, 14 April 2004</i>
13 May 2004	Scoping phase of Operation Augusta concluded and briefing for senior officers prepared – <i>Operation Augusta final report</i>
14 May 2004	HOLMES account set up for Operation Augusta

7 June 2004	Detective Superintendent A appointed as SIO
1 July 2004	Gold meeting with senior officers from GMP and MCC
18 July 2004	Following a shooting, members of the Augusta team were reallocated to this murder investigation
September 2004	Part 8 review into the death of Victoria Agoglia completed by the Manchester Safeguarding Children Board
23 September 2004	Gold meeting with senior officers from GMP and MCC
2 December 2004	Gold meeting with senior officers from GMP and MCC
December 2004	Operation Augusta joint protocol agreed by GMP and MCC
22 December 2004	Suspect 5 was charged with child abduction
16 February 2005	Suspect 5 pleaded guilty to abduction offences against a child

21 March 2005	The SIO agreed to add three new victims to the operation
6 April 2005	At a meeting with Operation Augusta staff, the SIO outlined his reasons for not accepting additional enquiries. This was mainly that he wished to complete all the enquiries relating to the existing victims list, of which there were still six outstanding
22 April 2005	Chief Superintendent A stated he was unable to put permanent staff into Operation Augusta and that the operation would finish on 1 July 2005
22 April 2005	Gold meeting informed that Operation Augusta would finish on 1 July 2005
31 July 2005	Child sexual exploitation report completed by team manager B
25 August 2005	Operation Augusta evaluation report completed by Detective Sergeant A
March 2007	Coroner's inquest into the death of Victoria Agoglia
15 October 2014	Chief Constable of Greater Manchester Police appeared on ITV News and gave a commitment that

	he was “quite happy” to look at Victoria’s case again
May 2017	The BBC broadcast <i>The Betrayed Girls</i> , a documentary about child sexual exploitation within Greater Manchester
18 May 2017	Margaret Oliver, a former detective, appeared on ITV and expressed her concerns about the premature closing down of Operation Augusta
September 2017	Andy Burnham, the Mayor of Greater Manchester, commissioned an independent assurance exercise

Appendix E

Summary table of sample of children

Child	Cohort	Looked after by which authority?	Significant probability of CSE?	Assurance that this was appropriately addressed by GMP and MCC?
Victoria Agoglia	SAFCOM report	MCC	Yes	No assurance
Child 2	SAFCOM report	MCC	Yes	No assurance
Child 3	SAFCOM report	Other local authority	Insufficient evidence	No assurance
Child 4	SAFCOM report	MCC	Yes	No assurance
Child 5	SAFCOM report	MCC	Yes	No assurance
Child 6	SAFCOM report	MCC	Yes	No assurance
Child 7	SAFCOM report	MCC	Yes	No assurance
Child 8	SAFCOM report	MCC	Yes	No assurance

Child 9	SAFCOM report	MCC	Yes	No assurance
Child 10	Designated victim	MCC	Yes	No assurance
Child 11	Designated victim	MCC	Yes	No assurance
Child 12	Designated victim	Other local authority	Yes	No assurance
Child 13	Designated victim	MCC	Yes	No assurance
Child 14	Designated victim	MCC	Yes	No assurance
Child 15	Designated victim	MCC	Yes	No assurance
Child 16	Designated victim	MCC	Insufficient evidence	Insufficient evidence
Child 17	Designated victim	MCC	Insufficient evidence	Insufficient evidence
Child 18	Designated victim	MCC	Yes	No assurance

Child 19	Potential victim on HOLMES	MCC	Yes	No assurance
Child 20	Potential victim on HOLMES	Other local authority	Insufficient evidence	Insufficient evidence
Child 21	Potential victim on HOLMES	Not in care	Insufficient evidence	Insufficient evidence
Child 22	Potential victim on HOLMES	Other local authority	Insufficient evidence	Insufficient evidence
Child 23	Potential victim on HOLMES	MCC	Insufficient evidence	Insufficient evidence
Child 24	Potential victim on HOLMES	Other local authority	Insufficient evidence	Insufficient evidence
Child 25	Potential victim on HOLMES	Other local authority	Insufficient evidence	Insufficient evidence

Appendix F

Serious crime demand at the time of Operation Augusta

Greater Manchester Police (GMP) provided the review team with the following contextual information relating to the period and location of the Operation Augusta investigation to illustrate the pressures GMP, the Force Major Investigation Team (FMIT) and City of Manchester Division resources were under.

Murder

GMP recorded the following murders during these years:

- 2003 – 50
- 2004 – 43
- 2005 – 45

These figures are roughly comparable to 2016 and 2017 – 41 and 38 respectively (not including the Manchester Arena terrorist murders). However, to put the 2003 to 2005 figures into context, it should be noted that throughout the whole of the period of Operation Augusta, FMIT was investigating the following long-running cases.

The Salford gang-related murders, a further 10 gang-related murders, were all long-running cases, and several of them are still undetected or were only detected after years of investigations. Furthermore, FMIT was investigating the murder of a police officer's father, three stranger murders of young girls/women, the murder by arson of two teenage girls (still undetected), the murder of a gang leader, and two murders in the 'red light' area of Bolton. All of these investigations placed a particular pressure on GMP and particularly FMIT resources in different ways (including community confidence and impact, lack of evidential opportunities, the murders of vulnerable women and girls, and the force's reputation).

Additionally, two specific murders are particularly relevant to the period when Operation Augusta was established (from scoping in

February 2004, to incident room set-up in June 2004, and closure in July 2005).

On 10 April 2004, an innocent bystander and local businessman was attacked by an Albanian gang in Manchester. He died 16 days later. This investigation was allocated to a major investigation team (MIT) based in the City of Manchester Division. This long-running investigation was partially concluded at the first murder trial in November 2005, when one man was convicted of murder. Two further trials and an appeal against conviction have followed, resulting in a further conviction for murder. The impact of this sensitive and difficult to detect murder on force resources cannot be overestimated.

The murder of a 17-year-old boy in Wythenshawe (where Operation Augusta was based) on 19 July 2004, just as the Operation Augusta incident room had been set up (also in Wythenshawe), had an equal and even more direct impact. This investigation only concluded in January 2006, when six men were convicted of murder, conspiracy to murder and firearms offences.

These two murders – one racially motivated and one of an innocent child – were being investigated by the two MIT ‘syndicates’ that were permanently based in the City of Manchester Division. The investigations ran during the whole period of Operation Augusta and beyond. They were brought to successful conclusions, but undoubtedly drained the force of resources that might otherwise have been available to Operation Augusta.

Firearms discharges

The following firearms discharges were recorded during the relevant periods:

- April 2003 to March 2004 – 131
- April 2004 to March 2005 – 114
- April 2005 to March 2006 – 109

Comparable recent figures:

- April 2015 to March 2016 – 55
- April 2016 to March 2017 – 43

It is clear that demand on force resources investigating firearms offences during the relevant period (2004/05) was huge in

comparison with recent figures. The 2004/05 figure is 265% higher than the 2016/17 total. In the immediate period prior to Operation Augusta, i.e. when CSE offences were being committed (2003/04), the figure was 238% higher than the 2015/16 figure.

Concentrating exclusively on the City of Manchester Division, officers were investigating the following:

- 2003/04 – 58% of all force-wide discharges
- 2004/05 – 69% of all force-wide discharges
- 2005/06 – 70% of all force-wide discharges

This compares to:

- 2015/16 – 22% of all force-wide discharges
- 2016/17 – 23% of all force-wide discharges

Appendix G

Timeline

Greater Manchester Police asked the review team to include this timeline of CSE-related events in our report.

1998 Barnardo's charity published 'Whose daughter next? Children abused through prostitution'

2000 (February) Death of child abuse victim Victoria Climbié

2001 Statutory inquiry by Lord Laming into the death of Victoria Climbié launched

2001 Barnardo's published 'No son of mine!' looking at sexual abuse of boys and young men

2003 (January) Laming inquiry report published, making 108 recommendations

2003 'Every child matters' government green paper published

2003 (November) Murder investigation following the disappearance of Charlene Downs, aged 14, in Blackpool

2003 (December) Bichard inquiry commenced following the murder of two schoolgirls in Soham, Cambridgeshire, by the school caretaker

2004 The Awaken Project established in Blackpool to tackle sexual exploitation of children following the murder of Charlene Downs.

This police and local authority team was one of the first in the UK to be established

2006 (September) Protect multi-agency team established in Greater Manchester

2006 Operation Messenger team established in Oldham to tackle CSE

2007 Greater Manchester Police – HMIC inspection report, review and action plan published, including section on CSE

2007 GMP force CSE document (written by DCI Lay) published

2007 Presentation by DCI Ashworth at public protection investigation unit (PPIU) D/I meeting; each division was asked what they were going to set up for this area of policing (Oldham had established a team called Operation Messenger, Wigan had drawn up a statement of purpose)

2008 to 2010 Initial investigation into CSE in Rochdale (Operation Span)

2008 Rochdale Sunrise multi-agency team launched

2008 Calls for Awaken Project to be rolled out nationally; government slow to respond

2009 Barnardo's published 'Whose child now?', looking at key issues for children affected by CSE, and links between CSE, missing from home and child trafficking

2010 (July) 'Policing in the 21st century: reconnecting police and the people' (Home Office paper) sets out direction of policing and the focus on target-driven culture

2010 (August) ACC Sweeney submitted a COG paper proposing the establishment of the Public Protection Department (PPD) as a result of recognition that public protection was a high-risk area of policing and had faced a number of high-profile reviews and incidents that highlighted a need for change in approach

2010 to 2012 Second phase of investigation into CSE in Rochdale (Operation Span) by PPD and Force Major Investigation Team

2011 (September) Public Protection Department (PPD) launched. Each divisional PPIU was geographically located and managed centrally by senior leadership up to assistant chief constable level. The scope of the unit was initially child abuse, domestic abuse, and vulnerable adults

2012 Conclusion of trial following Operation Span – nine men convicted of offences against five victims

2012 (May) GMP issues apology for failing victims in Operation Span (together with Rochdale Borough Council and Crown Prosecution Service)

2012 PPD takes responsibility for all rape and serious sexual offence investigations

2013 Launch of Project Phoenix multi-agency response to CSE

2013 (December) GMP issues apology for failing victims in Operation Span

2014 GMP Operation Storm focuses on burglary and drugs

2015 (March) GMP publicly apologises for failing victims in Operation Span

Appendix H

Context and previous public apologies by Greater Manchester Police for failings in relation to child sexual exploitation investigations

Greater Manchester Police asked the review team to include the following chronology.

Context

'Her Majesty's Inspector of Constabulary annual report 2004-2005' by Sir Ronnie Flanagan was similar to previous years, with a heavy focus on performance-driven targets based on the Government's priority offences: vehicle crime, domestic burglary and robbery. The emphasis was on not only reducing these crime types but also increasing detection rates. HMIC's baseline assessment of GMP in 2005 showed positive results for investigating crime and there is nothing in the report about child sexual exploitation.

The Chief Constable of Greater Manchester's annual reports for 2004/05 and 2005/06 echoed the language of the Home Secretary's national policing plan and the HMIC annual reports that the reduction and detection of serious acquisitive crime offences was the priority.

The Children Act 2004 stated that local safeguarding children boards (LSCBs) must be established for every local authority area. LSCBs were given a range of roles and statutory functions, including developing local safeguarding policy and procedures, and scrutinising local arrangements.

Greater Manchester Police: Child sexual exploitation

Tackling child sexual exploitation (CSE) is a priority for Greater Manchester Police (GMP). The development and continued growth

of Project Phoenix into a nationally recognised brand and response to CSE demonstrates the commitment of the police and wider partnership across Greater Manchester in tackling this issue. There are arrangements in place in each of the 10 districts to deal with child sexual exploitation, most of which involve multi-agency, co-located Phoenix teams with dedicated staff from GMP, local authorities and the wider partnership, in line with the principles of the target operating model. The teams have evolved at different paces dependent on local demand and commitment of services, therefore some teams are far more established than others, with work towards tackling CSE at different stages of development and maturity.

GMP's approach to tackling CSE was last inspected by Her Majesty's Inspectorate of Constabulary (HMIC) and College of Policing in 2015. HMIC recognised that there was some excellent practice across GMP with regard to CSE, in particular in the more established Phoenix teams, though it noted that some were less well developed. Inconsistency in practice was identified as a key issue.

During the follow-up visit in 2015, HMIC noted the important steps taken by the force to address the recommendations from the previous year, stating: "We are encouraged by progress and saw clear evidence of improvements. However, challenges remain, and the force will need to maintain its current momentum and focus on child protection for some time to come."

No new recommendations for CSE were given; however, the delays in the hi-tech examination of digital material were identified as a continuing priority.

Findings from the HMIC police effectiveness (vulnerability) review of GMP in 2015 reflected that inspectors were impressed by the effort and resource that the force had invested in understanding and tackling CSE, acknowledging the learning that came from Operation Span and seeking to move forward with partners under Project Phoenix.

In December 2014 local MP Ann Coffey wrote the 'Real Voices' report, which commented on the disparity in make-up of CSE teams and compared the differing levels of service received by victims across the force to a "postcode lottery". A number of recommendations were made, which were carefully considered, and some were acted upon.

In March 2017, Ann Coffey wrote a follow-up report entitled 'Real voices – are they being heard?'. This report acknowledged the

changes made in the approach to tackling CSE across Greater Manchester, and the efforts to raise awareness and educate young people of the dangers. It also highlighted positive examples of good work and practice by the Phoenix CSE teams, and recognised the Phoenix multi-agency peer review process as good practice.

Protecting children from child sexual exploitation is a clear priority for GMP and the Mayor of Greater Manchester. The 2018 police and crime plan 'Standing Together' has three main overarching priorities: keeping people safe, reducing harm and offending, and strengthening communities and places. Included within 'keeping people safe' is specific mention of keeping children safe from CSE.

Since April 2018, work has been undertaken with partners to develop a complex safeguarding approach to safeguarding young people who are exploited. This has developed from the learning that has emerged from Project Phoenix since 2014 in order to improve practice, standards and performance, not only in respect of reports of CSE but all forms of exploitation. The vision is that by 2021, Greater Manchester will be a national centre of excellence for complex safeguarding. All children in Greater Manchester who are known to be vulnerable to exploitation or other forms of serious and organised criminality will be protected from harm and exploitation.

Victims will be safeguarded, protected and provided with trauma-informed services to support their recovery. Services will be delivered in a coordinated, informed and consistent way with improved outcomes for children, families and communities being at the centre of our approach.

May 2012 apology

After the convictions of nine men for CSE in May 2012, Assistant Chief Constable Steve Heywood from Greater Manchester Police, Rochdale Borough Council leader Colin Lambert and the Crown Prosecution Service (CPS) chief prosecutor in the North West, Nazir Afzal, all admitted that there were failings in the way each authority handled the child sexual grooming cases in Rochdale and publicly apologised for these.

GMP's ACC Heywood said the force had already learned lessons since its failed investigation of 2008. He apologised for the quality of that investigation and for failing to challenge the CPS decision not

to charge the two men. Mr Heywood 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 in relation to 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 issues around 2008, it's that we are now in a much better place as a wider partnership of agencies dealing with some of these issues.”

December 2013 apology

In response to a media article following the publication of two Rochdale Safeguarding Children Board serious case reviews (SCRs) into victims of CSE in Rochdale, Assistant Chief Constable Dawn Copley of Greater Manchester Police said: “We must acknowledge that there were some failings with the initial investigation carried out by Rochdale division into a complaint of rape by the victim in 2008. The suspect was arrested on suspicion of rape, but he was released without charge. The case was investigated and the officer who supervised the investigation took the decision to discontinue the case. In 2009 the victim in this case made a number of disclosures to the police about some of the defendants in this case. A decision was made to file the information gathered during this interview as intelligence and the decision was supported by the officer's line manager.”

ACC Copley added that a review of the investigation by GMP's sexual crime unit highlighted a number of failings. The matter was referred to its professional standards branch in March 2011 and “formal management action” was given to two officers. The investigation was also referred to the Independent Police Complaints Commission (IPCC).

October 2014 apology

In October 2014, GMP Chief Constable Sir Peter Fahy was interviewed by ITV News regarding police failings in respect of the

investigation into the sexual abuse of Victoria Agoglia prior to her death.

Chief Constable Fahy admitted: "We made mistakes in the past where some of our officers developed a mindset that victims in these sorts of cases would always been [sic] unreliable, and I think that was also a mindset which developed among prosecutors as well."

March 2015 apology

GMP issued an apology to Rochdale CSE victims affected by GMP's Operation Span and took the unusual step of releasing an internal investigation (supervised by the IPCC) report to the public to demonstrate that a transparent investigation had taken place and that lessons had been learned from the mistakes made.

Assistant Chief Constable Dawn Copley said: "I want to start by saying we openly acknowledge that mistakes were made, and victims were let down. For our part in that we apologise to the victims and we give them our assurance that lessons have been learned, changes have been made and we are determined to use this to continue making improvements.

"This matter was referred to the IPCC in December 2010. They decided to supervise the investigation which was then conducted by our Professional Standards Branch.

"The first investigation report was based on the findings of an internal review which had already taken place. The IPCC rightly challenged this and further investigation work was required. GMP then proposed amended terms of reference, which the IPCC approved, and these have now been met in full.

"The investigation has examined the conduct and actions of 13 officers who were involved in Operation Span and the policing of Rochdale Division. These ranged from constables to the Divisional Commander.

"This report, and the previous SCR, identified that at the time in 2008-10 there was a strong target driven focus, predominantly on serious acquisitive crime. At best this was distracting for leaders and influenced the areas that resources were focused on. This has now changed significantly. CSE remains a huge challenge for GMP but it is now one of our top priorities and our understanding and

experience of dealing with these types of cases has increased significantly.

“Ultimately, despite the issues highlighted in this report, nine men were jailed for a total of more than 80 years for their part in the abuse and we should not lose sight of that.”

Appendix I

CSE live investigations

Greater Manchester Police asked the review team to include the following information on current CSE operations.

Greater Manchester Police (GMP) has accepted that Operation Augusta was a joint multi-agency investigation. However, the force has maintained the position that GMP and Manchester City Council are not one homogenous organisation, and GMP believes it has made significant progress since this date on how it deals with vulnerable children and child sexual exploitation.

GMP made the following statement: "This has been recognised in a number of external inspections conducted by national bodies such as the HMIC. Grouping both organisations together has the potential to significantly undermine the confidence victims are now displaying in GMP as demonstrated in the number of investigations we are currently undertaking relating to current and historic abuse of children."

Greater Manchester Police asked the review team to include the following outline of current CSE investigations.

As of March 2019, there are 49 multi-victim or multi-offender live CSE investigations across GMP, where there are multiple suspects/victims, or where there is a single suspect with a number of victims, or a single victim with a number of suspects.

There are 134 victims across Greater Manchester identified as a result of the 49 live investigations that fall into this category. (Please note: this number does not include the number of victims from the Operation Green Jacket investigation and a Salford investigation where the number of victims is unknown at this stage). Among the known victims there are 68 white females, 10 black females and seven Asian females.

There are 299 suspects across Greater Manchester as a result of the 49 live investigations that fall into this category. (Please note: this does not include the number of suspects from the Operation Green Jacket investigation and Operation Trafalgar (Bolton), which has multiple suspects, however because the investigation is ongoing an accurate figure cannot be provided at this time).

At this stage 57 suspects have not been identified. Of the 242 known suspects, 124 are Asian males, 66 are white males, 18 are

black males and eight are white females. Of the 242 identified suspects, seven facilitated their offending through their occupation: two were teachers at the time of their offending, two were football coaches, one was a taxi driver, one was a social worker and one was involved in numerous children's care homes.

Of the 49 live investigations, 31 are recent, 16 are historic, and four investigations are a mix of both recent and historic allegations.

End of Report

