Berkshire West Safeguarding Children Partnership

Local Child Safeguarding Practice Review (LCSPR)

'David'

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Executive Summary

This executive summary is produced by the BWSCP Business Unit as a condensed version of the full review. We recommend that the full review report be read as it contains greater detail and analysis and includes links to national guidance and other documentation used by the author as reference material.

Introduction

David is a black British 18-year-old man. At the start of the review process, he was aged 16. He is described as a lively, polite, thoughtful young person with a wicked sense of humour. David was seriously assaulted in 2020, sustaining a head injury which required significant medical intervention, and left long term effects. In November 2021, David was arrested for murder and was subsequently found guilty.

In his early life David experienced physical neglect, disrupted attachments and 6 foster placements before the age of 6. He moved into the care of family members under a Special Guardianship Order who have remained his main carers, although since 2018 there were periodic foster care and residential care placements. From 2019 David had missing episodes and there were increasing concerns that he was being criminally exploited.

The review was completed in two parts - the events in David's life in the two years before his assault (which originally triggered the LCSPR process), and the period from the assault to his arrest. David's main carers and his birth father were interviewed for the review, attempts were made to engage David, but he declined.

Key Episodes

In the two years leading up to David's assault in March 2020, there were several critical factors impacting on him:

- The breakdown of his SGO carers relationship in 2018, in part to them not feeling able to manage David's behaviour.
- Several indicators that David was being criminally exploited including unexplained money, additional phones, threats from adults, missing episodes, the victim of at least 2 physical assaults from other groups of youths and had been arrested for 3 allegations of robbery, possession of a weapon and involvement in drug supply.
- There was considerable instability in his care, including activity based residential care some distance from his home authority. David consistently did not wish to be away from his family and resented his periods in care.
- David was the subject of early help and child in need plans and many multi-agency meetings, including specific meetings regarding children and young people at risk of criminal and/or sexual exploitation. There was good information sharing at these forums, but this did not extend into the wider support network.
- David was at high risk of exclusion from school owing to his behaviours but despite his placement moves, he remained on roll at his senior school. David's school remained consistent in David's life, and he had a positive relationship with a particular member of staff. David had several different social workers and other professionals working with him during the review period.

Following David's assault up until his arrest in November 2021:

- March 2020 - David was made the subject of a child protection plan and discharged to the care of his sister. This was a 'family arrangement' and therefore there was no legal status given to this arrangement. There were two missing episodes, the second of which was for 7 days, and he was located in another part of the country. Concerns were raised about his involvement in 'county lines drug running'.
- May 2020 - David became the subject of an interim care order and secure order, and he was placed in secure accommodation. The local authority care plan was described as 'triple planning' and included a return to his SGO carers, family members or residential care. In June 2020, the secure order was extended for 3 months.
- August 2020 – an application for a 6-month extension to the secure order was refused and David was moved to a residential unit with a reunification plan for David to return to the care of his SGO carer.
- November 2020 - David to returned to the care of his SGO carer following introductory and overnight visits. The plan included attendance at college, however the college closed due to the pandemic and concerns were raised about David's 'unstructured' time – he was often out of the house and had access to 2 mobile phones.

- January 2021 - David was made the subject of a 6-month supervision order and was a Child in Need. Further Section 47 strategy meetings were held due to concerns he was running a drug line. A 'contextual safeguarding meeting' was held to consider the risks outside of the home.
- May – August 2021 – David was made subject to a child protection plan due to escalating risks and criminality. David's SGO carer reported not feeling safe and alternative care was considered. David was then involved in a robbery at knifepoint, and a police search of David's home address and found £1000 and 5 mobile telephones.
- September 2021 - There were 2 occasions where David became very distressed, fearing that he would be physically harmed by others. On the second occasion, David mentioned to the police that he was in 'real trouble with lots of enemies'. The risks were not considered 'new risks' and there was felt to be a robust support plan in place, so no further action was taken.
- October 2021 - David was not attending college and his SGO carer was struggling to keep him safe. She felt at risk in her own home and again requested David be accommodated. A professionals meeting was held with colleagues in Reading to consider the contextual risks. No placements were identified for David.
- November 2021 – David was arrested on suspicion of murder in early November.

Practice Themes and Learning

David and his carers experience of services and support

David's history and childhood trauma were seemingly not considered in the development of the Special Guardianship Support Plan when he was placed with his carers in 2010. The referral from the neighbouring children's services who placed David stated that 'no welfare issues' were identified. They were therefore tasked with caring for him with limited support, guidance, and advice. David presented with behaviour challenges throughout his childhood, which increased as he reached adolescence.

The carers report feeling let down by professional support agencies. They described feeling judged, not listened to and when asking for help they did not receive it. They felt unable to manage David's behaviour and risks and although they attended many meetings, they felt little was done to provide practical and emotional support or to put a coherent plan in place particularly when exploitation risks were identified.

There did appear to be a lack of compassion for the SGO carers and a professional view that the carers wanted a 'quick fix' behaviour change from David and the only solution was him being placed into care. Behaviour management and relationship building became the focus of interventions without considering the ability of the carers or David to effectively respond to that intervention. The carers reported that the support provided after the assault was positive but was only put in place in response to the incident.

Learning Points:

- Robust, child centred, and focused support plans must be in place for Special Guardians. They need to be reviewed and adapted to the needs of the child as they grow older.
- Parents and carers managing children and young people's complex needs, behaviour and risks need compassion and understanding. Developing positive, strengths-based relationships with parents and carers support safety planning. Professionals must be cognisant of victim blaming language.
- The impact of individual practice approaches can have significant impact on case direction, family engagement and safety planning. Children's services need to enable opportunities for learning and reflection from other practitioners when managing children who are exploited and focus on 'harm outside of the home'. Organisational changes to practice have not yet been embedded across the system.

Trauma informed and relationship-based practice

The relationship between David and his carers has been consistent and they have maintained their support of David throughout, however they undertook the responsibility for his care with no support and limited understanding of trauma. Their role was key to his safety however the initial focus on parenting behaviour and behaviour management techniques alienated them. David was described as an engaging and polite young person, but this persona was reported to hide a deep vulnerability and a mistrust of adults, particularly social workers. David's trauma and his emotional and behavioural responses were not the focus of plans and interventions, rather 'fixing' the immediate issues.

From 2019, practitioners and his carers were extremely anxious that David was likely to be seriously injured or killed. The professional frustration at the carers for not fully engaging with support, the lack of a coherent and agreed safety plan and the constant managing of the daily risks in a highly stressful environment led to a level of compassion

fatigue. Multi-agency professional disagreement and inconsistent messages on how to proceed by senior leaders, led to a lack of shared accountability for the risks and keyworkers feeling overwhelmed.

Throughout the review period David had many practitioners and social workers working with him. Some had developed strong and effective relationships with him however changes in systems, procedures and David's care status all led to many changes in his professional network. This has been a shared frustration from the carers and some practitioners and prevented real opportunity to build effective relationships with David and his carers. In contrast, when David became the subject of a child protection plan in June 2021 the sensitive and relationship-based approach taken by the team manager and social worker had a positive influence on the engagement of the carers and refocused the risks and safety planning 'outside of the family home'. This ended when David's case was again transferred to the looked after children service following his youth custody.

Learning Points:

- Escalation processes need to be embedded at all levels to ensure effective challenge of decision making.
- Children and young people at risk of child criminal exploitation need consistent professional involvement and relationships. Changing professionals who work with children, young people and families should be based on the needs of the child and family rather than the organisational parameters.
- Safeguarding professionals need to work in a culture where an understanding of secondary trauma is the norm and agencies actively promote good self-care matched with multi-professional supervision and support, with opportunities to de-brief and reflect, particularly when case work is high risk and complex.

The understanding of child criminal exploitation, thresholds, and the shared accountability for managing risk.
Where exploitation of a child is suspected or known, organisations and practitioners must see the child first and the criminal activity second. David had been the victim of 5 previous assaults and Thames Valley Police had numerous records, and intelligence reports in relation to David, but many of these were not shared with Children's Social Care. Since 2020 there has been an attempt by Thames Valley Police to be balanced and victim focused, yet there remains evidence that the police considered David a criminal first and a victim second.

David's risk of criminal exploitation was clearly identified, but initially his self-reports prior that he was not being exploited appears to have been accepted. A completed Child Exploitation Indicator and Analysis Tool highlighted his high risk, but the subsequent referral to early help support appeared incongruent. Later Section 47 enquiries and assessments maintained that he should be managed via early help and child in need arrangements. The assessments focused heavily on the child and carers relationship without fully articulating the risk outside of the home, leading to ineffective multi-agency safety planning and confusion over thresholds for intervention.

David later admitted involvement with gangs and spoke about his feelings more than once to practitioners, which was clearly indicative of his coercion into criminal activity and its consequences. There was not a well-developed policy or strategy for managing the risks associated with child criminal exploitation and David himself told practitioners working with him that 'professionals' knowledge of exploitation was outdated'.

The assessments written about David consistently used language that implied a child who made effective choices to be involved, rather than being coerced into doing so. This subtly changes the perception of David, and there was clearly a disagreement between the police and other agencies as to whether David was a perpetrator of criminal activity using up valuable resources or a victim of criminal exploitation.

When David became the subject of a child protection plan in June 2021 the team manager and the social worker, alongside partner agencies, developed a very robust and clear safety plan which included opportunities to meet cross borough to address the safety issues for several young people involved in criminal exploitation. This was very positive and refocused the risks and safety planning for David outside of the family home.

Learning Points:

- Gang culture and identity need to be better understood by the professional network. The sense of belonging, identity, and criminal ways of earning money are intertwined and need different approaches to addressing the risks. Professionals must be cognisant of victim blaming language.
- The reliance on out of borough care needs to be seriously considered against other alternative care planning considerations. Care options, including the child remaining with family members, needs to be robustly risk assessed and regularly reviewed.
- Child criminal exploitation is consistently changing and adapting its 'business model' and safeguarding agencies need to regularly review their approach to safeguarding children in this context. Professional agencies need to

take time and resource to hear and listen to the experiences of children and young people who have been criminally exploited. This learning should be applied to practice development.

Information sharing and the impact of meetings

Processes to strategically safeguard children subject to criminal and sexual exploitation were in place through a monthly multi-agency meeting that reviewed the risk assessments and safety plans. The meeting had a good level of representation, had strategic oversight of children being exploited in the borough and did share information about David and his situation. However, there was a lack of intelligence sharing and actions relating to the disruption of criminal activity from the police which resulted in flawed safety planning and interventions. Expectations were placed onto the police for intelligence gathering and disruption activity yet there was not an arrangement in place to share intelligence amongst professionals who had contact with David and his family.

The governance and accountability arrangements for this meeting were not clear, nor it's specific remit i.e. that it was not a case management forum. Differences of opinion, without resolution, increased the lack of shared ownership and accountability, leaving responsibility with the social worker and children's services. Meeting actions were not always completed, and services were not always held to account, meaning drift in assessments and interventions. While this forum has subsequently been the subject of review and there have been changes it appears to still rely on the chair to follow up the actions of partner agencies.

David was also the subject of many other professional meetings, some of which he and his carers attended, but they felt they achieved little. Meeting minutes or changes to care planning were not routinely shared across the network. When something unexpected or worrying occurred, the default position was to hold a meeting, but how this sharing of information supported safety planning and intervention was less clear and services remained disconnected. At times, agencies were working in isolation of each other with poor communication. David's school had a key role to play in the management of risk but were excluded from some discussions.

Learning Points:

- Intelligence gathering across the safeguarding partners and other agencies requires clarification and consistent application, with a more formal framework in place.
- Contextual safeguarding meetings should have the same 'status' as child protection case conferences.
- Strategic forums considering risks to children of exploitation need to reach out to authorities who have a more advanced understanding of child criminal exploitation to share learning.
- Effective meetings require a clarity of purpose and effective action planning.
- Communication and information sharing leads to more enhanced safety planning. Intelligence across the safeguarding system needs to be appropriately and proportionately shared to enhance understanding and lead to more effective safety planning and risk management.

Care Planning

Decisions in 2019 to place David out of borough for his safety were made quickly and although his social worker was proactive in ensuring placements were appropriate, they were based on availability rather than being needs led. This was always a short-term solution, and took no account that David was highly likely to be involved in county lines drug running locally and would provide an opportunity to his exploiters to further develop their network. David was very reluctant to engage and was distressed by being away from his family.

Following the assault in 2020, David's carers refused to sign an agreement for David to become 'looked after' under Section 20 of the Children Act 1989 and therefore David was moved to his sister's address under a 'family arrangement'. Therefore the local authority was not legally bound to support care planning for David but without this framework this arrangement was highly likely to fail, which it did in a matter of weeks.

Learning Points:

- Moves for young people to family members needs to be formalised. Local community and statutory services need to be engaged to ensure effective safety and care planning is in place.
- When children move to other local authority areas as part of a care plan, children's services in the 'home' local authority should continue to effectively manage the care plan in consultation with the care placement and 'host' authority to ensure effective care planning and risk management.

David's period in secure accommodation from May 2020 was more successful. He was described as engaging and stable, and work was undertaken with him on gang culture and drug running. Concerns remained, but his carers felt that he had made significant progress, which influenced the decision to end the secure order.

The triple planning for David during the care proceedings was appropriate. Some of the planning seemed a little disjointed, with not all agencies in agreement or consulted regarding decisions. The local authority and the court recognised the risks of David returning home but the alternatives available to keep him safe were limited. The transition arrangements and his time in residential care following the conclusion of the secure order were well considered and supportive, with a robust support plan to manage David's transition home.

Unfortunately, once home, and through no fault of any agency, David began disengaging with support and almost immediately began engaging with his 'county line', quickly becoming involved in old behaviours. Whilst the transition plan was robust, the sheer number of professionals involved and the expectations on the family to engage with support services led to a disengagement from family members. There were ongoing meetings held about David to assess the risk, but the issues previously highlighted regarding the effectiveness and impact of these meeting/discussions remained. Subsequently it has become clear that David was involved in criminal activity far 'deeper' than the professional network understood.

Cross authority working

David has lived in 2 local authorities that border each other. His missing episodes, offending, drug running and involvement in gangs, crossed between both local authorities. There was no available evidence of joint borough working to mitigate the risks for David and others involved in criminal exploitation.

The Thames Valley Police safeguarding teams responsible for managing child criminal exploitation risks are geographically based and work primarily to that locality and it's needs. This can lead to a difference in practice and approach, and some confusion from partner agencies about the roles and responsibilities.

Learning Point: Thames Valley Police need to consider their current arrangements for the safeguarding department and consider how effective having different arrangements in localities works for consistency.

Culturally aware practice

David describes himself as black, yet the assessments refer to him as white and black African. Consideration of safeguarding risks in the context of David's race and culture was not considered in any of the assessments undertaken or multi-agency safety planning. As risks escalated from 2020, David was 'stop checked' by police to 'catch and convict' and disrupt his involvement in the county line. However, this targeting does not seem to have been seen by officers in the context of his ethnicity and how this approach by police may be perceived by David.

Learning Points:

- Practitioners need to develop their understanding of culturally sensitive practice. They need to engage with opportunities for learning and understanding. Practitioners need to consider a young person's identity and how those young people might experience oppression, discrimination, and risk. This should form part of assessments and interventions.
- Culturally sensitive practice, cultural sensitives and strengths needs to be reinforced by senior leaders and pervade policy and procedures.

Missed Opportunities

In September 2021, David disclosed the level of vulnerability he felt to his SGO carer and subsequently to a police officer, who said that he had never seen David in this state before. The following day, once the information was passed to his social worker, David retracted all the statements, and it could not be evidenced by others as David had asked that the officers switch off their body worn cameras. It is not clear why the response officers that day did not consider David's vulnerability and use their police protection powers to safeguard him, and this was a missed opportunity to proactively intervene in his life and potentially safeguard him.

Learning Point: Safety planning for children and young people being exploited should include statements of 'agency intent' if a child or young person discloses their vulnerability to exploitation.

The significant injury was a trigger point for action yet there were other occasions where David showed vulnerability, anxiety, and worry, which were a missed opportunity. The lack of flexibility in work allocation and processes led to unhelpful changes in practitioners, hindering positive relationships being formed.

Despite several initiatives on contextual safeguarding and learning for individuals, operational practice has not significantly changed over the review period and the agencies remain challenged by working with this cohort of children. Leaders have not grasped the opportunity to be more creative and flexible in their approach.

Evidence of good practice

- Some practitioners have developed strong and meaningful relationships with David and his carers, and he engaged with them well. They have been persistent in working with him. When practitioners focus was on 'harm outside of the home', the carers felt less judged and alienated from engaging in safety planning.
- There has been consistent support and therapy funded through the adoption service.
- David's school have been a consistent part of his adolescence and have provided ongoing support.
- Practitioners have been committed to keeping David safe and want to achieve the best for him.
- David was given opportunities to be involved in his care planning.
- The local authority had commissioned appropriate ethnically diverse mentoring arrangements.
- Practitioners have been open, honest, and reflective in the review process.
- Some practitioners have a good understanding and more up to date knowledge of child criminal exploitation and could be used to mentor others.
- David's situation has prompted significant reflection, changes to process and procedure and to a better understanding of child criminal exploitation.

Recommendations

Shared accountability and responsibility for safeguarding children and young people should be reinforced through the safeguarding partners, the Community Safety Partnership and other strategic multi-agency forums.

1. The safeguarding partners alongside other relevant agencies should test and evaluate the application of a contextual safeguarding approach to existing practice framework and procedures. Task and Finish Groups should devise methods that enable the co-production of safety planning with children, young people, parents, and carers alongside the school and local community.
2. The safeguarding partners (children's social care, integrated care board, and police) working alongside the Serious Violence and Exploitation Group should consider piloting a 'child safeguarding pathway' for children exploited and use the evidence to inform future practice and staffing changes.
3. The safeguarding partners should consider working across and learn from other safeguarding partners and agencies who have developed effective contextual safeguarding practice, particularly in implementing Signs of Safety as a practice model.
4. The safeguarding partners alongside other relevant agencies and working collaboratively with other strategic forums should develop a safety planning toolkit which supports practitioners in their work with children and young people criminally exploited. This should include safe and effective plans for children and young people exiting exploitation.
5. Children's social care are encouraged to test out having a single social work practitioner for children experiencing exploitation.
6. The safeguarding partners with the Community Safety Partnership should review the multi-agency forums set up to address exploitation across the safeguarding system and build in quality assurance arrangements to evaluate their role and function including evaluating the impact on children and young people and the effective use of assessment tools to evaluate risk.
7. The safeguarding partners alongside other relevant agencies should consider how to implement a trauma informed approach to practice across the safeguarding system, including how to support staff with vicarious and secondary trauma and develop arrangements for critical debriefing post incident.
8. The safeguarding partners should reassure themselves that practitioners are using culturally sensitive and racially aware safeguarding practice through a process of multi-agency audit. This should include the voices of children and young people.
9. The safeguarding partners should undertake a review of all children in the Borough who are subject to exploitation to assure themselves that safety planning is effective, and enforcement and disruption activity is ongoing.
10. The safeguarding partners should review the existing agency escalation policy and include references to multi-professional meetings.
11. Thames Valley Police to fully review and adapt the process relating to Child exploitation, to provide effectiveness and consistency in information sharing and multi-agency response.
12. Thames Valley Police should develop a clearer framework for intelligence sharing amongst practitioners working with children and young people who are exploited, including expectations of safeguarding partners. This should include details about intelligence sharing from the police to other agencies.