Berkshire West Safeguarding Children Partnership
Rapid Reviews and Child Safeguarding Practice Reviews
Completion Report

Report Name:	Wokingham David CSPR Completion Report
Reporting Officer:	Alastair Harsant, Partnership Manager, Business Unit, Berkshire West Safeguarding Children Partnership with Wokingham Borough Council (Sara James, Kelli Scott and Estelle Kelleway)
What happened to the child/young person to initiate the review? (Please provide a short description)	In early 2020, David was seriously assaulted, and he sustained a head injury which required a significant operation and induced sedated state to enable his recovery. There are long term effects of this injury. In November 2021, David was arrested for murder and remained on remand until his trial in the summer of 2022. This child safeguarding practice review (CSPR) was completed in two parts. The first part of the review focused on the events in David's life from 2018 to March 2020. Following David's arrest for murder in 2021, the review author was asked to review David's circumstances from March 2020 to November 2021. The chronology, review learning and recommendations have been combined into one document, which is the published CSPR found here.
How was the review carried out?	**Timeline:** • Notification of serious safeguarding incident made on 06.03.20. • Rapid Review meeting was scheduled to take place on Friday 19.03.20 – cancelled due to new Covid-19 social distancing rules. • Rapid Review report was finalised using the extensively detailed agency involvement forms received – 20.07.20. • Independent Reviewer for both CSPR reports: Ian Vinall **Panel Meetings:** • First panel meeting took place on 15.06.20 • Second panel meeting took place on 21.12.20 • Third panel meeting took place on 11.03.21 • Fourth panel meeting took place on 15.06.21 • Strategic Leaders session took place on 30.06.21 • Fifth panel meeting took place on 20.10.21 • Sixth panel meeting took place on 18.12.22 • Seventh panel meeting took place on 16.09.22 **CSPR Report Submissions:** *First Stage (Before Arrest) – not published* • CSPR Report V1.1 received in June 2021 • CSPR Report V1.2 received in September 2021 *Second Stage (After Arrest)* • CSPR Report V2.1 received in September 2022 • CSPR Report V2.2 received in October 2022 • CSPR Report V2.3 received in November 2022

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	• The final version of the CSPR Report received in January 2023 **Publication:** • A partnership statement, executive summary and learning summary were published alongside the CSPR report in February 2023.
What were the learning points from the review?	**Emerging themes March 2018 to March 2020** Theme 1: David's and his carers experience of services and support Learning: • The impact of individual practice approaches can have a significant impact on case direction, family engagement and safety planning. Children's social care 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 been embedded across the system since the previous review was concluded. • 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. • Robust, child centered, 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. Theme 2: Trauma informed and relationship-based practice Learning: • Repeated changes of worker will have a negative impact on engagement. The local authority is encouraged to test out new approaches to case management that ensures the child and family remains with the same worker. • Safeguarding professionals need to work in a culture where an understanding of secondary or vicarious trauma is the norm and agencies actively promote good self-care matched with multiprofessional supervision and support, particularly in case work that is high risk and complex. • 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. Theme 3: The understanding of child criminal exploitation, thresholds, and the shared accountability for managing risk. Learning: • 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. • 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. Whilst risks can be mitigated against, all agencies need to be able to 'hold' the risk for children and young people. • Child criminal exploitation is consistently changing and adapting its 'business model' and safeguarding agencies need to regularly review their approach to safeguarding children and young people 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. Training alone will not address professionals understanding of the issues and how to respond.

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	Theme 4: Information sharing and the impact of meetings. Learning: • Intelligence gathering across the safeguarding partners and other agencies requires clarification and consistent application. If this approach is intended to safeguard the child or young person and members of the public, the agencies need to have a more formal framework in place. • Contextual safeguarding meetings should have the same 'status' in the safeguarding partnership 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. Whilst quarterly pan authority forums exist that discuss data and trends, the strategic forums that consider exploitation for children and young people living in the borough, placed in the borough or who have strong links between the local boroughs should be the subject of shared updates between those strategic forums. • Effective meetings at all levels require a clarity of purpose and effective action planning. A 'strengths based' approach to facilitating meetings will go some way to address anxieties regarding risk and safety planning. Children and young people's situations can be very unpredictable yet there needs to be a realistic discussion about risk and risk management. • 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. Theme 5: Cross authority working. Learning: • 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. **Emerging themes March 2020 to November 2021** Learning: • Moves for young people to family members needs to be formalised. Local community and statutory services need to be engaged before the placement is made 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. • 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. • 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.
What recommendations were made and what actions were taken to address the recommendations?	**Recommendation 1: The safeguarding partners alongside other relevant agencies should test and evaluate the use of contextual safeguarding meetings. 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.** **Recommendation 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.**

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Recommendation 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.

Recommendation 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.

Action 1.1: Review of existing child protection and child in need procedures and processes, with a view to applying a contextual lens to activity.

Impact: Work has happened to coproduce and co-design a new Multi-Agency Referral Form (MARF), with a view to creating an electronic version to go on the website. At time of publication this on hold as a new 'Portal' is being considered.
New workflow for 'Children Looked After', where there is Harm Outside The Home (HOTH), was designed so that dual Corporate Parenting (CoP) Plans may not be necessary. As part of this workflow work, new guidance for conducting strategy meetings for harm outside the family, as opposed to harm within the family, was drawn up, including clarification as to when Section 47 enquiries might be needed to determine outcome/next steps. This was launched in November 2023.

Wokingham Borough Council (WBC) are using our existing Children in Need (CIN), CoP, and Children Social Care (CSC) processes as the framework for addressing HOTH need and risk, with some 'revisions' specific to HOTH. These are:

1. Introduction of context assessments and contextual safeguarding meetings where required
2. Removal of need for children in care to have dual CP plan where there is a risk of HOTH
3. Scope to vary the statutory visiting requirements in accordance with the young person's needs/circumstances and context assessment.

Action 1.2: Review of existing multi-agency frameworks/approaches utilised to safeguard and disrupt, with a view to supporting effective contextual safety planning.

Impact: The multi-agency responses working group has been meeting monthly since November 2022. The following work has taken place as of April 2023:

1. The Child Exploitation Missing and Missing Process (EMRAC) Terms of Reference have been reviewed and amended.
2. National disruption toolkits were reviewed by the working group. It was agreed that the partnership would adopt the use of Home Office Child Disruption Toolkit. This was endorsed by the Exploitation Task and Finish Group. The toolkit has now been published on the Wokingham Tri.x Procedures page and is adopted by panel members and practitioners when considering the range of (legal) options available to support safeguarding/disruption activity.
3. Structural changes to the EMRAC meeting have been implemented to improve timeliness, the quality of discussion and therefore focus the disruption and safeguarding activity. These include - increasing the length of the meeting; the weighting of the agenda according to risk level; the development of risk focused questions, which have been incorporated into a Child of Concern form that practitioners

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complete prior to the meeting; and the review of the participants and inclusion of adult safeguarding/transition leads.

Whilst the initially agreed activities have now been concluded, the group has identified subsequent activities to further enhance exploitation practice. These are outlined in the forward plan and include:

- Training for panel members on the role & function of EMRAC to be developed. A session was delivered to the panel in February 2024.
- Training for practitioners on the role and function of EMRAC will be developed. A session is due be delivered in 2024.
- Work to expand the remit of EMRAC to include the 18-25-year-old cohort commenced in September 2023. The expansion requires discussion across directorates regarding agreement about shared resourcing of the meeting, including administration & chairing. Discussion also required as to accountabilities regarding statutory responsibilities. The expanded EMRAC agenda above is due to 'go live' a September 24th 2024 meeting.

Action 1.3: Consider link to the Serious Violence and Exploitation Board.

Impact: The Joint Chair of the Serious Violence and Exploitation (SVE) Board also chairs the Exploitation task and finish group. The connection between both groups is continuously maintained and exploitation is part of the Board's agenda. Links are also made to the operational learnings from the case review.

Recommendation 5: Children's social care are encouraged to test out having a single social work practitioner for children experiencing exploitation.

Action 2.1: As part of the Exploitation task and finish group process, to explore the options for having a single social work practitioner for children experiencing exploitation.

Impact: Funding mechanisms are to be explored from across the partnership, that support a multi-partnership approach to reducing HOTH. Initial conversations are currently taking place with the Community Safety Partnership to identify opportunities for more joined up working and to consider the most appropriate options for Wokingham. Funding was agreed and a Lead Specialist Exploitation is in post as of 2024.

Recommendation 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.

Action 3.1: For the Community Safety Partnership to ensure quality assurance arrangements are built into established multi-agency forums addressing exploitation.

Impact: A programme of work commenced in 2022 and concluded in 2023. The work was undertaken via a multi-agency working group lead by the EMRAC Chair in Wokingham. The multi-agency response to exploitation was reviewed, which included the EMRAC processes, namely the meeting structure and format, updated Child of Concern forms to support a more risk focused conversation and adopted use of the disruption toolkit. A smaller group (including the EMRAC Chair) was also responsible for developing the training package referenced in action 1.2 above.

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	An ongoing piece of work was identified to progress the transitional safeguarding aspect, which established a separate multi agency working group. The expanded agenda considers a cohort of 18–25-year-olds and is due to go 'live' at the September EMRAC. **Recommendation 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.** **Action 4.1: Develop a statement of intent which outlines the BWSCP commitment to trauma informed approaches to practice.** **Impact:** Trauma informed practice Newsletter was shared with the wider partnership. Information can also be found on the BWSCP website – here. **Action 4.2: Implementing a trauma informed approach to practice across Children's Services** **Impact:** Trauma informed practice is a key component of the Wokingham Borough Council (WBC) practice model and features in WBC values and practice principles. This is reviewed as part of the Core audit programme. **Action 4.3: Encourage use of the Wellbeing Matters (for NHS and Social Care staff, organized by Berkshire Health Foundation Trust) when individual staff or teams are affected by vicarious or secondary trauma.** **Impact:** The Wellbeing Matters Service continues to be in place and is accessible to staff. The service continues to be promoted by Human Resources in the NHS. **Recommendation 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.** **Action 5.1: BWSCP to organise multi-agency audit of cases of children experiencing exploitation to ensure culturally and racially aware practice.** **Impact:** A review of cases when the Early Help service has supported young people with Special Educational Needs and Disabilities (SEND) to establish how well Early Help has worked – whether it has met the young people's needs and what the experience was like for them and their families – occurred in January 2023. The output of the review identified some improvements, that will help provide a better service to young people and families. These include: • Sharing knowledge by professional working with children getting SEND support • Review the wording of the Early Help Offer and the criteria on the Early Help Hub to improve clarity and consistency. Information on the Early Help Hub was shared across a range of teams during 2023, enhancing colleagues understanding of the Early Help offer. Information regarding the Early Help Hub and the Early Help Service is publicly available via the online directory.

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	Recommendation 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. **Action 6.1: Community Safety Partnership (CSP) to undertake a review of children subject to exploitation to ensure effective safety planning, enforcement, and disruption.** **Impact:** A multi-agency audit looked at the EMARC process over a one-year period, back in November 2021. A consultant conducted a review of the EMRAC cohort and the panel's response in November 2021. Recommendations were worked through to ensure thresholds and actions were in line with effective safety planning enforcement measures required for effective outcomes. **Recommendation 10: The safeguarding partners should review the existing agency escalation policy and include references to multi-professional meetings.** **Action 7.1: Review existing agency escalation policy and include references to multi-professional meetings.** **Impact:** The policy update went live in September 2023, and it can be viewed here. However, it is too early to measure impact as Google Analytics figures will be too low for further analysis. From September 2023 to August 2024 the escalation policy was viewed 67 times by 43 different viewers. **Recommendation 11: Thames Valley Police should review and identify the differences in practice in the safeguarding department and develop a plan for consistency.** **Action 8.1: 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.** **Impact:** The Child Exploitation Service Improvement Review (SIR) was delivered on 30th November and made 17 recommendations for either the Multi Agency Safeguarding Hub (MASH), Public Protection Unit (PPU), service improvement or Local Policing. The findings of the review recognised that the new 'front door' process for child exploitation referrals has created a single-entry point and clear identification and management processes, and this is well embedded within the MASH teams. The recommendations focused on ensuring the relevant support to the MASH (e.g. through data provision from Service Improvement) and further embedding of the processes more widely in the force and ensuring consistency of application / management at a local level with the neighbourhood teams. Additional recommendations related to the upcoming introduction of Harm Reduction Units and ensuring clarity of these teams remit in respect of exploitation." **Recommendation 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.** **Action 9.1: The Force to review its processes to identify an appropriate way to share intelligence with partner agencies for the purpose of safeguarding children. Operational Guidance should be developed in consultation with both the MASH and Force Intelligence and Specialist Operations (FISO)**

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	Impact: TVP MASH and Force Intelligence Bureau (FIB) are continuing with the pilot project of a new intelligence process for sharing information with MASH in an adjacent county (Buckinghamshire) is being extended across the whole TVP police force area. This will be evaluated during 2024. Additional staff have been trained, and an evaluation of the trial will commence following a three-month period of embedding the new process.
Please provide an analysis of the impact of the actions on children and young people	See above for impact analysis against each recommendation.

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