Report of the Two-Year Review Independent Inquiry Telford Child Sexual Exploitation

Chaired by Tom Crowther KC

Commissioning Body: Eversheds Sutherland (International) LLP

EVERSHEDS SUTHERLAND

Support Services – Base 25

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Ensuring the Chair's Report is accessible

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Whilst the Independent Inquiry into Telford Child Sexual Exploitation is not a public body, and is not under a duty to comply with accessibility requirements, the Chair and the Commissioning Body are committed to ensuring that this Report, when published on the website, is accessible to as many readers as possible.

This statement aims to set out the various steps the Chair and Commissioning Body have taken with regards to accessibility of the Report.

Format of the Report

The Inquiry is conscious that the majority of those accessing and reading this Report will do so via the Inquiry's website, meaning that it will be read on screen as well as in printed form.

Given its length, the Inquiry has taken the following steps in an effort to ensure the Report remains as accessible as possible.

1. Executive Summary

The Report includes a comprehensive Executive Summary at the beginning, so that readers can benefit from a higher-level overview of the Report either in advance, or instead of reading the Report in full.

2. Contents

The Report has a master Table of Contents at the beginning, to help the reader to navigate to sections or topics of particular interest.

3. Sections

Each section has clear headings, to help the reader to navigate the Report and locate sections or topics of particular interest.

4. Analysis

The Chair's analysis of each of the Recommendations has been collated into one section, with a summary table of the implementation status of each Recommendation. Linked Recommendations have also been grouped into a number of sub-sections to assist the reader.

5. Conclusions

The Report includes a comprehensive Conclusions section at the end, with an overview of the status of the Recommendations.

6. Appendices

The Report is accompanied by Appendix A which sets out the Recommendations from the Inquiry Report.

7. Searchable text

The CTRL+F search function can be used to search for particular words, names or phrases.

8. Plain language

The Inquiry has sought to avoid the use of overly complicated language so far as possible, to avoid barriers to understanding. It is acknowledged that there are inevitably a significant number of acronyms, which the Inquiry has defined throughout, in order to assist the reader.

CONTACT:

If you have any queries in relation to the accessibility of the Chair's Report, or wish to request a copy of the Report in a different format, please contact:

mail@iitcse.com | **0800 389 4322**

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Executive Summary

Background

1. I published my Report of the Independent Inquiry into Telford Child Sexual Exploitation (the "Inquiry Report") on 12 July 2022.

2. The Inquiry's Terms of Reference[1] entitled me to make recommendations "*to ensure CSE is recognised, reported and steps taken to protect children and prevent CSE in the future"* and also allowed for a two-year review to assess any such recommendations made.

3. I made 47 recommendations in the Inquiry Report (the "Recommendations"), which are set out in full at pages 117 to 136 of Volume 1 of the Inquiry Report,[2] and which are also included at Appendix A to this report.

4. As I said in my press statement when releasing the Inquiry Report, my hope was that all stakeholder organisations would be encouraged to reflect on the findings, and approach the implementation of Recommendations with a ready acceptance of the mistakes that had been made. I hoped that they would embrace the Recommendations with an open mind, recognising the opportunity these provided for them to improve their practice in relation to Child Sexual Exploitation ("CSE") in Telford.

5. I am pleased to say that all organisations, without exception, have met my expectations in this regard; and in some cases, have gone beyond what I had expected.

Purpose of this Review

6. Paragraph four of the Recommendations section of my Inquiry Report explained that this two year review (the "Review") would *"assess the extent to which recommendations have been implemented, and I will require all key stakeholders to demonstrate that steps have been taken, and are being taken, in respect of each relevant recommendation, or to give good reason why they have not."*

7. While some may expect me to delve back into the wider Terms of Reference, and investigate again areas which fell within the scope of the Inquiry Report, that is not the purpose of this Review. Nor is it within the remit of this Review to investigate new concerns or investigate other matters as may relate to CSE in Telford, as tempting as that may be. Its purpose is solely to look at the progress of implementation of the Recommendations, and that is what I address in this two year Review report (the "Report").

Structure of this Report

8. **Section 1** of this Report sets out in more detail the background to this Review, whilst **Section 2** provides detail in relation to the preparation and timelines leading up to the Review taking place. I have set out at **Section 3** the responses of individual stakeholders to the Inquiry Report, and in **Section 4** I deal with the methodology of implementation – in other words, the approach taken by Telford & Wrekin Council (the "Council") to put in

[1] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/5d2859da1636a90001ba0c84/1562925531616/Terms+of+Reference.pdf

[2] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cd9f93d1afb577e0f4d785/1657642904848/IITCSE+REPORT+-+VOLUME+ONE.pdf

place governance and oversight structures for responding to the Inquiry Report and managing the review and implementation of the Recommendations.

9. In **Section 5** I analyse the evidence provided to me by the Council, on behalf of all partner organisations (as well as further information directly provided by stakeholders and individuals) in order to reach conclusions, as set out in **Section 6**, regarding overall implementation. In **Section 7** I look to the future, and what I hope will follow after the cessation of this Inquiry.

Commencement of the Review

10. This Review commenced in earnest on 30 December 2023, when I received a letter from the Council inviting me back to Telford to conduct the two year review. Following receipt of the letter, and during the course of January 2024, the Commissioning Body received disclosure from the Council, on behalf of all partner organisations, which included an Overview Report[3] and numerous packs of material with evidence of implementation of each Recommendation. Each Recommendation was addressed by way of a response report, summarising the action taken. I also received separate reports from other key stakeholders, such as the police.

11. Meetings with representatives of each key stakeholder and other individuals took place during the weeks of 11 and 18 March 2024, where I discussed the submissions made in detail, and sought the views of each in relation to where further improvements, if any, might be made. I have set out in **Section 2** of this Report a list of those individuals with whom I met.

12. Since those meetings, the Commissioning Body and I have reviewed the various response reports and evidence received, and have considered these alongside the valuable information gained during the face to face meetings in March 2024.

Response of stakeholders

13. Perhaps the most impressive response, and one that was <u>not</u> part of my Recommendations, was the decision by the Council to work closely with three victims/survivors, who acted as independent lived experience consultees ("ILECs") at all stages of the Council's response – from the governance and oversight structures for managing the Council's response; to the establishment of the Joint CSE Review Group ("JCSERG"), in line with the first Recommendation of the Inquiry Report; to attending meetings with all stakeholder bodies to consider progress with implementation of Recommendations; and to partnering with some to deliver training.

14. Inviting the ILECs to be an integral part of both the Council's and the JCSERG's response to the Recommendations necessarily meant inviting their direct challenge and scrutiny of every step taken by the Council and its partner organisations. I believe this decision demonstrated significant commitment by the Council to the implementation of the Recommendations, and the feedback from other stakeholders on this engagement has also shown to me the value the ILECs provided in this endeavour. One commented, of the decision:

[3] [redacted]

"*it was a really brave move and* [a] *brave move that they* [the Council] *stuck to*… [it was] *a really positive relationship and one that we're more than happy to continue*".[4]

15. Another said:

"[The] *consultees made us think really hard. Sometimes* [we] *can be told we need to do things because* [of] *fashion or phase and* [we] *don't truly believe or understand why we need to do it,* [but] *what Telford has learned from consultees is invaluable".*[5]

16. I have been pleased with the response of all stakeholders, and the engagement they have shown to addressing the Recommendations made in the Inquiry Report, to the extent that they have been able, and doing so in the spirit in which I had hoped.

Methodology of Implementation

17. The Council acted as the lead organisation for responding to the Inquiry Report, given its decision to commission the Inquiry in the first place.

18. Its first step following publication was to establish a Strategic Implementation Group ("SIG"), which involved representatives from West Mercia Police ("WMP"), the Office of the Police and Crime Commissioner ("OPCC"), and NHS Shropshire, Telford & Wrekin ("NHS STW"). It invited attendance from others, particularly: education (both Council and Academy); the public health, licensing and commissioning departments; Shropshire Council; and other specialists in the field of CSE. The ILECs were also standing attendees at the SIG.

19. In addition to the SIG, an Internal Operations Group ("IOG") was created to oversee internal work within the Council, as well as a Partners Operational Group ("POG"), which specifically sought to engage with the Telford & Wrekin Safeguarding Partnership.

20. Each group worked to establish terms of reference. The POG, in particular, centred around providing "*a positive forum that allows partners to work together in shaping the way in cross- organisational recommendations set out in the CSE Inquiry report will be implemented"*[6] as well as enabling individual stakeholders to provide updates on their own actions.

21. As time went on, the IOG was stood down as redundant; a decision that was taken (sensibly, in my view) by the Chief Executive of the Council following a review of progress and effectiveness of the governance structures. Whilst that group may have dwindled, others went from strength to strength. The ILECs' attendance at the SIG on a broadly six-week basis grew to the point where Council officers met the ILECs every three weeks from December 2022, and those meetings became weekly five-hour meetings from April 2023. I have stated in **Section 4** of this Report that I consider that the Council's decision to invite the ILECs to work with them has been key to the effectiveness of the implementation process.

[4] [redacted] pgs 3-4
[5] [redacted] pg 7
[6] [redacted] paragraph 1.2

Analysis & Conclusions

22. In **Section 5** of this Report, I include an analysis of each of the Recommendations, the response of the organisations responsible for implementation of them, and my view on whether those Recommendations have been met. I do so by considering the Recommendations in groups as follows:

22.1. The first five Recommendations (1 to 5);

22.2. The Children Abused Through Exploitation ("CATE") Team Recommendations (7, 10, 13);

22.3. Structural Recommendations (9, 11, 14, 18, 19, 21, 22);

22.4. Licensing Recommendations (23, 24, 25, 26, 27, 28, 29, 30, 31);

22.5. Training Recommendations (6, 12, 32, 42);

22.6. Schools Recommendations (33, 34, 35);

22.7. West Mercia Police ("WMP") Recommendations (8, 36, 37, 38);

22.8. Police and Crime Commissioner ("PCC") Recommendations (40, 41);

22.9. Health Recommendations (43, 44, 45, 46, 47);

22.10. Wider impact Recommendations (15, 16, 17, 20);

22.11. The National Referral Mechanism ("NRM") (39).

23. I explore the implementation of each Recommendation within these individual sub-sections, and I then go on to make Conclusions in **Section 6** regarding overall implementation.

24. In summary, however, taking these in the order they appear in this Report, the implementation status is as follows:

The First Five Recommendations	Recommendations 1 to 5	• Implemented
The CATE Team Recommendations	Recommendations 7, 10, 13	• Implemented
Structural Recommendations	Recommendations 9, 11, 14, 18, 19, 21, 22	• Implemented
Licensing Recommendations	Recommendations 23 to 31	• Recommendations 24 to 29 and 31 implemented • Recommendation 23 unable to be implemented • Recommendation 30 in progress
Training Recommendations	Recommendations 6, 12, 32, 42	• Recommendations 12, 32 and 42 implemented

		• Recommendation 6 in progress
Schools Recommendations	Recommendations 33, 34, 35	• Implemented
WMP Recommendations	Recommendations 8, 36, 37, 38	• Recommendation 8 implemented • Recommendation 37 in progress • Recommendations 36 and 38 unable to be implemented
PCC Recommendations	Recommendations 40, 41	• Implemented
Health Recommendations	Recommendations 43 to 47	• Recommendations 44 to 46 implemented • Recommendations 43 and 47 unable to be implemented
Wider impact Recommendations	Recommendations 15, 16, 17, 20	• Recommendations 15, 17 and 20 implemented • Recommendation 16 in progress
The NRM	Recommendation 39	• Implemented

25. In terms of overall satisfaction of the Recommendations, out of the 47 made I am very pleased to report that I consider 38 have been implemented in full, with a further four in progress.

26. In relation to those Recommendations noted as 'unable to be implemented', this relates to five Recommendations of the 47, and I accept the reasons given to me for being unable to implement them – which is that each relies upon wider legislative or national change stretching beyond the capabilities of the organisations alone. In such cases, whilst the Recommendations themselves may not be capable of implementation currently, I am content that stakeholders have tried to address these where possible, and will continue to press for change where they can.

27. As regards those Recommendations that remain in progress, in each case I have set out in the body of this Report my hopes for implementation.

28. Overall, I have concluded that, in line with my expectations set out in the Recommendations section of the Inquiry Report,[7] all stakeholders have demonstrated that steps have been taken, and are being taken, in respect of each Recommendation, and where steps have not been taken, they have given good reason as to why not.

[7] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cd9f93d1afb577e0f4d785/1657642904848/IITCSE+REPORT+-+VOLUME+ONE.pdf – at pg 132 of Volume 1, paragraph 4

The Future

29. As I acknowledged in Chapter 1 of the Inquiry Report,[8] Telford is not the first town to have been blighted by CSE. The patterns of CSE may change in future; what will not change is the necessity for the concerns of parents, teachers, youth workers, social workers, the police and the public as a whole to be recognised, acknowledged and acted upon by those agencies charged with protecting children.

30. My discussions with stakeholders also confirmed that there remain difficulties with national policy,[9] requiring the national Government's attention, and, some suggest, revision of legislation, policy and guidance. This plainly falls outside the scope of my original Inquiry, still less this Review.

31. I am, however, pleased that both the Council and WMP, as lead stakeholders, as well as NHS STW, have acknowledged this and have indicated they intend to lobby for wider change - notably in relation to taxi licensing, crime recording and statistics, and how national policy and guidance might better serve victims and survivors of CSE.[10]

32. Telford's CSE journey is not over, and some Recommendations made in my Inquiry Report remain in progress. With that in mind, and to preserve the valuable work done to date, I have set out in the body of **Section 7** certain future actions that I recommend the JCSERG should keep under consideration.

33. With this Review, the Independent Inquiry into Telford Child Sexual Exploitation is reaching its conclusion. It is over five years since it was commissioned, and in some cases[11] many decades after the exploitation suffered by the victims and survivors. Whilst this Inquiry will not be holding a further review, I hope that with the establishment of the JCSERG and the standing obligation to publish an annual report, the key stakeholders in Telford will continue to be held accountable for how they detect, prevent, and respond to CSE.

34. I hope that the public in general, but more specifically the victims and survivors of CSE in Telford, feel some sense of reassurance that this Inquiry has done all it possibly can to bring the stories of some of those affected by CSE in Telford to light; to identify past mistakes and to highlight failings where these have been found, across all organisations responsible for detecting and responding to CSE.

35. Inquiries are often criticised for the lack of any mechanism to ensure implementation of their recommendations. This Inquiry is different. I am fortunate that, as part of my Terms of Reference, I have been afforded this opportunity to return and review the implementation of Recommendations; something that was reflected in comments from stakeholders I spoke to:

[8] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cd9f93d1afb577e0f4d785/1657642904848/IITCSE+REPORT+-+VOLUME+ONE.pdf - Volume 1 pg 158 at paragraph 127

[9] [redacted] pgs 7-8

[10] [redacted] pgs 13-14

[11] E.g. see individual Case Studies in Volume 4 Chapter 8 - https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cd9ff9ba1c7b03a9af9c11/1657643011239/IITCSE+REPORT+-+VOLUME+FOUR.pdf

"I think having the review has been helpful in focus of minds."[12]

36. I have no doubt that the existence of this Review will have provided stakeholders with the impetus to take action, and indeed a deadline to aim for.

37. I said at the start of the Inquiry, in the Foreword to my Inquiry Report:

"If there is an overarching theme to be identified, I consider it is that concern and action about CSE came from individuals within organisations, rather than from the organisations themselves."[13]

38. I have seen something different on this return to Telford. I have seen a Council that recognises the stain of the past, but does not attempt to ignore it or erase it; rather to learn from it, to engage its partners and to ensure that the next generations of Telford's children will be safer than the last. Telford may be regarded as having been a "pariah town", but I consider at the conclusion of this Review that it is now an admirable model from which others can learn, when it comes to holding up a mirror to itself by commissioning this Inquiry, investigating what has gone wrong, why and how, learning from this and taking bold action, with the most important of objectives – safeguarding children from CSE.

39. This is but one quote, from one professional I heard during this Review, but it exemplifies the tenor I felt from many who were involved with this Inquiry:

"*… the whole thing, obviously it came from a dark negative place but it's been a positive journey, the way things have developed."*[14]

[12] [redacted] pg 20

[13] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cd9f93d1afb577e0f4d785/1657642904848/IITCSE+REPORT+-+VOLUME+ONE.pdf

[14] [redacted] pg 11

Section 1

Introduction

40. On 12 July 2022, I published my Inquiry Report of the Independent Inquiry into Telford Child Sexual Exploitation (the "Inquiry Report"), 51 months after Telford & Wrekin Council (the "Council") unanimously made the decision to establish the Inquiry, and just over three years after my appointment as Chair.

41. The Inquiry Report followed three years of investigation, with a significant period of time spent gathering documentary and witness evidence, which continued throughout the COVID-19 pandemic. I set out in Chapter 1 of my Inquiry Report the substantial volumes of disclosure received by the Inquiry, and the approaches taken to disclosure by the key stakeholders, including the Council, West Mercia Police ("WMP") the Office of the Police and Crime Commissioner ("OPCC"), NHS Shropshire, Telford & Wrekin ("NHS STW") (formerly Telford & Wrekin Clinical Commissioning Group), and Shropshire Council.

42. Paragraph five of the Inquiry's Terms of Reference stated that:

"If the Chair considers it appropriate, to make recommendations to ensure CSE is recognised, reported and steps taken to protect children and prevent CSE in the future. Any such recommendations will include a two-year review to assess the extent to which the recommendations have been implemented."

43. As a result of my findings, I considered it appropriate to make 47 recommendations in the Inquiry Report (the "Recommendations"), which are set out in full at pages 117 to 136 of Volume 1 of the Inquiry Report.[15]

44. The responsibility for implementing those recommendations lay with those key stakeholders referenced at paragraph 41 above, and I explained at paragraph four of the Recommendations section of my Inquiry Report that I would be publishing a two-year post-publication review (the "Review"), stating that I would:

"… assess the extent to which recommendations have been implemented, and I will require all key stakeholders to demonstrate that steps have been taken, and are being taken, in respect of each relevant recommendation, or to give good reason why they have not."

45. In my press statement at the time of publication of the Inquiry Report on 12 July 2022, I also expressed the hope that organisations and agencies that were subject to criticism would accept the findings of the Inquiry Report in a way that is reflective and self-critical; that they would commit to accepting the Recommendations in the acknowledgment that these were designed to drive continued change in the approach of those organisations towards Child Sexual Exploitation ("CSE") in Telford, and that such progress would be assured for current and future generations of Telford's children.

[15] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cd9f93d1afb577e0f4d785/1657642904848/IITCSE+REPORT+-+VOLUME+ONE.pdf

Section 2

Preparation and Timelines for Review

46. The purpose of this Review is, as I indicated in July 2022, to seek to ensure stakeholders remain accountable to the victims, survivors and public at large, for their response to the Inquiry's Recommendations, and I have set out below the approach taken to this Review.

47. Following publication of the Inquiry Report on 12 July 2022, the Inquiry paused its work to allow all stakeholders time to digest and consider the Recommendations made, which included the requirement that the Council and WMP should take the lead in establishing a Joint CSE Review Group ("JCSERG"), together with other key stakeholders and third sector agencies as deemed appropriate.[16] I also recommended that the group should publish an annual report (the "Annual Report") setting out relevant statistics and data gathered, and (amongst other things) provide an update on the steps taken by each organisation in response.[17]

48. The first Annual Report of the JCSERG was published on 13 July 2023, and this was delivered to the Cabinet at a Full Council meeting that same day.[18] At that meeting, the Leader of the Council committed to ensuring that all Recommendations (insofar as these related to the Council itself) would be implemented by the end of 2023, with a view to inviting me to commence this Review at the end of 2023.

49. Following publication of that Annual Report in July 2023, the Commissioning Body made contact with the Council in order to discuss progress and begin to make preparations for this Review.

50. Between September and December 2023, the Commissioning Body and I remained in contact with the Council, during which the Council explained that it had been leading on the implementation of the Recommendations, engaging with all key stakeholders, and that it had been agreed by those stakeholders that the Council would continue to co-ordinate and submit a combined partnership response on behalf of all the organisations, in preparation for the Review. The Council also confirmed that all parties were on track to complete the joint response by the end of December 2023, at which point I would be invited to commence my Review.

51. The Council explained that the joint response would comprise an overview report (the "Overview Report"), together with individual response reports (referred to below as "Response Reports") and evidence packs in support of each individual Recommendation, to demonstrate the action taken to comply.

52. I proposed that, following receipt of the partnership response and evidence packs, I would return to Telford to meet with key stakeholders in order to discuss their submissions and the details of the actions taken by each to implement the Recommendations.

[16] Recommendation 1

[17] Recommendation 2

[18] [redacted] paragraph 3.4 of https://democracy.telford.gov.uk/documents/s18500/CSE%20Report.pdf

Invitation to Commence Review

53. On 30 December 2023 I received a letter from the Council inviting me to commence this Review. In that letter, the Council explained that it had been working closely with three independent lived experience consultees ("ILECs") to support the implementation of the Recommendations, and suggested that I might wish to speak to them, as well as other key individuals who had been involved in the partnership response, as part of my Review.

54. Following receipt of the letter, and during the course of January 2024, the Commissioning Body received disclosure from the Council, which, as promised, included the Overview Report,[19] Response Reports, and numerous packs of material with evidence of implementation of each Recommendation. I also received an Addendum Report on behalf of the ILECs[20] (the "ILEC Addendum Report"), as well as a separate update report from WMP entitled "West Mercia IITCSE Overview".[21]

55. Initial calls were also arranged during January and February 2024 with WMP, NHS STW and the ILECs. During those meetings I explained the process I intended to follow in reviewing the partner response and conducting the Review, to give those stakeholders an opportunity to provide any additional updates or information, to clarify initial information I had reviewed, and to request further details as needed.

Stakeholder Meetings

56. Meetings with representatives of each key stakeholder took place during the weeks of 11 and 18 March 2024, where I discussed the submissions made in detail, and sought the views of each in relation to where further improvements, if any, might be made. I met first with the ILECs - Holly Archer, Scarlett Jones and Joanne Phillips - followed by the various stakeholders as follows:

    56.1. On behalf of the Council, I met Councillor Shaun Davies, Councillor Lee Carter and Chief Executive David Sidaway. I also spoke with three members of the current Children's Social Care team, four members of the Children Abused Through Exploitation ("CATE") Team, and two members of the Council's Policy & Governance leadership who have been instrumental in steering the Council's response to the Inquiry Report.

    56.2. On behalf of WMP, as well as meeting Temporary Chief Constable Alex Murray and Temporary Deputy Chief Constable Richard Cooper, I also spoke with the Detective Superintendent in charge of Vulnerability and Safeguarding and the Detective Chief Inspector ("DCI") who had been leading the response to my Report, as well as the DCI in charge of the Child Exploitation ("CE") Team, and two members from the CE Team itself.

    56.3. I also attended a meeting with the Police and Crime Commissioner ("PCC") John Campion and his Chief Executive, Gareth Boulton, and spent time speaking with the Head of Policy and Commissioning and one of the Senior Policy Officers.

19 [redacted]
20 [redacted]
21 [redacted]

56.4. In terms of those organisations responsible for health, I met a number of individuals from NHS STW and associated health bodies, including the Chief Nursing Officer and Designated Nurse in Safeguarding Children, and members of the Commissioning and Public Health teams at the Council.

56.5. In order to explore actions taken on behalf of the education sector, I met senior leadership team members and those holding Designated Safeguarding Lead and CSE Lead roles from two Telford secondary schools and one primary school.

56.6. Similarly, I met with two representatives from the Council's Licensing Team, in order to discuss the actions taken in response to my Recommendations in the area of taxi and premises licensing.

56.7. I also met with representatives from Base 25, the support service to the Inquiry, to understand the level of (but importantly not details of) take-up.

56.8. Finally, I met Councillor Andrew Eade, leader of the (then) Opposition group on the Council, as well as Lucy Allan, who was then an MP, and Mark Pritchard MP, to obtain their views in response to my Inquiry Report and the progress of implementation of Recommendations.

57. As a result of those meetings, certain follow up requests for information were made by the Commissioning Body on my behalf, which I have considered alongside the submissions and documentary evidence received in January.

58. In total the Inquiry has received over 450 documents and over 4,100 pages of evidence in preparation for this Review.

59. I have used the information gleaned during those meetings and the documents gathered as part of the Review to prepare this Report and to determine the extent to which the Recommendations have been implemented.

60. I have also considered the initial responses of each key stakeholder to the publication of the Inquiry's Report in July 2022, and commitments made by them at the outset.

Section 3

Responses to the Inquiry Report

61. On the day of publication of the Inquiry Report, the Council, WMP, the PCC and Shropshire Council all issued their own press statements acknowledging the report and, in the case of WMP and the Council, issuing apologies to victims and survivors for past failings and for the pain caused. Whilst those agencies acknowledged improvements already made in the approach to, and management of, CSE within their organisations over recent times, in their responses they also expressed their own commitments regarding implementation of the Recommendations.

The Council

62. On the day of publication, the Council issued the following public statement:

"We apologise wholeheartedly to victims and survivors for the pain they have gone through and thank them for sharing their experiences with the Inquiry, which must have been incredibly difficult to do. Child sexual exploitation is a vile crime that disgusts us and all right thinking people. The Independent Inquiry acknowledges we have made significant improvements in recent years. We are working very hard, day in and day out, to provide the best possible support for victims of this crime. We will continue to work alongside and listen to victims and survivors.

Telford & Wrekin Council commissioned the report that dates back to 1989 and accept the Inquiry's recommendations, many of which we are already carrying out."[22]

63. In his statement to the Full Council Meeting on 14 July 2022, Council Leader Shaun Davies also confirmed that the Council fully accepted and would act upon all of the Inquiry's Recommendations, to ensure these are implemented in full.[23]

64. On 13 October 2022, three months after publication, the Council provided an update report to Cabinet members, setting out the initial steps that had been taken in response to the Recommendations, which included the development of a 149 point action plan.[24] This action plan was stated to be a working document, with actions assigned to each agency, and setting out expectations for delivery. The action plan also anticipated what evidence would be required to demonstrate that each Recommendation has been implemented.

WMP

65. On 12 July 2022, in response to publication of the Report, WMP released the following statement:

[22] https://newsroomarchive.telford.gov.uk/News/Details/16368

[23] Full Council Meeting minutes dated 14 July 2022, [redacted]

[24] (Public Pack)Independent Inquiry Update Report Agenda Supplement for Cabinet, 13/10/2022 10:00 (telford.gov.uk); https://democracy.telford.gov.uk/documents/b4928/Independent%20Inquiry%20Update%20Report%20Thursday%2013-Oct-2022%2010.00%20Cabinet.pdf?T=9

"We are making an unequivocal apology to victims and survivors of Child Sexual Exploitation in Telford for past failings by the force.

This evening the Independent Inquiry into Child Sexual Exploitation in Telford (IITCSE) is published. The Inquiry, which was commissioned by Telford and Wrekin Council in April 2018, found that there were significant failings by public services, including West Mercia Police, in the handling of child sexual exploitation in the borough dating back to the mid-90s.

Speaking on behalf of West Mercia Police, Assistant Chief Constable Richard Cooper, said: "I would like to say sorry. Sorry to the survivors and all those affected by child sexual exploitation in Telford. While there were no findings of corruption, our actions fell far short of the help and protection you should have had from us, it was unacceptable, we let you down. It is important we now take time to reflect critically and carefully on the content of the report and the recommendations that have been made.

Whilst we are in a different place now there are no excuses for the past. What I can give you are assurances that we have made vast improvements to the way we tackle these crimes, but we cannot and will not stop there. We're absolutely committed to continually looking to improve our approach.

We now have teams dedicated to preventing and tackling child exploitation. We also have an Online Child Sexual Exploitation Team (OCSET) to ensure that we are targeting offenders both online and in person. The officers in these teams work incredibly hard, day in day out, to actively root out perpetrators and put them before the courts as well as preventing offending.

The way we work with other agencies has evolved and we now work better together so that we can act quickly to safeguard children at risk of being targeted and prevent harm whenever we can.

When the worst does happen and a child is harmed, or if someone reaches out about an offence that happened some time ago, we have specially trained officers who understand the complex and sensitive nature of these issues and can ensure the right and necessary support is there.

Some years ago we have introduced exploitation and vulnerability trainers delivering training to those in jobs and roles that may be able to spot the signs of offences such as council workers, teachers, hotel staff and taxi drivers which has been invaluable.

We want people who are, or think they are, being exploited or are concerned about child sexual exploitation to report this to us. We will listen and we will act on any information given to us."[25]

66. In September 2022, the then Chief Constable, Pippa Mills, said:

"I was saddened and disheartened at the extent to which those affected by CSE had been let down and it was right that we made an unequivocal apology. I want to add to the apology my personal promise and commitment to ensuring that the force will not fail in

[25] https://www.westmercia.police.uk/news/west-mercia/news/2022/july/our-response-to-the-findings-of-the-independent-inquiry-into-child-sexual-exploitation-in-telford/

this way again. The teams dedicated to preventing and tackling child exploitation tirelessly pursue offenders and we are working with our partners to prevent such abhorrent crimes."[26]

67. In the lead up to the one year anniversary following publication, WMP issued a further update on progress against specific recommendations. Acting Assistant Chief Constable ("Acting ACC") Damian Barratt acknowledged that whilst improvements had been made, there was still more work to be done, and WMP remained "*unwavering in [its] determination to keep improving*" the way the service responds to CSE. [27]

PCC

68. In his response to the Inquiry Report, the PCC said:

"Victims and survivors, along with their loved ones, have been let down and I am sorry that this has happened. I cannot say with absolute certainty, just because lessons have been learnt, that it will never happen again. However, my drive as PCC remains resolute to ensure the system, that is there to keep people safe, continues building on the progress that has been made.

This report will no doubt have people questioning their confidence in policing. This is why my commitment is clear. I want victims to feel empowered to speak up, knowing that their local police, who are there to keep them safe, have learnt important lessons.

I am reassured that West Mercia Police has greater knowledge and understanding, better training and dedicated resources than it had in the past. Despite this progress, I will continue to support and challenge the force in delivering the level of service that victims and our community would expect.

Across West Mercia I have not only invested in more local police officers, but also in services and projects that raise awareness so that people can spot the signs of this abhorrent crime. This has to be a whole society approach if we are to be successful, in which communities play a vital role. I will equip communities to not only protect themselves, but those around them, and encourage them to report any concerns they have.

Doing everything possible to keep our vulnerable young people safe, and seeing that the full force of the law is brought down on those that seek to exploit them, is quite rightly what the public expect. This includes taking the recommendations from the inquiry and ensuring they are implemented. I will therefore ensure their voice is heard, reflected and represented as we continue in this drive to do better." [28]

69. At the one year anniversary mark, the PCC John Campion suggested that significant but unspecified progress had been made, and agreed with Acting ACC Damian Barratt's comments in his one year update, that more remained to be done.[29]

[26] https://www.westmercia.police.uk/news/west-mercia/news/2022/september/the-chief-reflects-on-her-first-12-month-in-post/

[27] https://www.westmercia.police.uk/news/west-mercia/news/2023/july/one-year-on-significant-progress-made-in-our-response-to-child-sexual-exploitation-in-telford/

[28] https://www.westmercia-pcc.gov.uk/telford-inquiry-pcc-statement/

[29] https://www.westmercia-pcc.gov.uk/pcc-statement-on-telford-inquiry-one-year-on/

Shropshire Council

70. Following publication, Shropshire Council issued the following statement:

"Child Sexual Exploitation is a horrific crime which must be rooted out at every opportunity.

The Inquiry has shown how this has ruined many young lives of its victims over a period of nearly 35 years and that opportunities to prevent this were missed. Our thoughts are with the victims and their families who must live with the impact of this crime and ensure they get the support they need.

The crimes that the inquiry has focused on in the neighbouring authority of Telford & Wrekin, are happening right across the country.

Thankfully awareness of this crime is now far greater. In Shropshire, we now have much stronger safeguards in place to help partners and the community identify, intervene and protect those at risk.

Practice among the very broad range of partners involved in protecting children at risk of sexual and other exploitation is now very different from that in 1989, the start of the period covered by the Inquiry but remains a challenge for all involved in children's safeguarding.
[…]

Everyone has a part to play in tackling this terrible crime: from our staff, our partners and professionals to the wider community. Perpetrators must be brought to justice and this is best achieved by partners working closely together.

We continue to work as part of Shropshire Safeguarding Community Partnership and to raise awareness of all forms of exploitation including Child Sexual Exploitation.
[…]

In the coming days, we will be taking time to read the report 1,249 pages in detail and consider its recommendations and the learning that we take from this to ensure we and partners are doing all we can to prevent exploitation of young people in Shropshire."[30]

71. At a Cabinet meeting of its members the following week, the Leader of Shropshire Council, Lezley Picton, issued her own apology to those who were failed by any shortcomings in Shropshire County Council's practice prior to 1998, and acknowledged that whilst the Inquiry focused on Telford & Wrekin, "*the lessons that must be learned apply across* [sic] *whole of the UK as nowhere, including here in Shropshire, is free from this crime*".[31]

72. In that statement, Councillor Picton went on to confirm that Shropshire Council was reviewing the Inquiry's 47 Recommendations, and would implement those that would improve practice in the area – including Recommendation 23 in relation to taxi licensing which applied directly to Shropshire and other authorities in the area. Shropshire Council

[30] https://newsroom.shropshire.gov.uk/2022/07/shropshire-council-statement-on-independent-inquiry-telford-child-sexual-exploitation/

[31] https://newsroom.shropshire.gov.uk/2022/07/leaders-statement-independent-inquiry-telford-child-sexual-exploitation/

said it would also be inviting relevant scrutiny committees to review the Recommendations to ensure that its processes "*are clear and open for all to see*".

NHS STW

73. The Inquiry Report was presented to the NHS STW Integrated Care Board ("ICB") Committee meeting on 28 September 2022,[32] where it was acknowledged that five specific Recommendations were relevant to the ICB,[33] and seven further Recommendations were relevant to joint agencies of which health was a part.[34]

74. In her report to the ICB, Alison Bussey, Chief Nursing Officer ("CNO") explained that:

"NHS STW ICB will consider the Report in full and review the recommendations with safeguarding partners locally and regionally and also in association with partner commissioners of services in health and social care. We also have to look beyond the recommendations to elicit further learning that is not set in the recommendations themselves…

… the ICB are the statutory health partner on the Telford & Wrekin Family Safeguarding Partnership Board and this is an opportunity to review our local system arrangements, looking wider than the Inquiry Report recommendations, to enable us to be assured we are delivering a real difference to our population.

The CNO, as ICB accountable executive, will lead the response to health recommendations, ensuring the delivery of all actions within the integrated plan, holding partners to account for robust and sustainable delivery of these. The Family Safeguarding Partnership Board and the newly recommended joint CSE subgroup hold multi-agency system safeguarding oversight and will approve the integrated action plan and provide progress assurance."[35]

75. She also issued an apology, and indicated the steps taken since the Inquiry Report, as follows:

"It is important that we recognise past failings and we apologise unreservedly for those, as well as welcoming recommendations in the Report that will help drive further improvements. […]

Much has already changed, and we have confidence that safeguarding procedures and multi-agency working are now far stronger than they have been historically. Steps that have been taken include: increased staff awareness; improving information sharing across agencies; recognition and response, training; and shared learning; as well as better partnership working across the system at all levels. The upward trend in referrals to the CSE panel offers some assurance that victims are being identified and receiving an appropriate response."[36]

[32] [redacted]

[33] Recommendations 42, 43, 45, 46 and 47

[34] Recommendations 1, 6, 10, 11, 18, 20 and 44

[35] [redacted] pg 120

[36] [redacted] pg 116

76. I was pleased to read the responses and commitments made by these organisations, and hoped that all agencies would seek to undertake the kind of reflective and comprehensive consideration of my Recommendations that I envisaged at the time of publication.

Section 4

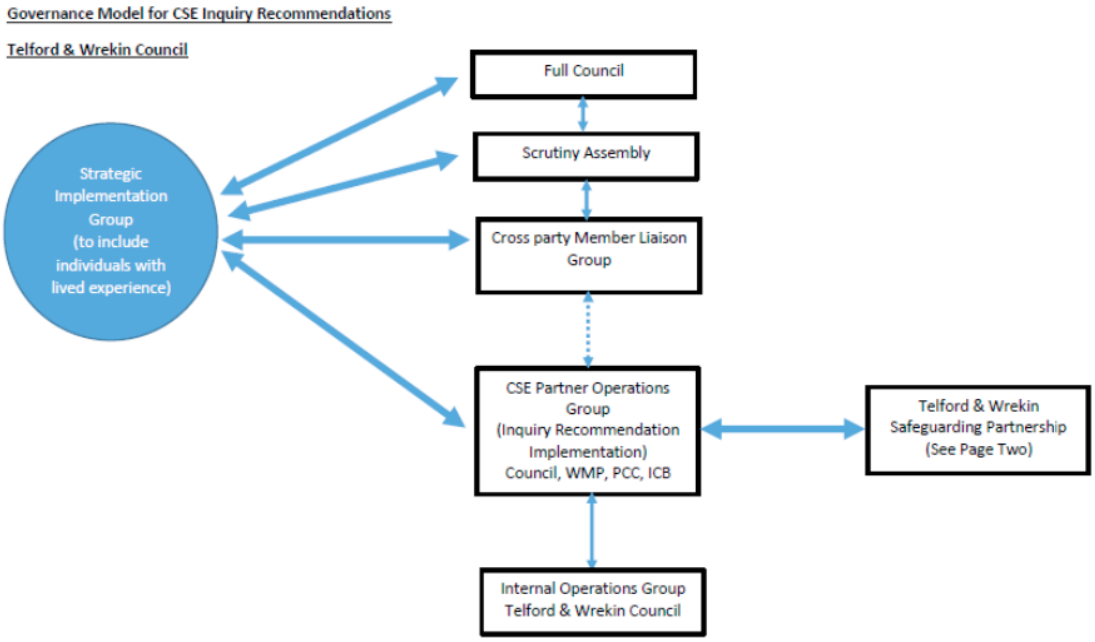
Methodology of Implementation

77. The need to set up structures to bring together key stakeholders and to drive change was of course an obvious and necessary step. The Council's Overview Report[37] noted that:

"…[f]*ollowing publication of the Inquiry Report in July 2022, it was necessary for governance structures to be agreed to ensure proper oversight of the recommendations both internally within each organisation and externally to ensure partnership working"*.

78. A crucial decision had, however, been taken very soon after publication of my Inquiry Report. At a Cabinet meeting on 14 July 2022, the Leader of the Council indicated that the Council would be working with individuals with lived experience of child sexual exploitation in shaping the response to the Recommendations.[38] These were the ILECs and it is important to note that the decision to bring them into the process was one for which the Council, through its political and officials' leadership, was entirely responsible.

79. I have read that the Council's proposed governance structure was as follows:[39]



80. The diagram demonstrates the central importance of the Strategic Implementation Group ("SIG"), and the Council's Overview Report explained the centrality of the ILECs to the process, in that it notes that the SIG was to be independently chaired, with that Chair being

[37] [redacted]

[38] https://newsroomarchive.telford.gov.uk/News/Details/16374

[39] [redacted]

selected following a recruitment process in which the ILECs were involved at every stage - including interview. Furthermore, the three ILECs were to sit on the SIG along with the Council's Leader and Lead Cabinet Member for CSE, the Chief Executive, the Executive Director of Children's Services and the Directors of Policy and Governance and Children's Safeguarding and Family Support.

81. WMP is represented in the SIG. The force also placed senior tactical oversight of its response to the Recommendations with the Head of Vulnerability and Safeguarding, a Detective Superintendent, and I was told that it has sought to ensure that Telford's Local Policing Area Commander and Crime and Vulnerability Lead have also been engaged in the process. I also heard that the force's response to the Inquiry has been regularly considered at the Strategic Vulnerability Delivery Board and progress towards Recommendations has also been considered at the Chief Officer Meeting and at the West Mercia Governance Board.[40]

82. NHS STW is represented in the SIG by its Director of Quality and Safety. NHS STW operated a six weekly IITCSE Health Subgroup, and there were scheduled meetings with the Chief Nursing Officer and Designated Nurse for Safeguarding Children, as well as a System Quality Group chaired by the Chief Nursing Officer.

83. The OPCC is represented in the SIG by the Chief Executive and/or the Deputy Chief Executive;[41] within the OPCC itself the Head of Policy and Commissioning has responsibility as the Strategic Lead for IITCSE. I understand that progress around Recommendations has been discussed in monthly meetings between the PCC and the OPCC Head of Policy and Commissioning, and in the OPCC Managers' Meetings, which take place weekly and are chaired by the Chief Executive or the Deputy Chief Executive. I have noted that the OPCC Governance Board, chaired by the PCC monthly, discussed IITCSE as an agenda item in August and September 2022 and in February 2023.[42]

84. The SIG's terms of reference[43] make clear that it has the ability to invite attendance from others, particularly education (both Council and Academy), the Council's public health, Licensing and Commissioning departments, and Shropshire Council, as well as specialists in the field of CSE. Meetings were initially scheduled on a "*broadly*" six-weekly basis.[44]

85. In addition to the SIG, an Internal Operations Group ("IOG") was created to oversee internal work within the Council as well as a Partners Operational Group ("POG"), intended, according to its terms of reference, to:

"*bring… together officers from a number of organisations across Telford and Wrekin who have a statutory safeguarding responsibility. Its purpose is to provide a positive forum that allows partners to work together in shaping the way in cross-organisational recommendations set out in the CSE Inquiry report will be implemented. It will also provide a forum for stakeholders to provide updates to the group on the implementation of recommendations that rest solely with one organisation, with the group acting as critical friend and providing constructive challenge in an open environment as needed*".[45]

[40] WMP Overview Report pgs 3-4 [redacted]
[41] [redacted] paragraph 3.13
[42] [redacted] paragraph 3.16
[43] [redacted]
[44] [redacted] paragraph 3.1
[45] [redacted] paragraph 1.2

86. The POG was intended, in particular, to provide liaison between SIG and the Telford & Wrekin Safeguarding Partnership.[46]

87. In my Inquiry Report I was, at times, scathing about the multiplicity of safeguarding groups and subgroups that had existed within the Council's structures, and sceptical as to their effectiveness.[47] It seemed to me that some of the groups continued to exist even when their usefulness had ceased. Against that background I was pleased to read that after the Council's Chief Executive began to take personal meetings with Directors and officers within the Council as to progress against Recommendations, the IOG was stood down as redundant.[48] I applaud the Chief Executive's decision and consider that him assuming personal responsibility likely gave the process impetus and urgency.

The Work of the ILECs

88. The appointment of the ILECs was no empty gesture. I have already indicated that they were closely involved with the formation of the SIG and were standing members of the group. In addition to their role within the SIG, Council officers met the ILECs every three weeks from December 2022 and those meetings became weekly five-hour meetings from April 2023.

89. ILEC meetings also took place with all other key stakeholders. As will be seen later in this Report, the ILECs played a central role in interpreting many of my Recommendations and placing them into context, as well as reviewing the work undertaken by key stakeholders, and offering advice and criticism. While I have heard that advice and criticism from the ILECs was often direct and sometimes unsparing, it was almost without exception regarded as tremendously valuable.[49] The following comments are typical of the views I heard in my meetings:

"I think the work of the ILECs has been absolutely fantastic… and I think the relationship that we've got with the ILECs has kind of developed alongside the relationship that they've developed with the council, as I say. So it's the amount of learning that we've kind of done as a result of the conversation. It's gone back, tested things out. It's been really helpful".[50]

"…it does make your teeth and your head and your fingernails hurt because it's so complicated. So, I kind of rewrote it to make it user friendly and we talked to the consultees about that and said 'you know I work for [a key stakeholder] *and I struggle to understand it' so tried to write it down for a lay person to understand".*[51]

"…talking to the consultees, to me it has been invaluable. You know we've had ideas of what we could do but they have really, actually adding so much to that and then our perspective of how people feel".[52]

[46] [redacted] paragraph 1.5

[47] Volume 2, Chapter 3: The Council Response to CSE in Telford https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cda0472b8809050c35b91d/1657643086095/IITCSE+REPORT+-+VOLUME+TWO.pdf

[48] [redacted] paragraph 3.5

[49] [redacted] pg 37

[50] [redacted] pg 15

[51] [redacted] pg 30

[52] [redacted] pg 7

"…working with [the consultees] has just been a complete experience… you feel so accountable… It has been the single most important thing."[53]

90. I have no doubt that the Council's decision to invite the ILECs to work with them on the implementation of Recommendations, and the ILECs' commitment to making the Recommendations work in the best way, has been key to the effectiveness of this process.

[53] [redacted] pg 13

Section 5

Analysis

91. In my detailed assessment of progress against Recommendations, I have considered them in groups as follows:

91.1. The first five Recommendations (1 to 5);

91.2. The CATE Team Recommendations (7, 10, 13);

91.3. Structural Recommendations (9, 11, 14, 18, 19, 21, 22);

91.4. Licensing Recommendations (23, 24, 25, 26, 27, 28, 29, 30, 31);

91.5. Training Recommendations (6, 12, 32, 42);

91.6. Schools Recommendations (33, 34, 35);

91.7. WMP Recommendations (8, 36, 37, 38);

91.8. PCC Recommendations (40, 41);

91.9. Health Recommendations (43, 44, 45, 46, 47);

91.10. Wider impact Recommendations (15, 16, 17, 20); and

91.11. The National Referral Mechanism ("NRM") (39).

The First Five Recommendations

92. The first five Recommendations deal with the formation of a Joint CSE Review Group (the "JCSERG"); the expectation that it will collect data relating to CSE from key stakeholders; and that it will publish an annual report setting out that data. The purpose of these Recommendations was to ensure a uniform approach to the collection of data, and also to ensure that the people living in Telford have the opportunity to understand the incidence and trends of CSE in the town, in order to understand better and, if necessary, challenge the steps being taken to combat CSE.

Recommendation 1

Recommendation 1

Establishment of a Joint CSE Review Group

The **Council** and **WMP** should take the lead in establishing a joint group, and shall identify and include other key stakeholder authorities, to include education and health sectors and such third sector agencies as the Council and WMP as lead agencies deem appropriate. The joint group's function will be to meet every six months, in order to:

- Consider data and information gathered – such data to include the incidence, trends and locations of CSE within the borough; missing persons/truancy data; referral numbers and investigations/complaints; licensing and night-time economy information; and any other data considered relevant;
- Analyse such data and information in order to provide a reliable set of statistics against which the threat/risk and prevalence of CSE can be measured, and any apparent increase or decrease in the number of CSE considered;
- Maintain minutes of each meeting, with appropriate action plans attached; and
- Publish a report setting out the results of the analysis and accounting to the public for the action being taken in response – as set out in **Recommendation 2**.

93. The Response Report on this Recommendation[54] submits that the Council has implemented it completely.

94. In considering this conclusion I have taken into account the following documents:

94.1. Joint CSE Review Group terms of reference;[55]

94.2. Annual Report of Joint CSE Review Group;[56]

94.3. Joint CSE review Group minutes;[57]

94.4. Presentation to the CSE Review Group;[58] and

94.5. Locality report.[59]

95. I have been told that shortly after publication of the Inquiry Report, the Council arranged a meeting of representatives from WMP, NHS STW and the Council. The purpose of the first meeting was to agree:-

95.1. Membership of the JCSERG;

95.2. Draft Terms of Reference for the JCSERG;

95.3. Practicalities of how data would be identified, collated, shared and analysed;

95.4. Who would lead on the preparation of the Annual Report required under Recommendation 2; and

95.5. The dataset to be used for the purpose of publishing the Annual Report.

54 [redacted]
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57
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96. Thereafter, the JCSERG met informally from October 2022 to March 2023 to develop its terms of reference and an action plan.

97. The JCSERG terms of reference[60] provide that membership of the group was as follows:

97.1. From the Council:
- Service Delivery Manager, Policy and Development;
- Insight Manager;
- Service Delivery Manager: Assessment, Child Protection & Family Support;
- Education Safeguarding Co-ordinator;
- Customer Relationship and Quality Assurance Team Leader; and
- Public Protection Group Manager;

97.2. From WMP, the Head of Analysis and Insight;

97.3. From NHS STW, the Deputy Director of Nursing and Quality; and

97.4. From the Midlands Partnership NHS Foundation Trust, the Head of Strategic Safeguarding.

98. The terms of reference provided that the JCSERG would also invite attendance from other individuals relevant to their area of expertise.

99. As to the processes of the group, the JCSERG terms of reference declared that:

99.1. The group will be chaired by a Chair and Vice Chair to be elected at the first meeting and holding the post for four years;

99.2. The group will meet every six months and be supported by the Council's statutory Partnership Team;[61]

99.3. Agendas and reports will be shared with attendees at least three working days in advance of each meeting;

99.4. Where a decision requires cross-organisational agreement and a consensus cannot be reached, matters will be decided by way of a vote. For that purpose, each organisation will have one vote each. The Chair will be responsible for administering, and recording the outcome of the vote. When called upon to do so, each member can choose to vote either in favour of a proposal, against a proposal or can abstain. In the event of an equality of votes, the Chair will have a casting vote;

99.5. Where an organisation has concerns that the outcome of a vote may result in harm to children or young people, they can utilise the Telford & Wrekin Safeguarding Partnership escalation procedure to seek resolution; and

[60] [redacted]

[61] [redacted] paragraph 5.14 – *"The statutory partnership team within the Council is responsible for supporting the Telford & Wrekin Safeguarding Partnership. This includes support with providing training to members of the Partnership."*

99.6. Minutes of each meeting will be taken and circulated within five working days of a meeting.

100. The JCSERG's terms of reference were to be reviewed no later than 12 months after the first meeting and no less than 12 months thereafter.

101. At a meeting of the group on 1 February 2023 the terms of reference were agreed in principle.[62] In March 2023, the group met formally for the first time. There have since been formal meetings on 26 July 2023 and 21 December 2023.[63]

102. **Having considered this material, and the commitments made in the terms of reference, I consider that the Recommendation as to formation of the JCSERG has been met.**

103. As to the JCSERG in operation, Recommendation 1 specifically suggested that the group should:

"*Consider data and information gathered – such data to include: the incidence, trends and locations of CSE within the borough; missing persons/truancy data; referral numbers and investigations/complaints; licensing and night-time economy information; and any other data considered relevant."*

and

"Analyse such data and information in order to provide a reliable set of statistics against which the threat/risk and prevalence of CSE can be measured, and any apparent increase or decrease in the number of CSE cases considered".

104. I have seen material which suggests that in preparing the Annual Report there had been agreement within the JCSERG that in addition to the above, the focus of the first Annual Report was intended to be to "*present a data profile of the multi-agency pathway in place*" to identify and support those at risk of, and victims of, CSE within Telford.[64] It was further agreed that data for the years 2020/21, 2022/22 and 2022/23 would be collated and analysed to provide a robust baseline position for the first Annual Report; such data to include:

104.1. *"The numbers of CSE contacts into Family Connect and their outcome, referrals into the CATE team and an assessment of which of these referrals were assessed as at risk of CSE or were actual victims of CSE";*

104.2. *"All cases that had been referred into CATE were to be shared with the Police so that they could audit their records to assess whether information about CSE cases was being shared appropriately between partners";*

104.3. *"An analysis by West Mercia Police of their records and any investigations instigated for these children and young people to develop a suspect profile and spatial analysis of crime location"; and*

62 [redacted] pg 5
63 [redacted] pg 9
64 [redacted] pg 7

104.4. *"Analysis of those CSE cases that school and college settings had identified."*[65]

105. The JCSERG considered the following features of the data during its preparation of the Annual Report:

105.1. *"How many contacts were made to Family Connect with indicators of CSE? Has the annual number of these contacts changed?";*

105.2. *"Who/which organisations made these contacts?";*

105.3. *"What was the outcome of these contacts? What support was provided?";*

105.4. *"What was the key characteristics of those who were provided with support?";*

105.5. *"What was their age, gender, ethnicity, special education needs and disability ("SEND") status and school or college attendance, have they been "missing"?;*

105.6. *"How many of those that received support were at risk of becoming a victim of CSE and how many were victims of CSE based upon the definition adopted by the IITCSE Report?";*

105.7. *"What criminal investigations were undertaken into the confirmed cases of CSE and what were the outcomes?";*

105.8. *"Where did the criminal activity take place?";*

105.9. *"What were the key characteristics of identified suspects?";*

105.10. *"How many children and young people have been identified with indicators of CSE by schools and colleges – whether assessed as vulnerable and provided with Early Help support or acute and complex and referred to Family Connect?";*

105.11. *"What risk indicators did schools or colleges identify?";*

105.12. *"What were the key characteristics of these cases including age, gender, ethnicity, SEND status and school or college attendance?";* and

105.13. *"What support did the schools or college provide?"*[66]

106. It seems to me that these matters encompass and indeed, in some cases, go beyond the specifics I set out in bullet points one to four of Recommendation 1.

107. The Annual Report sets out these raw statistics and, importantly, notes changes over the preceding three-year period. Further, and importantly in my view, it also looks beyond the data and seeks to derive from the data patterns to inform further actions. I do not propose to rehearse the contents of the report in detail: it is a public document, after all. But the value of the preparation of the JCSERG's Annual Report, both for the stakeholders and for the public, is shown in the following examples and findings:

[65] [redacted] pg 7 paragraph 5.2

[66] [redacted] - Annual Report of JCSERG, July 2023 pg 9 paragraph 35

107.1. The discovery that children with special educational needs were overrepresented amongst those receiving Safeguarding or CATE support for CSE;

107.2. The discovery that children receiving Safeguarding or CATE support for CSE were likely to have persistent or chronic absence from school in the term before referral;

107.3. That the number of NRM referrals "could be higher";[67]

107.4. That 20% of the 181 crimes reported (in connection with all confirmed CSE cases from the three-year research period) reflected online offending, and that fewer than 3% of those remaining reported crimes took place in licensed premises; and

107.5. That of 120 CSE suspects, 89% were male. Ethnicity was not stated for 31 of the suspects, but for the remaining 89 suspects, 83% were white.[68]

108. The Annual Report notes that it contains the first such in-depth analysis of CSE in Telford, and that subsequent discussions between the stakeholders throughout the development of the Annual Report have led to the development of a series of actions for further analysis and research, which will shape later reports by the JCSERG.[69] Those actions were that:

108.1. Research is shared with other local authorities and police forces and that they are invited to share data for the purposes of benchmarking and mapping CSE across England;

108.2. Anonymous contacts to Family Connect are monitored to understand the impact of changes to the Family Connect online contact form in accordance with the changes made in line with Recommendation 21;

108.3. Analysis is undertaken to benchmark the number of CSE contacts that are received from health providers, given that the initial research showed a relatively small number of such contacts, and which health providers these come from;

108.4. Further work should be undertaken through the secondary school and college CSE Lead Network to raise further awareness of the signs and indicators of CSE; to develop professional understanding of the contextual safeguarding thresholds; to update the online questionnaire for reporting; and to monitor the number of "vulnerable" cases that are being identified by each educational setting;

108.5. Re-referrals of cases that have been provided with support for CSE, whether via Early Help or CATE, are monitored to understand how frequently re-referrals occur and the reasons for such re-referrals;

108.6. Further work should be undertaken to profile the specific SEND support that is provided to the victims, and those at risk of becoming a victim, of CSE;

[67] [redacted] - Annual Report of JCSERG, July 2023 paragraph 64
[68] [redacted] - Annual Report of JCSERG, July 2023 pg 18
[69] [redacted] - Annual Report of JCSERG, July 2023 paragraph 76

108.7. Work should be undertaken to profile suspects, including their education attendance levels, SEND information, NEET status (not in education, employment or training), to understand their modus operandi and any evidence of CE to inform the development of early intervention programmes and how they can be targeted;

108.8. Locality profile of criminal activity should inform both the evolution of ongoing CSE awareness training programmes with specific reference to relevant businesses and cyber security for young people;

108.9. Return Home Interviews ("RHIs") should be analysed to identify any common patterns or trends in the reasons why children and young people who are a victim, or at risk of becoming a victim of CSE go missing and any other common features, and that this should include analysis of missing incidents before any referral to CATE; and

108.10. Referrals to the NRM are monitored to understand the impact of training programmes that have been revised to include the NRM and ensure increased NRM referrals, and such monitoring to include reflecting upon the implementation of Recommendation 39 and the multi-agency approach to NRM referrals.[70]

109. **This data collection and analysis not only meets what I contemplated in Recommendation 1, it goes beyond it. In my view, the stakeholders have taken the Recommendation as a foundation and have gone further, creating a framework for data sharing and analysis which is plainly relevant not only to the direction of support and disruption resources, but also to a greater public understanding of the nature and extent of CSE within Telford. This is an extremely positive approach which shows in my view a wholehearted adoption of the spirit of the Recommendation.**

Recommendations 2 to 5

110. These Recommendations provide for the publication of an Annual Report by the JCSERG containing specified information, which I have already touched on above. Notwithstanding its relatively recent creation, the JCSERG did publish its first Annual Report in the summer of 2023 – as noted above. It was then adopted at a Council meeting on 13 July 2023 and published on the Council's CSE webpages.[71] WMP also provided a link from a progress report on its website directing users to the Annual Report.[72]

111. The Council's Response Report[73] on Recommendations 2-5 suggests that they have been fully implemented. In assessing that conclusion I have taken into account the content of the Annual Report itself.

[70] [redacted] - Annual Report of JCSERG, July 2023, paragraphs 77-87

[71] https://www.telfordsafeguardingpartnership.org.uk/downloads/file/240/report-of-joint-cse-review-group-annual-report-2023

[72] [redacted] paragraph 5.10

[73] [redacted]

Recommendation 2

Recommendation 2

Joint CSE Review Group to publish an annual CSE Report

The **Council** and **WMP** should lead the Joint CSE Review Group in publishing an annual report, titled "Joint CSE Review Group Annual Report" (or similar). This report should include, at a minimum:

- The output of the statistical analysis carried out in accordance with **Recommendation 1**;
- Current staffing numbers/caseload ratios within the WMP CE team and the Council's CATE Team;
- The extent of collaboration and support sought from third sector organisations, including transparency about the level of funding ring-fenced for such support;
- Details of steps taken in relation to CSE training and awareness campaigns;
- Details of PCC funded resources and initiatives relevant to CSE;
- Statistics regarding the number of NRM referrals;
- Updates as to work undertaken to improve relevant services to children within the health and education sectors; and
- A summary of any complaints received by any of the member authorities regarding the handling of a CSE matter.

Each member organisation should publish a copy of the report on its website.

112. Recommendation 2 sets out the minimum information to be expected in the Annual Report. Those minimum requirements are in the left hand column of the table below, with references in the right hand column to the paragraphs of the Annual Report in which they are covered:

Recommendation 2	Paragraph in JCSERG Annual Report
The output of the statistical analysis carried out in accordance with Recommendation 1	35-73
Current staffing numbers/caseload ratios within the WMP CE Team and the Council's CATE Team	89-91 (WMP CE) 123-128 (CATE)
The extent of collaboration and support sought from third sector organisations, including transparency about the level of funding ring-fenced for such support	92-94
Details of steps taken in relation to CSE training and awareness campaigns	95-100
Details of PCC funded resources and initiatives relevant to CSE	104-106
Statistics regarding the number of NRM referrals	62-64
Updates as to work undertaken to improve relevant services to children within the health and education sectors	107-118
A summary of any complaints received by any of the member authorities regarding the handling of a CSE matter	119-122

113. As with the work of the JCSERG itself, I consider the contents of the Annual Report not only meet the requirements of Recommendation 2 but in many ways exceed them - for example, in order to provide a baseline for the statistical analysis, data from the years 2020/21, 2021/22 and 2022/23 was analysed and detailed information provided in relation to numbers of CSE contacts into Family Connect and the CATE Team, with information shared with WMP to provide effective audit.

114. **This response shows, in my view, a welcome intention to work with the spirit as well as the letter of the Recommendation. It is, after all, the stakeholders who know best how to measure their own performance and this is a task that seems to have been enthusiastically adopted.**

Recommendation 3

Recommendation 3

WMP to prepare mapping and prevalence data to be shared with the Joint CSE Review Group

In line with **Recommendations 1 and 2**: in advance of each Joint CSE Review Group meeting, and for the purposes of its Annual Report, **WMP** should prepare the following:

- An analysis of the incidence of, and its response to, CSE within Telford (a "prevalence report"). Subject to the need to protect the integrity of ongoing investigations and policing tactics, this should include reference to the numbers of complaints, reports, investigations, arrests, charges and conviction rates, as well as geographical distribution of CSE hotspots within Telford.

- A CSE activity analysis (a "mapping report") based on intelligence received from its own sources (including that collated via the Joint CSE Review Group), in order to ensure that an ongoing and targeted approach to CSE is maintained.

Copies of the prevalence report and mapping report should also be shared with the PCC in line with **Recommendation 41**.

115. As to Recommendation 3, it is important to note that while the Recommendation was that prevalence and mapping reports be prepared, there was no Recommendation that either report be published. The purpose of these reports was for WMP to bring the relevant data to the JCSERG in a conveniently digestible format, so that it could be reflected upon and used to inform ongoing strategy and action plans. A summary of the matters contained within the Annual Report is as follows:

115.1. WMP confirmed that all CSE cases shared by the Council were known to their Child Exploitation Team in line with multi-agency safeguarding procedures and that 96% made a disclosure of sexual abuse, sexual exploitation and/or sexual assault to the police;

115.2. From this, 181 crimes were investigated with 120 suspects identified;

115.3. Fifteen suspects were identified in more than one criminal investigation relating to sex offences;

115.4. To date, four (2%) suspects have been charged or summonsed against a national rate for the year ending 2019 of 4% of child abuse offences; and

115.5. Of those cases, 34% were halted because the victim no longer felt able to proceed; and 23% were halted because of evidential difficulties.[74]

116. It is right that I note that during some of my meetings with stakeholders in March 2024, queries were raised as to the accuracy of some of the data supplied by WMP.[75] Having carefully considered the disclosed data I do consider that such concerns centred around interpretation rather than accuracy; it is a lesson, though, that a public-facing report such as that envisaged by the Recommendations must ensure that its commentary and conclusions are carefully, and so far as possible neutrally, framed.

117. As to mapping, I have seen an analysis of CSE crime investigations by location within Telford – in essence a map with prevalence laid over the geography.[76] That document was not published as part of the Annual Report itself, and although thought was plainly given to doing so, I have received the following explanation as to why it was not:

"*In terms of locational data, whilst this information was obtained, there was concern that due to the small number of cases involved, the concentration of cases in any particular locality could cause concern amongst residents and could also lead to community tensions. However, this information is included in the evidence folder for the benefit of the Chair to demonstrate that the work has been done…*".[77]

118. I do understand the sensitivities about publishing location or map data and the potential for misunderstanding and the attendant risks. Ultimately, whether the JCSERG chooses to publish this data is a matter for it to decide, with the specialist knowledge and expertise of its constituent parts.

119. **It seems to me, though, that such an analysis should continue to be prepared for consideration by the JCSERG itself, and that it may be possible to publish the data in a way which does not cause concern, and which does serve to underline that CSE is not just a problem in particular areas, even if prevalence varies by area.**

Recommendation 4

Recommendation 4

Council to prepare CATE data to be shared with the Joint CSE Review Group

In line with **Recommendations 1 and 2**: in advance of each Joint CSE Review Group meeting, and for the purposes of its Annual Report, the **Council** should prepare the following:

[74] [redacted] paragraph 56
[75] [redacted] pg 28
[76] [redacted]
[77] [redacted] paragraph 5.13

- An analysis of its response to CSE within Telford & Wrekin to include numbers of CSE cases dealt with by Safeguarding processes, those dealt with by CATE processes, and to detail how many are new cases, how many are active, and how many have been closed.

120. As to Recommendation 4 and the sharing of CATE data, I note that this information was contained within the wider "baseline" historical material sought by the JCSERG in preparation for the first Annual Report.[78]

121. **Moreover, the information obtained went further than I had suggested in my Recommendation and included detailed analysis of CSE contacts into Family Connect as well as CATE, and sub-analysis of CATE contacts drawing distinctions between "at risk" cases and CSE contact cases. I therefore consider that Recommendation 4 has also been met.**

Recommendation 5

Recommendation 5

Schools and colleges to prepare data to be shared with the Joint CSE Review Group

- A six-monthly CSE statement (to be submitted prior to the six-monthly Joint CSE Review Group meeting) giving details of specific children showing indicators which may be indicative of CSE (the "children at risk report"), whether or not that behaviour merits immediate referral to CATE or Safeguarding; and

- A further six-monthly report (to be submitted prior to the six-monthly Joint CSE Review Group meeting) containing such information as may allow effective mapping of CSE ("school mapping report"), including but not limited to ages of children involved, the place of exploitation where known, their general places of residence, and any information which may establish the identities of perpetrators.

The above information should also include statistics and information relating to any missing from school episodes/ truancy records, in order to agree any steps that should be taken in relation to children that are shown to have regular difficulty attending school.

The children at risk report and the mapping report should be shared with the CATE Team, which in line with **Recommendations 1 and 2** will share the reports with the Joint CSE Review Group meeting for the purposes of its Annual Report.

122. As to Recommendation 5, it is clear from the material I have seen that the Council has made use of Recommendation 33 - that CSE Leads be introduced in schools (see paragraphs 333 to 342 below) - to create an information-sharing network of these CSE Leads to support Recommendation 5. A questionnaire for CSE Leads was developed to capture information relating to children with indicators of CSE. The information sought by the questionnaires related to:

[78] [redacted]

122.1. Age, gender and ethnicity;

122.2. Nature of indicators of CSE;

122.3. Location of incident;

122.4. Attendance record;

122.5. SEND support; and

122.6. Details of support provided.

123. In combination, I am satisfied that the information sought via the questionnaire adequately covers the terms of Recommendation 5 insofar as schools' data is concerned, and that this was shared with the JCSERG, and clearly reflected on in the Annual Report. I heard that this material would not previously have been centrally held or available to other stakeholders, as schools use different IT systems, but that following implementation of this Recommendation and Recommendations 33 to 35 relating to schools, there is now a live-updated central database relating to CSE data from schools.[79]

124. **These first five Recommendations were intended to be the foundation upon which change in Telford would be built. The establishment of the JCSERG was not an end in itself, of course, but a method by which data could be collated, shared, and published. That goal has clearly been met.**

125. The Annual Report itself noted:

"*This is the first time that analysis of this breadth has been undertaken to explore CSE in Telford & Wrekin. Its development has strengthened data sharing and analysis between the Council, schools, colleges and West Mercia Police".*[80]

126. Furthermore, I am pleased to say that during my Review my sense from stakeholders was that the JCSERG has been welcomed and has served a useful purpose. One joint response noted:

"*The value of the Annual Report cannot be underestimated in that it gave a new insight into CSE in the borough and, as such, will shape policy across all partner organisations for future years."* [81]

[79] [redacted] pgs 29-32
[80] [redacted] paragraph 74
[81] [redacted] paragraph 5.16

The Cate Team Recommendations (7, 10, 13)

Recommendation 7

Recommendation 7

Ring-fencing of CATE Team resource

- The **Council** should commit to the continued existence of the CATE Team within Telford at no less than its current strength in both numbers and budget (adjusted for inflation), for a period of no fewer than five years from the date of publication of this Report.
- Following the expiry of that period, in the event of no such further ongoing commitment, the Council should state publicly the reasons why, and the proposals for future management of children at risk of CSE.
- The Council should ensure that (i) CATE practitioners are protected from abstraction to cover other work; and (ii) practitioner caseload remains no higher than the current level.
- The Council should publish information regarding the resourcing and workloads of the CATE Team as part of the Joint CSE Review Group's Annual Report.

127. The Response Report on this Recommendation suggests that the Council has implemented it completely.

128. In considering this conclusion I have taken into account the following material:

128.1. Agenda for Full Council on Thursday 2 March 2023, 6.00 pm - Telford & Wrekin Council;[82]

128.2. Agenda for Cabinet on Thursday 4 January 2024, 10.00 am - Telford & Wrekin Council;[83]

128.3. Abstract from Director of Children's Safeguarding and Family Support Monthly Performance Dashboard: CATE Team Caseloads;[84] and

128.4. A statement from the Executive Director, Children and Family Services.[85]

129. As to commitment to CATE funding, I understand that:

[82] https://democracy.telford.gov.uk/ieListDocuments.aspx?CId=1136&MId=2179&Ver=4

[83] https://democracy.telford.gov.uk/ieListDocuments.aspx?CId=1134&MId=2404

[84] [redacted]

[85]

129.1. On 14 July 2022 the Council's Leader stated in a Full Council meeting that commitment to CATE funding would be protected for five years and beyond, so long as Labour continued to lead the Council;[86] and

129.2. Funding for CATE featured as part of the Medium Term Financial Strategy 2023-2027, and that the Strategy was agreed by Telford's Cabinet in February 2023 and Full Council in March 2023.[87]

130. It seems to me that this is as complete a commitment as can reasonably be given by the Council. I pause to note, though, that it would be reassuring if all major parties represented upon the Council would echo the commitment.

131. As to CATE workloads, the Director's statement reads as follows:

"*I declare that the practitioners within the CATE team have not undertaken, nor will they be expected to undertake, different roles, remits or responsibilities outside of the scope and function of the CATE team. In making this declaration, I confirm my ongoing commitment to the CATE team, to ensuring the sufficiency and capacity within the team to deliver the support needed to those impacted by exploitation*".[88]

132. Beyond that statement, an examination of the CATE Team's caseload reveals that between April 2021 and December 2023, maximum individual caseloads were overwhelmingly in the 9 to 11 case range, with a peak at 15 cases, corresponding with a peak of "open involvements" cases (meaning that a child has had contact with the CATE Team) of 101 against a usual number of between 60 and 80. This demonstrates, I consider, an effective "smoothing" of individual caseloads notwithstanding some volatility of open involvements – which are, of course, by nature to be expected and yet unpredictable.

133. CATE Team workloads featured within the first Annual Report of the JCSERG and I have been told that will continue.

134. **I am of the view that this Recommendation has been implemented in full.**

Recommendation 10

Recommendation 10

CATE Pathway to be reviewed

- The **Council** should carry out an immediate and thorough review of the published CATE Pathway to ensure that it sets out, with clarity, the model of response, intervention and support to be expected where a child has been sexually exploited, or is considered at

[86] Full Council Meeting minutes dated 14 July 2022 [redacted]

[87] https://democracy.telford.gov.uk/documents/s16834/Medium%20Term%20Financial%20Strategy%20202324%20202627_v1.pdf

[88] [redacted]

risk of future sexual exploitation, including the circumstances in which a child on the child protection pathway can obtain CATE support, and vice versa.

- This review should include consideration of current research and national best practice.
- The CATE Pathway should be reviewed annually to ensure that it remains fit for purpose.

135. The Response Report on this Recommendation suggests that the Council has implemented it completely.

136. In considering this conclusion I have taken into account the following documentation provided to me together with the Response Report:

136.1. CE pathway v1 flowchart;[89]

136.2. CSE pathway flowchart;[90]

136.3. CATE Practitioner Operational Guidance (October 2023 update);[91]

136.4. CSE Care & Support Pathway 2022/2023 (the "Pathway") (which was due for review in June 2024);[92]

136.5. Explore More Agenda;[93] and

136.6. Meeting notes 20 October 2023.[94]

137. I have also seen material which shows that:

137.1. The Pathway was under review from August 2022, following publication of the Inquiry Report, until November 2023. Initially the review was undertaken through October and November 2022 during meetings involving the Council's Director for Children's Safeguarding and Family Support, CATE practitioners, the Principal Social Worker, Children's Services managers and the police. I note that particular attention was given to the initial response section of the Pathway, which looked at how the Council responded on the receipt of CSE concerns. This led to combining the child protection and CATE pathways "*to ensure integration and fluidity between child protection services and the CATE service*",[95] with changes including a single point of referral (Family Connect) for all concerns.

137.2. During February and March 2023 the key meetings structure and activities associated with the Pathway were considered and reviewed by CE Subgroup members, CATE practitioners and their managers, police and Social Work

89 [redacted]
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95 paragraph 5.1

Managers. Additionally, CATE practitioners gained feedback from children at risk from exploitation and their parents. This ongoing review included consideration of best practice and national developments, including the University of Durham's contextual safeguarding approaches.

137.3. There were practical changes to the CE Risk Panel, which included amendment to the Panel's set agenda to include the views of parents and young people, and a disruption discussion, to ensure that contextual matters were discussed including what disruption actions had taken place and other actions agreed. It also added the inclusion of representation from a manager from the Council's Safer Stronger Communities, and the Neighbourhood and Enforcement Services, each to strengthen the contextual element of safeguarding.

137.4. Members from the Child Exploitation Subgroup delivered a contextual safeguarding workshop at the Telford & Wrekin Partnership Child in Need conference on 13 February 2023.

138. Notably, there was a meeting to discuss the Pathway on 7 March 2023 between the Director for Children's Safeguarding and Family Support, the Principal Social Worker, Service Delivery Managers from Family Connect and CATE, and the ILECs. I have seen notes of the meeting, and I was told about it by people present during my stakeholder meetings in Telford in March this year.[96] It is quite clear that, at the beginning of the process, the hoped-for approval of the Pathway, and perhaps even praise from the ILECs, was not forthcoming. The ILECs raised a number of concerns, with the overall theme being a risk of loss of focus on the particular imbalances of power characterising CSE, while considering wider definitions of criminal exploitation and child sexual abuse.[97]

139. There was disappointment on both sides; but instead of leading to disenchantment and stalemate, it is to the credit of all concerned that instead, the response was to establish a working group comprising:

139.1. The Council Director, Policy and Governance;

139.2. CATE Manager;

139.3. Safeguarding Social Workers;

139.4. CATE Practitioners;

139.5. Family Connect Social Workers; and

139.6. ILECs.

140. That group worked over the course of the next nine months or so to co-produce a bespoke CSE indicator document which was named "Explore More". This document, which was intended to provide a practical guide to any practitioner working with children as to the indicators that commonly suggest exploitation,[98] was endorsed by the Safeguarding

96 [redacted]
97 [redacted]
98 [redacted]

Partnership Board in December 2023 and has been in use by Family Connect since 18 December 2023.

141. At the same time, meetings were taking place between CE Subgroup members - the DCI and Detective Inspector ("DI") responsible for local policing of child exploitation in Telford, CATE Practitioners, and Safeguarding Managers - with a view to producing a guide as to how CSE is approached in Telford, how children are safeguarded and supported and, crucially, what a child and their parents can expect. These documents – the Pathway itself, and the associated "CATE Practitioner Operational Guidance"[99] – were also subject to ILEC review in late September 2023 and there followed a further series of meetings with the ILECs resulting in consequential amendments to the Pathway and its supporting documents. This included:

141.1. Professionals in Early Help services were now able to consult directly with CATE Managers should further consideration be needed for a young person to be allocated to a CATE Practitioner, strengthening the Family Connect service;

141.2. Family Connect will give parents details of a parental support project when children are received into Family Connect with CSE concerns;

141.3. The existing CE Pathway and supporting documents were changed to draw up and adopt a dedicated CSE Pathway[100] to ensure the focus was on CSE, rather than CE more broadly; and

141.4. In the event a social worker takes the view that no further support is required, there is now a mandated discussion with a CATE manager.[101]

142. The Pathway and supporting materials were provided to Service Delivery Managers in Children's Safeguarding and Family Support for discussion in November 2023, with approval from the Safeguarding Partnership Board following in December 2023.[102]

143. It seems to me that this process has been a model of collaborative working.

144. It is not easy to hear criticism, and it is easy to fall back on old ways of doing things – Telford's history, as set out in my Inquiry Report, shows the risk of doing that, and that harm can come to children when they cannot be supported unless they fit rigid criteria. It seems to me that the Pathway as it now stands demonstrates an admirable openness by Telford's professionals to listen to the experiences of those who know exploitation. I am told that this Pathway is intended to supplement or supplant statutory safeguarding processes in appropriate cases, "*underpinned by a contextual safeguarding approach*"[103] with the CATE Team at the centre.

145. **I accept that the process has included a wide-ranging review of national and local best practice and further, note with approval that there is to be an annual review process. My hope is that the rigour and determination that has been brought to this process – even when it has been uncomfortable – is not lost.**

[99] [redacted]
[100] [redacted]
[101] [redacted] pgs 5-6
[102] [redacted] paragraph 5.11
[103] [redacted] paragraph 32

146. **I accept that this Recommendation has been implemented in full.**

Recommendation 13

Recommendation 13

Case File Review/Audit

The **Council** should commit to an annual external audit of no fewer than ten randomly selected CATE case files and of no fewer than ten randomly selected Safeguarding case files relating to children who have been exploited or are at risk of exploitation, to ensure proper emphasis is established and maintained.

The **Council** should also ensure that:

- Safeguarding and CATE Team members focus appropriately on contextual safeguarding and not simply upon child behaviour modification; and
- That the extent and quality of information sharing is properly assessed.

147. The Response Report on this Recommendation suggests that the Council has implemented it completely.

148. In considering this conclusion I have taken into account the following information:

148.1. National Working Group ("NWG") proposal for audit;[104]

148.2. Agreement between NWG and the Council for a Case File Audit;[105]

148.3. NWG audit itinerary for the case file review;[106]

148.4. Case selection by NWG;[107]

148.5. NWG Independent Case Audit Report (24 and 25 July 2023);[108]

148.6. The Council's response to NWG's Audit Report;[109]

148.7. CATE training presentation on Contextual Safeguarding;[110]

104 [redacted] pg 5
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148.8. CATE training session notes/evidence sheet for Contextual Safeguarding session;[111] and

148.9. CATE away day and NRM development presentation.[112]

149. The Response Report on this Recommendation[113] suggests that the Council formally requested assistance and support from the NWG with regard to this Recommendation on 28 November 2022. The NWG, as described on its website, is:

"a charitable organisation formed as a UK network of over 14,500 practitioners who disseminate our information down through their services, to professionals working on the issue of child exploitation" and they *"offer support, guidance and raise the profile, provide updates, training, share national developments, influence the development of national and local policy informed by practice."*[114]

150. I have been told that the NWG was chosen as a result of its existing team of exploitation experts working in over 200 local authority areas, including undertaking reviews of exploitation provision.

151. In reply, the NWG's proposal encompassed:

151.1. Preparatory work to develop an annual audit framework and provision process i.e. methodology for random case selection, anonymisation (if required) and sharing with the NWG Network;

151.2. A "tabletop review" of the Council's approach including the structure of the CATE Team, the current Pathway and agreeing the audit framework to be used;[115]

151.3. Review of 20 cases (the NWG to select randomly ten CATE cases and ten 'safeguarding' cases); the auditor was not to be the person who completed the tabletop review referenced above and the case files were to be audited against the most recent version of the Council's own audit tool, dated June 2023;[116]

151.4. Access to the NWG Network Direct Delivery team and Network on an ad hoc basis to support the Council in the ongoing development of their contextual safeguarding approach;[117] and

151.5. Training for senior decision makers.[118]

152. The proposal included the NWG sharing its findings in a final report and repeating the audit process annually.

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111 [redacted]
112 [redacted]
113 [redacted]
114 https://nwgnetwork.org/
115 [redacted] paragraph 2.1.1
116 [redacted]
117 [redacted] pg 13
118 [redacted] pg 13

153. The Council accepted the proposal and the NWG audit took place over 24 and 25 July 2023. Care was taken to identify reserve cases in case the random selection resulted in an imbalance of cases e.g. too many from one team member. The auditor remarked that:

153.1. *"It was pleasing to note that in all safeguarding cases audited there was also CATE involvement resulting in all children and young people being able to access specialist CSE support and the pathway."*[119]

153.2. *"...the CATE Team consisted of individuals with diverse professional backgrounds/experience that complimented the aims of the work, a team that was agile and flexible in its response to children and clearly very passionate about their work."*[120]

153.3. They *"…particularly liked the model of joint working with social care colleagues, in all cases where social care were engaged a CATE practitioner was allocated and in many cases remained so after social care scaled down their interactions."*[121]

153.4. *"There was evidence of coordination by the CATE practitioners with care being taken not to overload the child with professionals and consideration of wider family support being made available."*[122]

153.5. *"It was evident there was a shared understanding of roles and responsibilities and a particularly impressive approach where between them they planned interactions with the child and who was best placed to make the contact."*[123]

154. In relation to the standard of case records and supervision, the auditor noted that this was *"an area of concern in many less mature local authority areas"*, but the cases they had reviewed for Telford were of a high standard, being comprehensive and up to date.[124] The audit found that:

154.1. *"supervision was evident within the notes, with evidence of specific supervisory reviews that demonstrated discussion, knowledge of the case and a subsequent plan with direction and support for the practitioner"*, and *"…supervisory entries were not simply a process to be followed but a meaningful part of disruption and prevention."*[125]

154.2. *"Again, in all cases it was evident that consideration by all staff, CATE, Social Workers and Supervisors kept all options open in terms of the right practitioner for the right intervention."*[126]

[119] [redacted] paragraph 2.1.2
[120] [redacted] paragraph 4.3
[121] [redacted] paragraph 4.4
[122] [redacted] paragraph 4.4
[123] [redacted] paragraph 4.4
[124] [redacted] paragraph 4.6
[125] [redacted] paragraph 4.6
[126] [redacted] paragraph 4.7

154.3. Assessments were completed in a timely fashion and recorded within the case notes and there was evidence that they informed planning and activity.[127]

155. The auditor paid particular attention to language used by practitioners and found "*no inappropriate descriptive phrases such as victim blaming, behaviour modification or exclusionary language*".[128] The audit further remarked how in discussions the practitioners displayed an awareness of both the issue and how it can impact directly and indirectly on the child as well as the service provided.

156. The auditor expressed the view that:

"*It was pleasing to see the scale of not just the child's voice being captured and recorded but how it informed activity that not only served to build trust and rapport with the child but also informed appropriate planning for the child. The benefit was made clearer in the risk panel in two cases where this approach not only contributed to the CATE team's ability to respond to the child but intelligence and understanding shared with other agencies made for planning that was far more likely to succeed*".[129]

157. The audit did however find some room for improvement:

157.1. In five of 20 cases, there was a delay in accessing a specialist school placement recommendation following an EHCP (Education and Health Care Plan), which was thought to reveal a need for the CATE Team to escalate these issues more effectively. The NWG recommended this be attended to;[130]

157.2. A greater awareness of disruption activity and understanding of disruption tactics available might benefit CATE practitioners. The audit made clear that the auditors had seen evidence of a good local relationship between CATE and police colleagues, which could be built upon in this regard. The NWG recommended this be attended to;[131] and

157.3. There was some inconsistency about consideration of the NRM, although the audit noted that the position was now that in all cases an NRM referral is the default position, with agreement between police and the Council as to who would lead the referral.[132]

158. The audit concluded that:

"[t]*he NWG Network have been left feeling confident that this audit is indicative of a strong CATE team, supported by enthusiastic supervision, social care colleagues and wider partnership colleagues. There is a palpable enthusiasm and passion within the team to progress child and family centered outcomes which through additional training will only grow. The parallel but not exclusive pathway that brings social care and the CATE team*

127 [redacted] paragraph 4.9
128 [redacted] paragraph 4.10
129 [redacted] paragraph 4.11
130 [redacted] paragraph 4.12.1
131 [redacted] paragraph 4.12.2
132 [redacted] paragraph 4.12.2

together and the default position relating to the NRM are both areas the NWG Network will reference as good practice to other local authority areas".[133]

159. I have seen material which shows that, since the NWG audit, the Council has:

159.1. Dealt with the NWG recommendation relating to children's educational needs: by way of a separate review of the audited cases by the Service Delivery Manager for Special Educational Needs; by ensuring that SEND are represented at the post-17 transition meetings; and by ensuring that CATE has a SEND "champion" in the team. An escalation process of unresolved children's education matters has also been put in place.[134]

159.2. Responded to the NWG recommendation that CATE practitioners should have a wider understanding of disruption activity and tactics by way of: discussion between the respective managers of CATE and the WMP CE team about the NWG audit finding and recommendations;[135] by the WMP CE team manager arranging CATE training in relation to police and disruption; and by a further contextual safeguarding training session for CATE[136] and NRM training from a lived experience consultee.[137]

160. The Council has agreed to repeat the audit annually.

161. As to the other parts of Recommendation 13, I have seen material relating to contextual safeguarding training delivered on 15 February 2023[138] and a note of the session which remarks:

"*The team worked well to identify some of the ways in which plans could be improved, changing the focus to a wider context, language that was more inclusive, spending time with the young person and parent/carer to develop plans that would be helpful, relevant, and realistic and reduce risk from all contextual perspectives. The feedback on the session was that this was really helpful to refocus and produce assessments and plans that were more meaningful and informed, based on a model that was developed to assist in reducing harm outside of the family home and took into account the influences that young people, parents and cares are facing on a daily basis in a realistic way*".[139]

162. I have also seen material relating to a CATE "Away Day and NRM Presentation" which took place on 23 October 2023[140] and reflected the post-NWG audit position that all young people supported by CATE would have an NRM referral made.

163. **It seems to me that the Council's response to this Recommendation has been positive and comprehensive. The NWG audit revealed much to celebrate in the**

133 [redacted] paragraph 5.1
134 paragraph 5.9
135 pg 5
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CATE Team and the approach to CSE generally, making clear that the "*parallel but not exclusive pathway*" is a model of good practice.

164. I should note that the NWG recommendation that the CATE Team learn more about disruption led to some disquiet amongst the ILECs and I understand they felt that it was not a CATE practitioner's responsibility to educate themselves on what they saw as a police responsibility regarding disruption activity.[141] I understand that there will be strong memories of a time, as I recall from my earlier investigations in this Inquiry, when CATE Team youth workers were putting themselves at risk to engage in their own disruption activities. I do not consider that anyone is suggesting that should happen again. My interpretation of the Recommendation has been that CATE Team members should understand the tactics of the police, as a partner agency.

Structural Recommendations (9, 11, 14, 18, 19, 21, 22)

Recommendation 9

Recommendation 9

Council should review its subgroups

- The **Council** should review the number, membership and remit of all groups and subgroups – internal and with partners - dealing with CSE.
- Group membership should be limited, to ensure effective meetings, and be open to those most qualified to bring value - not be based simply on seniority.
- Strategic meetings should <u>always</u> include a practitioner – someone working directly with children and their families.

165. The Response Report on this Recommendation suggests that the Council has implemented it in full.

166. In considering this conclusion I have taken into account the following documents:

166.1. Telford & Wrekin Safeguarding Partnership Review of Partnership Arrangements dated 9 May 2023;[142] and

166.2. Child Sexual Exploitation and Child Exploitation Sub-Group Terms of Reference.[143]

141 [redacted] paragraph 5.7
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167. The Council's Response Report on this Recommendation[144] notes that following publication of the Inquiry's Report, there was a review of the governance arrangements for the Telford & Wrekin Safeguarding Partnership, with emphasis upon:

167.1. The structure and membership of the Partnership, its boards and associated sub-groups;

167.2. The arrangements for independent scrutiny and the role of the Chair; and

167.3. Arrangements with other strategic partnerships.

168. The review of the Safeguarding Partnership noted the statutory duties upon the local authority to safeguard children and adults under the Children Act 2004 and Care Act 2014, and the requirement under the Working Together guidance to ensure effective challenge of multi-agency safeguarding arrangements.

169. The review went on to consider the then-current arrangements, namely that the Partnership Executive oversaw both a Safeguarding Children Board and Safeguarding Adults Board, with all three bodies chaired by the same independent chair - who had served in equivalent roles since 2012. The review noted that this state of affairs "[limited] *the independent challenge and scrutiny that the Executive provides.*"[145]

170. The review noted that there was no specific statutory guidance as to the proper term an independent chair should serve, but did make comparisons with other local authority oversight roles – for example complaints and audit roles – and found that a term in the region of four to five years, with a restriction on more than one renewal, was common. Nor, despite the potential for very long service in the role, was there a mechanism to provide for scrutiny of how the independent chair discharged the role.[146]

171. The review considered attendance rates at the latest Safeguarding Children Board subgroups and found, in an echo of my Inquiry Report, a disturbing lack of engagement.[147]

Group	% attendance
Partnership Development	56
QPO	69
Child Exploitation	50
Neglect	43
Child Safeguarding Practice Review	77

144 [redacted]
145 [redacted] paragraph 5.10
146 [redacted] paragraph 5.6
147 [redacted] paragraph 5.15

172. The review concluded that:

172.1. The Safeguarding Partnership Executive should be stood down;

172.2. The safeguarding boards for adults and children should remain separate, given that historic experience showed that merged boards did not provide adequate capacity to cover the necessary ground;

172.3. The safeguarding boards should retain an independent chair, but that the chair of each board should not be the same person, and with each chair serving a maximum of 25 days per year;

172.4. Each board should have a three year rolling strategic plan with an annual review, the review to be published on the partnership website;

172.5. Each board should publish an annual report setting out how it has delivered against its strategic plan;

172.6. Each board should meet no fewer than four times a year;

172.7. Attendance at all meetings and subgroups should be monitored and reported to the respective boards;

172.8. There should be a merger of certain subgroups of the Safeguarding Children Board and the inception of thematic subgroups, though with retention of the Neglect and Child Exploitation subgroups; and

172.9. The Child Exploitation subgroup should ensure its membership includes appropriate participation from practitioners.[148]

173. **It seems to me that the Council's response to this Recommendation is complete. It has carefully considered a longstanding system; such scrutiny is not always easy. It has removed an upper tier of bureaucracy with the Safeguarding Partnership Executive and ensured independent scrutiny by ensuring that independent chairs do not chair more than one board; and I note that this combination of measures has reduced spend on independent chairs, given a slight reduction in the daily rate and an overall maximum of 50 days' service over two boards rather than the previous 60 over three. It has sought greater focus with the inception of thematic groups and specifically retained the Exploitation and Neglect groups, underlining the importance of these areas.**

148 [redacted]

Recommendation 11

Recommendation 11

Implementation of an Adulthood Transition Meeting

The **Council** should commit to immediate implementation of an Adulthood Transition Meeting as part of the CATE Pathway for cases where a CATE child transitions to adulthood.

174. The Response Report on this Recommendation[149] suggests that the Council has implemented it fully.

175. In considering this conclusion I have taken into account the following material provided:

175.1. Adulthood Transition Panel Overview template document;[150]

175.2. Template Agenda for Post-17 Transition Panel Meeting;[151]

175.3. Flowchart for Adulthood Transition Meeting;[152]

175.4. Terms of reference for the Post-17 Transition Meeting;[153]

175.5. Post-17 Transition Meeting Case study;[154]

175.6. Post-17 Transition Panel Action log;[155] and

175.7. The Pathway.[156]

176. The Council indicated compliance with the Recommendation by way of the following:

176.1. A formal process is in place as part of the Pathway to ensure that all young people affected by CSE continue to have their needs supported as they transition into adulthood;

176.2. This process is to include a panel of professionals who collectively can identify and secure an individual package of support for each young person affected by CSE going into adulthood; and

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176.3. All young people aged 17 currently open to the CATE Service, whether they are experiencing CSE or at risk of it, will be discussed at this panel, having gained the young person's consent to do so. If consent is not gained the young person will not be discussed at the panel.

177. I have heard that the establishment of an Adulthood Transition Meeting (also known as Post-17 Transition Meeting) was considered during the Pathway review.[157] A draft terms of reference[158] initially issued in January 2023 spoke of the Post-17 Transition Meeting as comprising:

"…a 'floating' group of specialist officers from across council services and the voluntary sector, which aim to provide a menu of support appropriate to a young person's needs, after experiencing CSE. This support will continue to be tailored to the point they reach 18 but will also serve them 'here and now', with advice being given from 17 years to ensure young people are supported in their journey to adulthood and beyond".[159]

178. The terms of reference further set out that the group will act as an advisory panel, called during the regular Risk Panel meetings when a young person who has been abused through CSE reaches 17. The group will discuss the young person's present risks and needs to understand what non-statutory adult social care support can be provided at 18. This may include:

178.1. *"NEET support";*

178.2. *"Emotional wellbeing support";*

178.3. *"Tenancy sustainment support, including signposting to independent living support in the community";*

178.4. *"Financial support, such as for universal credit, or council tax reduction";*

178.5. *"Healthy relationship support";*

178.6. *"Employment support via Telford Job Box";*

178.7. *"Learning and education offer via Learn Telford courses";*

178.8. *"Substance misuse support, via external agencies such as STARS";*

178.9. *"Community and Neighbourhood support";* and/or

178.10. *"The Holly Project, a charity focused on adult victim/survivors of CSE".*[160]

157 [redacted] paragraph 5.1
158 [redacted]
159 [redacted] pg 3
160 [redacted] pg 3

179. Notably, the specimen agenda for a Post-17 Transition Panel[161] includes the final question "*NRM – Has it been submitted? Has it been updated?*". This is, in my view, appropriate given the support that is available via the NRM to those who are victims of trafficking or modern slavery and its value to a young person transitioning to adulthood.

180. I have read that the young person is invited to attend and to participate in the discussion about what transition plan would be most suitable for them and that the designated practitioner would follow up at each relevant Risk Panel until the child reaches 18, when a final package of contacts and support will be set out and provided to the young person.[162]

181. The Response Report on this Recommendation notes that Post-17 Transition Meetings are now fixed within the Pathway and take place on a rolling six week cycle. At the point the information was submitted for the purpose of my two year review, all young people had accepted the offer of the transition meeting. This is encouraging.

182. I was told during my conversations with Council officials with knowledge of the working of the Post-17 Transition Meetings that the meetings are under constant review, and that this review process, together with input from the ILECs, has already led to a material addition - housing support is now included in the meetings.[163] This is much welcomed – as a demonstration of the fact that the systems are not set in stone, but for the practical benefits; housing is a fundamental need, and the absence of safe accommodation is a major concern for children facing adulthood.

183. I also understand that a review of the Post-17 Transition process took place on 27 June 2024 with all Panel members, and all agencies were of the view that the process was working well. It was also agreed that a multi-agency audit of five young people that have been considered at the Post-17 Transition Panel will be undertaken in September 2024 to review both the plan and the outcomes. I am told this is to ensure that the process is effective and working well, as well as to identify any learning opportunities that would enhance the process. This would be 12 months on from the process being implemented. Again, I welcome this ongoing review.[164]

184. **I do take the view that the Council is right to regard this Recommendation as complete. I noted in the Inquiry Report that the Post-17 Transition has been a notorious cliff-edge for too many children for too long. I consider that the changes made by the Council to ensure that those open to CATE are prepared for adulthood transition in this way, with appropriate panel oversight and signposting to Council and NRM support, represent very positive developments.**

161 [redacted]
162 [redacted] pg 3 and [redacted]
163 [redacted] pg 3
164 [redacted]

Recommendation 14

Recommendation 14

CATE's information sharing protocols with schools to be reviewed

The **Council** should review the information sharing protocols in place with schools, and update them as necessary to ensure that the CATE Team shares information with schools that identifies CSE threat levels, trends and groups as well as individuals; with a view to allowing schools to react, monitor and protect children better.

185. The Response Report on this Recommendation[165] suggests that the Council has implemented it in full.

186. In considering this conclusion I have taken into account the following documents:

186.1. CSE Information Sharing Agreement;[166]

186.2. CSE Information Sharing Pathway Guidance;[167]

186.3. Terms of reference for CSE briefings for nursery, infant, junior and primary schools;[168]

186.4. Various CSE Designated Safeguarding Leads ("DSL") Network meeting minutes;[169] and

186.5. Example Note of a School Visit.[170]

187. The CSE Information Sharing Agreement, which was made on 25 September 2023 between the Council and all schools and colleges within its area, states as its purpose "*to enable all schools and colleges in Telford and Wrekin to receive and share information in context of child sexual exploitation (CSE) with the CATE Team*". It provides for sharing of "*non-person specific information such as geographical locations, social media trends and other thematic information*", while providing a method for sharing of sensitive identifying information by way of the "*CSE Leads Network and Primary School CSE briefings*".[171] The agreement sets out a legal basis, not dependent upon consent, for sharing information and provides for a two-yearly review of its operation by the CSE DSL Network.

188. The operation of the agreement and accompanying guidance relies on the CSE Leads (that were the subject of Recommendation 33), the CSE DSL Network, and delivery of CSE briefings that have been created as a result. I note that on a half-termly basis at the CSE

165 [redacted]
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171 [redacted] pg 1

DSL Network meeting, and on a termly basis at the CSE briefings for nursery, infant, junior and primary schools, the CATE Team and WMP, who are in attendance, share information regarding CSE threat levels, trends and groups.

189. CATE's involvement in the process is specified within the terms of reference for the CSE DSL Network[172] and the CSE briefings for nursery, infant, junior and primary schools,[173] each providing for attendance by CATE practitioners and WMP staff to "*discuss and update on themes and local intelligence*".

190. I understand further that the Education Safeguarding Team conducts both cyclical and risk-led safeguarding audit visits to all schools and colleges in the Borough,[174] and that as part of these visits, officers review with DSLs and CSE Leads how they have used the information received.[175]

191. I have been told of further developments beyond the documents originally submitted – namely:

191.1. That as a result of ILEC concern about professional disagreement, an escalation policy has been put in place across the Council's services generally and that this policy applies where there is a disagreement about information sharing – an important feature given what my Inquiry Report found in respect of the concerns of teachers historically being ignored, and information sharing being discouraged;[176] and

191.2. That school nurses are now part of the CSE DSL Network meetings.[177]

192. **Again, I take the view that the Council is right to regard this Recommendation as satisfied. I was pleased to hear that all schools, including independent schools, have signed the agreement and particularly gratified to hear from a group of teachers from different schools about the extent to which they welcomed and had embraced the new system.**

Recommendation 18

Recommendation 18

Council to review annually all CSE therapeutic support services

The Council should annually review its CSE therapeutic support offering, to include services it provides directly and services it commissions, to ensure that:

- The offering is sufficiently broad in scope, encompassing mental health support and specialist trauma based support;

172 [redacted]
173 [redacted]
174 In line with its obligations to do so under s157 and s175 of the Education Act 2002
175 [redacted] pgs 7, 12 and 16
176 [redacted] pg 4 and [redacted] pg 3
177 [redacted] pg 7 and [redacted] pg 3

- The support is available for victims/survivors as children, when transitioning to adulthood, and ongoing support for victim/survivors in adulthood, including a focus on relationships and parenting;
- Such support is sourced from a range of providers, including national and local third sector groups;
- The support offering as a whole is clearly signposted to CSE victims/survivors and their families; and that
- The allocated budget is sufficient for need.

The review should be published annually as part of the Joint CSE Review Group Annual Report.

193. The Response Report on this Recommendation[178] suggests that the Council has implemented it completely.

194. In considering this conclusion I have taken into account the following documents provided to me:

194.1. Call-off framework specification;[179]

194.2. Email correspondence with the British Association for Counselling and Psychotherapy ("BACP");[180]

194.3. Children and Young People's Contingency Offer;[181]

194.4. Provider market research;[182] and

194.5. Emails regarding budget.[183]

195. I heard from the Council that there was a gap in provision for therapeutic CSE support services, but not an unusual one – its research had shown that other local authorities did not offer such services. The Response Report notes that, as a result and in response to the Recommendation, the Council worked with the ILECs and a therapist to develop a specification for the service required.

196. That specification was reviewed by the NHS STW's Safeguarding Nurse and her team, who were also co-opted onto the tender evaluation panel. On 22 December 2023, tenders were issued to invite local and national organisations with relevant experience to join a call-off

178 [redacted]
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framework to support children, adults and families affected by CSE. I have seen a list of those organisations.[184]

197. I was told during my meetings with stakeholders that the tenders closed in January 2024, and that contracts were issued to three providers in early March 2024[185] – the issuance of contracts after tender suggests a sufficiency of budget. The contracts will require quarterly activity reports to be submitted by the providers detailing the number of referrals and the progress of people accessing the service, within the remits of patient confidentiality, to provide the Council with ongoing assurance as to the services provided.[186]

198. I heard that the next step is to develop, in conjunction with the ILECs, a website to promote the service.[187]

199. **It seems to me that the Council is right to regard this Recommendation as satisfied, and in fulfilling the Recommendation I am of the view that it has created a support service which I hope will be of great value to those affected, directly and more broadly, by CSE.**

Recommendation 19

Recommendation 19

Youth support

The **Council** should commit to collaborating with those bodies best able to offer replacement for community support services for children - for example, youth club provision - no longer provided by the Council.

200. The Response Report on this Recommendation[188] suggests that the Council has implemented it in full.

201. In considering this conclusion I have taken into account the following:

201.1. Terms of Reference, Youth Partnership Board;[189]

201.2. Meeting Agenda for Youth Partnership Board, 10 January 2024;[190]

201.3. Youth Development Officer Job Description;[191] and

201.4. Website and Directory of resources.[192]

184 [redacted] paragraph 5.2 cross-referenced to [redacted]
185 [redacted] pg 6
186 [redacted] pg 23
187 [redacted] pgs 6-8
188 [redacted]
189 [redacted]
190 [redacted]
191 [redacted]
192 [redacted]

202. The Response Report indicates that the Council began an initial consultation with young people in July 2022, following publication of the Inquiry Report, with a view to establishing the scope for the work of a "Youth Officer" in Telford. There was then an exercise in mapping existing provision and seeking feedback from the SIG.

203. The purpose of the "Youth Officer", or "Youth Development Officer", according to the job specification I have seen, is to:

"…build capacity in the community to support the development of quality youth work and enhance the quality and scope of youth provision in community settings, so that young people can be healthy, stay safe, enjoy and achieve, make positive contributions and achieve economic wellbeing. Alongside this, to coordinate the project management of the delivery of the Telford and Wrekin provision to the youth sector". [193]

204. The Youth Development Officer is a full time or full time equivalent role. I heard in my meetings with stakeholders that the Youth Development Officer is now in post.[194]

205. In the meantime, in September 2023 the Department of Culture, Media and Sport ("DCMS") issued a requirement under Section 507B of the Education Act 1996, that local authorities must fulfil their statutory duty to secure, so far as is reasonably practicable, access for young persons[195] to sufficient educational and leisure-time activities and facilities for the improvement of their well-being and personal and social development.

206. The result was the inception of the Telford & Wrekin Youth Partnership Board, chaired by the Executive Director of Children's Services and including representatives of the following organisations:

206.1. The Council (including Children's Social Care, Education and Skills, and Safer, Stronger Communities);

206.2. Town and Parish Councils;

206.3. WMP;

206.4. The OPCC;

206.5. Telford & Wrekin Community and Voluntary Services;

206.6. Shropshire, Telford & Wrekin Integrated Care System; and

206.7. Youth Voice Representative.

207. I was told that the emphasis on children's voices in the Youth Partnership Board was a direct result of the submissions made by ILECs.[196]

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193 [redacted]

194 [redacted] pg 6

195 Defined as young people aged 13-19 years old and up to 24 years old for those with learning difficulties or disabilities

196 [redacted] paragraph 5.4 and [redacted] pg 7

208. The Youth Partnership Board's terms of reference suggest that it will meet every two months initially and then quarterly, with an aim of "*shaping the delivery of priorities set by the partnership which are informed and influenced by the local context and the voice of young people.*"[197]

209. I have read that the Telford & Wrekin Youth Partnership website has been established and went live on 15 January 2024. The website initially acted as a directory for young people, parents/carers and professionals to search for youth activities taking place, and a live map calendar of events has subsequently been added. A communications plan targets providers to share any events, activities or groups that can be added to the site.[198]

210. The Council has also been looking at improving the breadth of its youth activities on offer, by both designing a communication campaign to raise awareness of the youth provision in Telford, and by speaking to providers and encouraging them to seek support from the Council for funding applications for new provision.[199] I also heard that, in line with statutory guidance, the Council will launch a youth survey to take on board young people's views to inform its priorities.[200]

211. In my discussions with Council representatives I heard that existing youth workers have also been CSE trained and that has been "*key to increasing confidence that they will now know how to respond effectively when CSE/CE is suspected*".[201] This is not strictly required by this Recommendation but I consider it is important and sensible, given the central role youth workers played in the uncovering of Telford's CSE in the 1990s and 2000s, as detailed in the Inquiry Report.

212. **It seems to me that the Council is right to regard this Recommendation as complete, and in fulfilling the Recommendation it has created an imaginative structure which I hope will provide a strong youth offer within Telford both now and in the future.**

Recommendation 21

Recommendation 21

Council should refresh its system for reporting of concerns

- The current website based system for reporting of concerns via Family Connect requires registration. This could serve as a barrier to reporting.
- The **Council** should institute and publicise a system whereby such concerns can be reported truly anonymously via a number of channels, whether by whistle-blowers or members of the public.

197 [redacted]
198 [redacted] paragraph 5.4
199 [redacted] paragraph 5.6
200 [redacted] paragraph 5.7
201 [redacted] pg 6

213. The Response Report on this Recommendation[202] suggests that it has been implemented in full by the Council.

214. In considering this conclusion I have taken into account the following:

214.1. The webform on the Council website;[203] and

214.2. The CSE Communication Campaign www.saysomethingtelford.co.uk.

215. The Response Report on this Recommendation accurately notes that the previous "anonymous" system of reporting required a user to register using personal information. I was told during the course of the Inquiry that this material was disregarded when dealing with a case, but I took the view that the requirement itself might serve as discouragement.

216. I have read that between December 2022 and February 2023, the Council engaged in discussions and meetings with its Information Design Technology Local Authority Service to develop a truly anonymous referral system.[204] When technological matters had been resolved, there was discussion with the ILECs around the design and language of the reporting form and advice sought from ten other local authorities which operated anonymous referral systems. The form was finalised in May 2023 and tested thereafter before going live in December 2023, following formal adoption by Family Connect and the development of a campaign to publicise the CSE reporting process.

217. I have read further that the campaign, and associated website ("Seen Something? Say Something")[205] was launched on 19 January 2024 to raise public awareness of signs and symptoms of CSE and to encourage this to be reported.[206] The web pages provide a clear 'call to action' button on every page to report concerns and this links to the CSE anonymous referral form, as do the CSE pages on the Council's own website.

218. Interestingly, an analysis carried out in Family Connect during the development of the anonymous reporting system showed that anonymous reporting – including of CSE - by other means was increasing, reinforcing the need for the revamp of the online system.[207]

219. Finally, I understand from the Council's Response Report that the Family Connect Strategic and Operational Board and the Child Exploitation sub group will monitor, review and analyse the data generated by the new anonymous referral system.[208]

220. **I agree that this Recommendation has been satisfied, and I am fortified by the data showing a need, and an increasing need, for anonymous reporting. I recognise that technological changes are never as easy to implement as non-experts think they should be and I am therefore delighted by the progress shown here.**

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[202] [redacted]

[203] https://webforms.telford.gov.uk/form/489

[204] [redacted] paragraph 5.1

[205] www.saysomethingtelford.co.uk.

[206] [redacted] paragraph 5.14

[207] [redacted] paragraph 5.6

[208] [redacted] paragraph 5.15

Recommendation 22

Recommendation 22

Council to review its CSE complaints procedure

The **Council** should carry out a full review of its complaints process, insofar as this relates to the handling of CSE cases. This should include:

- Preparing and publishing a comprehensive complaints procedure for complaints relating to CSE which should be readily accessible and published on its website;
- Setting out a uniform process for dealing with all complaints relating to CSE, led by a named team within the Council;
- Establishing a suitable repository for all complaints relating to CSE, so that all documents relevant to a complaint including, ultimately, its outcome, are readily accessible;
- Ensuring that all staff, in particular CATE practitioners, are suitably trained so as to identify complaints, or feedback from service users which is not in the form of a complaint but which suggests cause for concern;
- Signposting to assistance which can support individuals with the process and substance of a complaint; and
- Publishing annually, as part of the Joint CSE Review Group's Annual Report, a summary of suitably anonymised CSE complaints and a review of complaints or concerns relating to CSE to include themes and lessons learned.

221. The Response Report on this Recommendation[209] suggests that it has been implemented in full.

222. In considering this conclusion I have taken into account the following documentation:

222.1. Policy and Procedure for Complaints involving CSE April 2023 (Updated January 2024);[210]

222.2. An extract from a consultation response sent by the Council to the Local Government and Social Care Ombudsman;[211] and

222.3. Dealing with Complaints training slides.[212]

223. Following the publication of my Inquiry Report, the Council drafted, in consultation with the ILECs, a policy for CSE complaints falling outside statutory procedures (as referred to at paragraph 222.1 above). The document sets out the need for confidentiality in CSE cases

209 [redacted]
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and also provides details of support services and advocacy services that complainants may find helpful to access, to gain support in progressing their complaint. In particular, it states that there is to be a uniform process for dealing with all complaints relating to CSE and that such complaints (as with all complaints received by the Council) will be led by the Customer Relationship Team.

224. The Council's Response Report notes that there have however been significant national developments relating to local authority complaints matters in the time since the publication of my Inquiry Report – and, indeed, since it created its Policy and Procedure document in April 2023.

225. In Autumn 2023 the Local Government and Social Care Ombudsman and the Housing Ombudsman undertook a Joint Complaint Code consultation. The proposals contained in this consultation were that there should be one complaints process covering all complaints relating to local government, social care and housing. I am given to understand that the proposals would have made aspects of the newly drawn separate system for CSE complaints unworkable. The Council replied to the consultation as follows:

"*TWC have made a commitment to our community that we will rightly review complaints relating to historical Child Sexual Exploitation (CSE) no matter the time period that has passed. A separate complaints procedure was written following a Recommendation from the council commissioned inquiry in to historical CSE. This procedure was written with input from survivors. The policy outlines that for cases that fall outside of the statutory procedure we will progress under our dedicated CSE complaints procedure which confirms that we will try and respond at stage 1 within 10 working days (extended to 20 working days), however we do have a caveat as follows:*

'Due to the challenges that may be posed by investigating historical matters, timescales may be extended if access is required to archived records or if complaints relate to multiple council services. Complainants will be advised if this is the case and will be regularly updated on the progress of the investigation. These timescales will reflect challenges that may be posed by investigating historical matters. Investigating such matters will require an extensive review of records often covering a substantial period of time and different systems. However, we aim to respond in advance of the timescales provided to the complainant, where possible.'

This statement was supported by survivors as they felt it was important to ensure that a thorough investigation was completed and recognised the challenges a historical complaint can pose. Therefore, we would like some guidance on how this new statutory code will impact on cases such as these and some clear guidance on the LGSCO's position in relation to this"".[213]

226. On 26 February 2024, the revised Complaint Handling Code providing a single standard for complaint handling by local councils was launched in response to the consultation, with it becoming statutory on 1 April 2024. The 'FAQs' on the code say that "*Local councils should follow the Code unless there are good reasons not to.*"[214]

[213] [redacted]

[214] https://www.lgo.org.uk/assets/attach/6559/Complaint-Handling-Code-FAQs-updated-April-24.pdf

227. I was told in meetings that a solution to this seemingly intractable problem had been developed in that the Council will, as it must, abide by the national Ombudsman process but will provide additional guidance dealing with those matters specifically important to CSE.[215] It seems to me that this works: the desirable outcome of a uniform and published process is met by the national standard, and additional matters such as signposting complaints procedures and the particular need for confidentiality can be met by the local guidance.

228. **Accordingly I agree that the Council is right to regard this Recommendation as satisfied. Rather than use the national position to stymie implementation of the Recommendation, I consider that its decision to go beyond the simple adoption of the national guidance shows an innovative and flexible approach, which is to the Council's credit.**

Licensing Recommendations (23 to 31)

Recommendation 23

Recommendation 23

Licensing information sharing with neighbouring authorities

The **Council** should seek to agree with its neighbour authorities a stricter information sharing agreement, a joint enforcement protocol and a common licensing pricing structure.

229. The Response Report on this Recommendation[216] suggests that it has not yet been implemented completely.

230. In considering this conclusion I have taken into account the following documents:

230.1. Neighbouring local authorities CSE update presentation;[217]

230.2. Action log of local authority working party meetings;[218]

230.3. Taxi Licensing Information Sharing Agreement between neighbouring local authorities;[219]

230.4. Sanitised copy of NR3 register;[220]

215 [redacted] pgs 39-40
216 [redacted]
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230.5. Schedule of planned multi-agency operations and cross local authority working;[221] and

230.6. Lobbying letters.[222]

231. I understand that following the publication of my Inquiry Report, a local authority working party was set up with Shropshire Council, Wolverhampton City Council and South Staffordshire District Council with a view to considering an information sharing agreement, a joint enforcement protocol and a common licensing pricing structure. Meetings continued during 2023 with the following results:

231.1. So far as information sharing was concerned, the authorities noted that while a gateway to share information already existed, a joint information sharing agreement was appropriate and a draft was proposed;

231.2. As regards enforcement, all agreed that given local authorities have their own enforcement policies, a simple written enforcement document setting out their agreed aims and commitments would be useful to set out their stance on joint working, working in each other's areas and addressing any common themes, and that a joint partner statement would be an appropriate way of publicising this work; and

231.3. In terms of a common pricing structure, it was agreed that this would not be possible as it was incompatible with the obligation on local authorities to operate licensing on a costs recovery basis.[223]

232. Since those meetings I have noted that:

232.1. The information sharing agreement has been signed;[224]

232.2. Multi-agency enforcement meetings are taking place on a monthly basis with CSE as a standing agenda item; and

232.3. Enforcement action routinely results in sharing of information between local authorities regarding neighbour-licensed drivers.[225]

233. Additionally, I note with approval that the Council continues actively to lobby national government to implement its own Task & Finish Group's 2018 Recommendations, including proposals as to out of area and cross border working, for which parliamentary time has subsequently been promised and not found.[226]

234. I made clear in my Inquiry Report that I regard a world where local authorities fight each other for licensing custom on price to be undesirable; and at the risk of self-indulgence I

221 [redacted]
222 [redacted] and [redacted]
223 [redacted]
224 [redacted] pg 13
225 [redacted]
226 [redacted]

repeat, in the light of Telford's recent lobbying, the comments I made in my Inquiry Report at paragraph 4.190:

"*I confess that I regard a system that encourages drivers to choose lighter touch, non-local regulators and in doing so to starve the local regulator of funds as utterly bizarre and quite unjustifiable. This is a matter for central government, and out of my remit; but I can say that I regard the lobbying attempts of Telford politicians on the point as measured and persistent and the response of central government as disappointing in the extreme*".[227]

235. **I do, however, understand that the Council has to operate within the existing structures. Only the national Government can change those structures. I am pleased that Telford and its neighbours at least considered whether a common licensing pricing system could be made to work within the existing regime. With regard to pricing, that is all that this Recommendation asked them to do.**

Recommendation 24

Recommendation 24

Taxi driver training

The **Council** has an established CSE training programme for taxi drivers; this course should be offered, at a cost, to drivers licensed elsewhere.

In the interim, the Council should publicise the high standards that Telford licensed taxis are already required to meet and raise awareness of how to recognise a locally licensed taxi.

236. The Response Report on this Recommendation[228] suggests that the Council has implemented it in full.

237. In considering this conclusion I have taken into account the following documents:

237.1. Safeguarding driver training package;[229]

237.2. Training attendance records;[230]

237.3. Taxi and Private Hire Licensing FAQs;[231] and

237.4. CSE information leaflet.[232]

[227] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cda0472b8809050c35b91d/1657643086095/IITCSE+REPORT+-+VOLUME+TWO.pdf

[228] [redacted]

[229] [redacted]

[230] [redacted]

[231] [redacted]

[232] [redacted]

238. The Response Report on this Recommendation notes that the parties to the local authority licensing working party (as referred to at paragraph 231 above) discussed their own training and assessments for drivers, and the Council offered its training package as a training source. The local authority working party also offered to attend each local authority's training to ensure consistency and look at any improvements, albeit it is unclear whether any of those offers to observe the training were taken up. The working party concluded that there was "*appropriate and high level training across the authorities*". There was, as a result no appetite by neighbouring local authorities to use Telford's provision. [233]

239. So far as publicising high standards is concerned, I note that there has been a full review of the Council's taxi licensing web pages to include a comprehensive FAQ section,[234] which was designed in consultation with the ILECs, to assist members of the public to identify Council vehicles and driver badges. Taxi driver training has also evolved. All licensed drivers operating in the Borough are being required to undertake CSE training by September 2024, with the ability to do this either in person or online. I am told that the Licensing Committee will also be considering an update to the Taxi Licensing Policy in respect of refresher training on licence renewal at the next scheduled meeting in July 2024, with the expectation that the Policy will be implemented from that point onwards, so that no renewal applications will be granted unless CSE training has been undertaken.[235]

240. **As in relation to Recommendation 23, I am of the view that, as Recommendation 24 asked them to do, the Council has made proper efforts to seek to share the contents of its training course with other local authorities but it appears this has not been met with enthusiasm. That is a shame, but the reality may well be that while the market in licensing continues to operate as statute currently dictates, this is an impractical solution, and wider change is required to effect that broader learning. The Council has, in my view, satisfied this Recommendation.**

Recommendation 25

Recommendation 25

Council to review and improve its complaints process for public complaints or concerns in relation to licensing and/or taxi drivers

The **Council** should:

- Review the ways in which the public can report licensing complaints, to include consideration of instant reporting by way of text or online services;
- Publicise its role in taxi regulation, the need for the public to report concerns, and the ways in which concerns can be reported, to include prominent advertising in night-time economy hot spots and a requirement for in-taxi notices; and
- Ensure a continuing programme of public awareness raising the requirement for licensed drivers to display their licence, so as to address 'badge-swapping'.

233 [redacted] paragraphs 3.2 and 4.1
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241. The Response Report on Recommendation 25[236] suggests that the Council has implemented this recommendation in full.

242. In considering this conclusion I have taken into account the following documentation:

242.1. "Report a problem with licensed premises" extract for publicising complaints process;[237]

242.2. Examples of Licensing Security and Vulnerability Initiative ("LSAVI") stickers;[238]

242.3. Online reporting system details;[239]

242.4. Taxi QR reporting sticker;[240] and

242.5. The Council's Campaign/Communications strategy in relation to licensing and the night-time economy.[241]

243. I have read within the above documentation that, following the publication of my Inquiry Report, there was a review of the Council's app and webpages to ensure ease of reporting complaints concerning taxis. Taxi complaint stickers were also refreshed and now include a QR code which links directly to the online reporting form; it is a condition of licensing that taxis carry the reporting stickers. Additionally the Council, following the lead it set in taxi licensing, has requested that licensed premises, both LSAVI[242] registered businesses and other premises, carry an approved feedback/complaint sticker (albeit it is only voluntary for non-LSAVI registered premises), and LSAVI-registered premises also now receive a star rating sticker with a QR code to encourage feedback.

244. The Council also produced a communication plan[243] with the objective of:

244.1. Promoting reporting of licensing concerns;

244.2. Ensuring licensing concerns can be reported quickly and efficiently;

244.3. Awareness raising in key areas – taxis and licensed venues;

244.4. Promoting the work of the Licensing Team; and

244.5. Encouraging partnerships between the Council, WMP, and residents via, for example, Pub Watch, LSAVI, and Multi-Agency Enforcement exercises.

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242 Licensing Security and Vulnerability Initiative (Licensing SAVI) is a self-assessment tool designed to help licensed premises provide a safer and more secure environment for their managers, staff, customers and local communities. Venues take part in a self-assessment, which covers safety and security issues the premises may face.

243 [redacted]

245. The communication plan indicates an intention to communicate these messages across a variety of media channels using different methods and, delightfully, to "*review all communication for plain English*". Specified tasks included promotion of the work of taxi marshals, explanation of LSAVI, and publication of the results of vehicle stop exercises. I also heard during my meetings with stakeholders that the awareness campaign included, for example, a Tik Tok about reporting complaints about taxis and the importance of checking drivers' badges and that they match the driver.[244]

246. I heard from stakeholders that:

"the Recommendation really gave us the opportunity to engage with consultees… and what we might consider as "that'll be workable"… you know, actually getting a different perspective on it, where the QR code is positioned in the vehicle, writing the badge number on, the plate number on, little bits like that [have] really made a difference".[245]

247. **It seems to me that the Council is right to regard Recommendation 25 as satisfied; it has gone beyond publicity to schemes such as the QR code reporting and has in my view demonstrated open mindedness and innovation.**

Recommendation 26

Recommendation 26

Council to collate data relating to complaints against taxi drivers

The **Council** should publish annually, as part of the Joint CSE Review Group Annual Report, a taxi licensing review to include:

- How many complaints it has received about taxi drivers;
- How many of those complaints related to drivers licensed by the Council;
- How many complaints related to sexual behaviour, including use of sexualised language or harassment, and of those, how many related to complaints involving such behaviour towards children; and
- How many complaints resulted in action by the Licensing Team, and what action resulted.

248. The Report on Recommendation 26[246] suggests that the Council has completely implemented it.

249. In considering this conclusion I have taken into account:

[244] [redacted] pg 9
[245] [redacted] pg 7
[246] [redacted]

249.1. The Council's Annual Licensing Report 2022/23, considered at the Licensing Committee on 14 March 2023;[247] and

249.2. Emails from April 2023 in relation to taxi complaint data.[248]

250. The Annual Licensing report prepared by the Council was produced covering data from March 2022 to December 2022, and the report was put before the Council's Licensing Committee on 14 March 2023. The report stated as follows:

"*There are currently 270 vehicles and 330 drivers holding a licence provided by Telford & Wrekin Council. Since April 2022 there have been an additional 3 private hire operators licensed alongside 193 vehicle and 150 driver, new and renewal licences granted.*

Since April 2022, 54 complaints were received regarding taxis with only 14 relating to those licensed by Telford & Wrekin Council. 27 complaints were referred to neighbouring local authorities, the remainder (13) either had insufficient information or the complainant did not want to take the matter further. The council has a duty to refer and action complaints received and all complaints have been investigated with 1 resulting in a warning being issued that related to a road safety matter.

There have been no revocations or suspensions during this period. Licensing sub-committee considered one driver licence review with the council refusing two applications as they did not satisfy the approved Licensing policy. The Council is awaiting the outcome of one appeal following refusal to grant".[249]

251. Additionally the following data, referring to earlier years, has been compiled.[250] In 2020/21 - there were in total 35 complaints (low in number due to COVID), of which:

251.1. Seven related to the Council;

251.2. Ten related to Wolverhampton City Council;

251.3. Seven related to Shropshire Council;

251.4. Ten were unable to be identified (no further information from complainant despite further attempts to contact);

251.5. One complaint was not a licensed vehicle (wrong details supplied by customer); and

251.6. From the seven identified as Council complaints, there were no safeguarding complaints.

252. In 2021/22 – there were in total 65 complaints, of which:

247 [redacted]
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249 paragraphs 3.5-3.7
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252.1. 15 related to the Council;

252.2. 17 related to Wolverhampton City Council;

252.3. 14 related to Shropshire Council;

252.4. 19 were unable to be identified (no further information from complainant despite further attempts to contact);

252.5. From the 15 identified as Council complaints, two were safeguarding matters (school contracts) and warnings were issued;

252.6. One complaint resulted in a suspended vehicle plate; and

252.7. Four were warnings about driving standards (one having to re-sit their Driving Standards Agency Test).

253. This material was supplied to the JCSERG so that it could populate its Annual Report, with the data provided at pages 43 and 44 of that report.[251] The Response Report on this Recommendation confirms that an Annual Report on taxi complaint data will be submitted to the Licensing Committee each year.[252]

254. **It follows that this Recommendation has been satisfied in full.**

Recommendation 27

Recommendation 27

Council to implement a protocol for the sharing of safeguarding information for the purposes of taxi licensing

The **Council** should draft and publish within six months of this Report a protocol for the sharing of safeguarding information for the purposes of taxi licensing, setting out:

- The procedures by which, on receipt of a new application, renewal, or a complaint about a driver, information will be requested by Licensing from Safeguarding, WMP, neighbouring local authorities and such others as are deemed appropriate; and

- The circumstances in which the Licensing Team will share information with Safeguarding, WMP, neighbouring local authorities and such others as are deemed appropriate, upon the receipt of a complaint and, if applicable, later imposition of a sanction against a taxi driver.

255. The Response Report on Recommendation 27[253] suggests that the Council has implemented it in full.

251 [redacted] pg 3
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256. In considering this conclusion I have taken into account the following:

256.1. Consolidated hackney carriage and private hire information sharing policy March 2023;[254]

256.2. Document setting out the process the Licensing Team follow for new dual driver application dated 6 July 2023;[255]

256.3. Flowchart setting out the information processing flow between licensing and safeguarding;[256]

256.4. Example driver check;[257] and

256.5. Flowcharts setting out the processes for referrals between LADO/safeguarding and licensing in relation to a taxi driver.[258]

257. I have read that at the Licensing Committee on 14 March 2023, the Committee approved a consolidated information sharing policy. That policy[259] sets out that on application or renewal for a licence, the Council as licensing authority will seek information from:

257.1. *"the Council's Independent Safeguarding team, including the Local Authority Designated Officer and the Multi-Agency Safeguarding Hub (MASH)";*

257.2. *"the Council's Personal Safety Precautions register (PSP)";*

257.3. *"West Mercia Police, or other relevant police force";*

257.4. *"Other local authorities with licensing responsibilities (where appropriate) – this includes, but is not limited to, their licensing teams and their safeguarding teams";*

257.5. *"the NR3 National Register";*

257.6. *"the Disclosure & Barring Service (including information on the Barred Lists)";*

257.7. *"Private Hire Operators (where appropriate)";*

257.8. *"The Council's complaints team";* and

257.9. *"Any other organisation, team or agency that may hold information that is relevant to an application for a dual driver's licence, vehicle proprietor licence or private hire operator's licence."*

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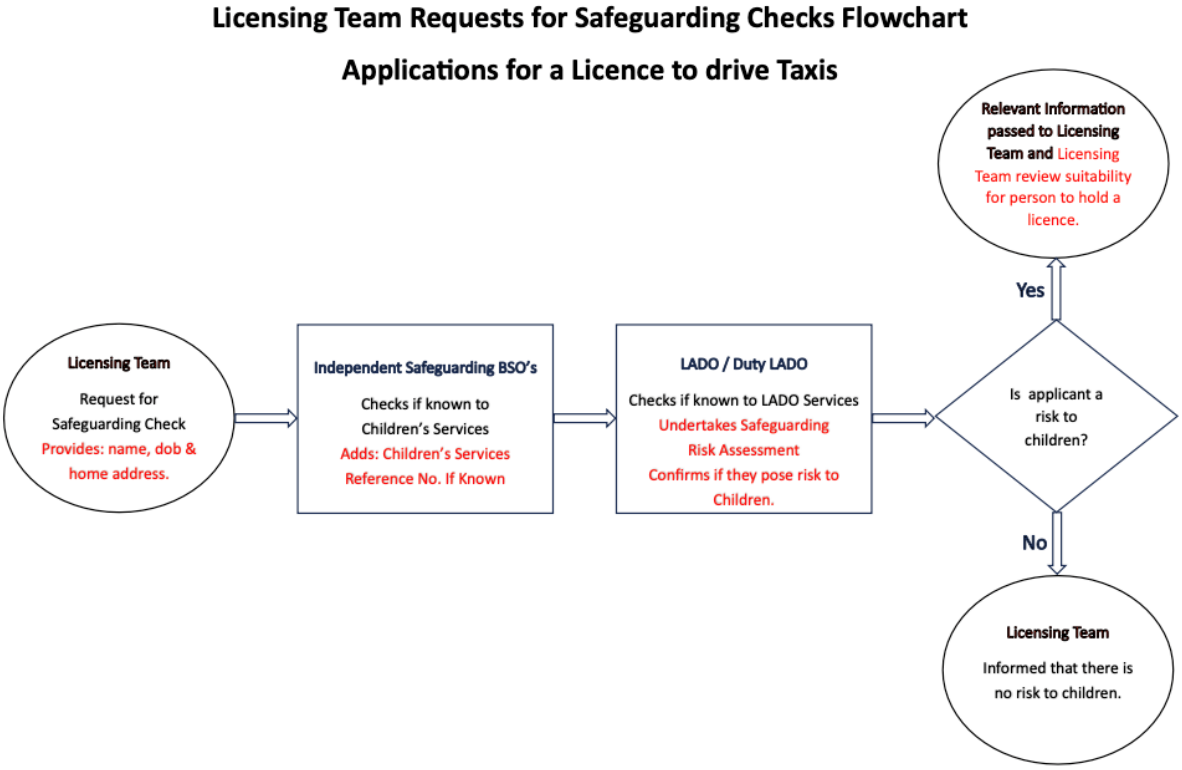
258. Additionally, I was told that all procedures relating to internal and external information sharing and requests have been refreshed by the Council. For example, I have been provided with a flowchart which sets out the process the Licensing Team will follow for all taxi driver applications relating to requests for safeguarding information from the Council's Independent Safeguarding Team, as set out below:



259. I have seen an email chain which demonstrates this process operating – and, indeed, operating very efficiently, with results coming through within half an hour.[260]

260. The policy further provides that in the event of a complaint being made, the Council may securely share complaint information prior to taking any action with:

260.1. *"The Council's Safeguarding Team including the Local Authority Designated Officer and the MASH";*

260.2. *"Other Licensing Authorities where there is reason to believe that the licence holder may also hold a licence with that authority";*

260.3. *"West Mercia Police; or other relevant police force";*

260.4. *"Private Hire Operator if the complaint relates to a driver working with that operator";* and

260 [redacted]

260.5. *"Any other government or local authority regulatory body or agency where the information relates to public safety, protection of public funds and for the prevention and detection of crime."*

261. The policy also provides that where any complaint is made which could reasonably indicate that the licence holder poses a risk of harm to children, the information will be shared:

261.1. *"With the Council's Safeguarding Team so that appropriate investigations can be made in relation to any children who may have contact with the licence holder";* and

261.2. *"With the Council's Passenger Transport Team so that appropriate action can be taken in relation to school contracts or prospective contracts".*

262. The policy provides that when a complaint has been concluded, the Council may securely share information with the following, providing the information relates to the protection of public safety, protection of public funds and/or for the prevention and detection of crime:

262.1. *"The Council's Safeguarding Team including the Local Authority Designated Officer and the MASH";*

262.2. *"Other Licensing Authorities where there is reason to believe that the licence holder may also hold a licence with that authority";*

262.3. *"West Mercia Police; or other relevant police force";*

262.4. *"Private Hire Operator if the complaint relates to a driver working with that operator";* and

262.5. *"Any other government or local authority regulatory body or agency."*

263. **It seems to me that the Council is right to regard Recommendation 27 as satisfied. The policy clarifies what is expected and when, and it seems the sharing of relevant data (or its absence) is now firmly embedded – it is all a far cry from the days in the 2010s when data was regarded as an effectively private resource. Furthermore, I am reassured that the processes and procedures around this area will be reviewed annually.**

Recommendation 28

Recommendation 28

Council to explore implementation of CCTV in taxis

- The **Council** should explore the possibility of installing CCTV in taxis. It should begin by carrying out a full consultation amongst interested parties, in the borough and in the region.

- The Council should consider any funding applications that may be available to assist in this regard.

264. The Response Report on Recommendation 28[261] suggests that the Council has implemented it completely.

265. In considering this conclusion I have taken into account the following documents:

265.1. CCTV consultation Action Plan 2023-24;[262]

265.2. Licensing Committee Agenda Tuesday 21 November 2023 and Report on Review of Taxi CCTV Policy;[263]

265.3. Licensing Committee Minutes Tuesday 21 November 2023;[264] and

265.4. Applications for Community Safety Partnership funds.[265]

266. As I set out in my Inquiry Report, there was a failed attempt to mandate CCTV in taxis in Telford in 2010, which failed for what I described in paragraph 4.188 of the Inquiry Report as a "*somewhat overenthusiastic and even petty approach to enforcement*".[266] I thought it time to try again – society expectations of being under surveillance have changed markedly since then.

267. The Council's CCTV consultation action plan noted that "*While only a small minority of licensing authorities have so far mandated all vehicles to be fitted with CCTV systems, the experience of those authorities that have has been positive for both passengers and drivers*"[267] and noted the specific reinforcing effect upon people thinking of reporting sexual offences which had taken place in taxis. Furthermore, there was a positive in terms of driver safety.

268. In December 2022 a pilot scheme for CCTV in taxis, involving initially 20 vehicles, then a further five, was launched by the Council.[268] The units were bought by the Council with Community Safety Partnership and other funding. The scheme was voluntary for drivers but, it seems, well-subscribed. Those 25 amounted to 11% of licensed taxis in Telford.[269]

[261] [redacted]
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[266] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cda0472b8809050c35b91d/1657643086095/IITCSE+REPORT+-+VOLUME+TWO.pdf
[267] [redacted]
[268] https://newsroom.telford.gov.uk/News/Details/16592
[269] [redacted] paragraph 5.3

269. There was then a full public consultation between late June and mid-August 2023, publicised on Telford's web channels and on social media. Some of the feedback obtained by the consultation was as follows[270]:

"CCTV should be regarded as a safeguarding measure both for the passengers and the driver."

"Found it reassuring like having someone with you looking out for you."

"Please ensure that all taxis or the majority of taxis are fitted with working CCTV. I will then be able to feel safe to use taxis."

270. Additionally I have read that driver feedback on CCTV was positive, and that they felt safer and less likely to be a victim of crime when working at night. At a basic level, passengers were better behaved when CCTV was fitted – a feature which is significant when figures from WMP's May 2022 crime report show that 20% of drivers had reported being a victim of a crime committed during their work.[271]

271. After the consultation closed an action plan was completed. By October 2023, funding had been obtained for a further 15-18 units (a fixed sum of £12,000; the unit number cost-dependent) with an intention to install in the early part of 2024. I was also told that the Council had been able to secure funding from the Community Safety Partnership for a further 45 installations, and an intention to lobby central government to mandate CCTV fitment in taxis given the positive reactions from the public and drivers to the new Telford model.[272]

272. As I have remarked, I suspect that society has changed and that we all regard CCTV as part of the fabric of our world and are largely comforted by it. The Council's recent efforts appear to have been met with enthusiastic acceptance from both drivers and members of the public, and I am heartened that the initial pilot numbers of installations has grown so significantly and that plans remain to secure funding to install more units. There are, I was told, not plans to make CCTV compulsory while it is not nationally mandated, and I understand the reasoning for that – Telford wants to continue to licence the drivers who meet its other high standards rather than deter them to such a degree that they obtain a license from an alternative local authority. It is, though, yet another argument in what I regard as the irrefutable case for nationally mandated standards.

273. **It seems to me that this Recommendation has been satisfied in full.**

Recommendation 29

Recommendation 29

WMP role in taxi licensing enforcement to be reviewed

- **WMP** should carry out a review of its current involvement in joint taxi licensing enforcement exercises in order to ensure that the exercises are sufficiently regular and

270 [redacted] pg 4
271 [redacted] pg 5
272 [redacted] pgs 5-7

rigorous, and that any information or intelligence of concern relating to CSE activity is captured and acted upon.

- This should include considering which officers are involved in such enforcement exercises, and that those officers are of an appropriate rank and level of training.
- If not already in place, a named officer should be designated to liaise with colleagues in the Council's Licensing Team to ensure appropriate sharing of information relating to taxi drivers who may pose a risk/concern.

274. The Response Report on Recommendation 29[273] and WMP's IITCSE Overview Report,[274] (which summarised the steps WMP has taken in implementation of the Recommendations) suggest that this Recommendation has been completely implemented.

275. In considering this conclusion I have taken into account the following:

275.1. Schedule containing Telford & Wrekin Licensing Enforcement and Night-Time Economy taxi and licensed premises planned multi-agency (MATES) operations;[275] and

275.2. Email correspondence in relation to the process of sharing information from Council bodies to WMP.[276]

276. Following the publication of my Inquiry Report, the Council and Telford's local policing area completed a review of licensing operations. The review found a need for greater co-ordination of taxi licensing enforcement and operations – comprising principally ply for hire operations, the purpose of which is self-evident and, more recently, mobile operations, involving random stops to ascertain the nature of the journey. These operations are now co-ordinated under a given Operation name and responsibility for the operations lies with the Licensing Team within the Council and the Problem Solving Hub at Malinsgate police station.[277]

277. I have read that since February 2022 taxi enforcement exercises are planned and results discussed in monthly Multi-Agency Strategy (MATES) meetings, which also serve as a forum for information and intelligence sharing and to consider which businesses and people represent a potential risk. These meetings are attended by Licensing, Trading Standards, Environmental Health, Private Sector Housing, Public Protection, Shropshire Fire and Rescue Service, Immigration, Gangmasters and Labour Abuse Authority, Driving Standards Agency, HMRC and the Security Industry Authority. Additional information sharing takes place at a quarterly Night Time Economy Meeting which is attended by the Licensing Police Constable for WMP, Problem Solving Hub Sergeant, and the Principal Licensing Officer and Public Protection Group Manager for the Council. The CSE Detective Sergeant and the Child

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Exploitation Co-ordinator are the designated points of contact for the Local Authority Licensing Team.[278]

278. I have also read that further work is ongoing regarding capturing intelligence relating to the use of taxis for the purposes of exploitation, with monthly meetings with the designated safeguarding manager of a local taxi firm to identify any intelligence of concern relating to nominals and hot spots. This work has borne fruit, and information received in respect of premises has led to more focussed intelligence gathering work. I have been told that there is an ambition to broaden the involvement of this meeting to other operators within Telford.[279]

279. In addition, a Taxi Forum has been instigated - a joint initiative between the Council and WMP intended to strengthen relationships with those working in the taxi trade. The forum has focussed on trying to raise awareness and encourage drivers and operators to report any instances of CSE, but has also served as a test-bed and feedback forum for the literature sent to drivers regarding CSE and which has led to that literature being comprehensively re-drafted and simplified for clarity.[280]

280. As to the rank and training of those WMP officers involved in operations, I am told that they are sourced from the CE Team, Safer Neighbourhood Team, the Operational Policing Unit and the Problem Solving Hub, ensuring both uniform officers and detectives are present. A named officer then holds the title of Licensing/Multi-Agency Targeted Enforcement Strategy Officer and leads the operations and associated briefings. That officer has received modern day slavery training to undertake the role, and both that officer and others conducting licensing enforcement operations will receive the newly-minted CSE continuing professional development training. All the relevant contact points in WMP and the Council Licensing Team have been respectively shared and a commitment given that the contact list will be updated on an ongoing basis and shared as needed.

281. **It seems to me that it follows from the above that this Recommendation has been implemented in full.**

Recommendation 30

Recommendation 30

Council to review historic premises licences

- The **Council** should take steps to ensure that appropriate conditions are applied in respect of any premises operating under a historic licence; and
- Whatever the terms of a historic licence, the Council should make clear its expectation that any nightclub should operate an '18 or over' entry policy.

278 [redacted] paragraphs 5.2 and 5.9-5.10
279 [redacted] paragraph 5.4
280 [redacted] paragraph 5.5

282. The Response Report on Recommendation 30[281] suggests that the Council has not completely implemented it.

283. In considering this conclusion I have taken into account the following:

283.1. Letter to licensees in relation to historical licences and response;[282] and

283.2. Emails with licensees regarding "no 18s" policy.[283]

284. The Council's Response Report on this Recommendation[284] notes that:

284.1. Nine premises licences had been identified with historical conditions applied through "grandfather" rights and which were unchanged since the inception of the Licensing Act 2003, and that those licences contained a mandatory condition in relation to an age verification policy but not further conditions relating to protecting children from harm; and

284.2. The sole mechanism for variation of an existing licence is a request for a minor variation of that licence. The Council could only impose conditions after a licence has been granted if it could show that one of the four licensing objectives are not being met.[285]

285. As a result, the Council wrote to all nine licence holders requesting they consider an extra condition being added by way of a voluntary minor variation, with the Council waiving the ordinary fee for such an application.

286. There was a single response, which noted:

"*…an application for a minor variation is an open consultation and therefore could potentially attract representations from any of the responsible authorities or local residents. Accordingly, the application would not be entirely without risk. Additionally, there would be my costs to draft and submit the application which, with the current climate, is an unnecessary and avoidable expense.*"[286]

287. I note there had been no complaints or issues raised about these nine premises and therefore there was no suggestion that they were not meeting their licensing objectives, so as to allow a review of the licence.

288. As to entry policies, the Council identified three premises that were classed as nightclubs. One had a "No under 18s" entry policy in place. The other two did not. Again, the Council asked the licence holders to consider varying their licence to apply this condition; the replies came that the condition would restrict business as the venues had diversified their businesses including by concentrating on family parties, weddings and daytime groups that

281 [redacted]
282 [redacted]
283 [redacted]
284 [redacted]
285 [redacted] paragraph 4.1
286 [redacted]

include children attending. Furthermore, the venues indicated an intention to run their own under 18s events.[287]

289. The Council's Response Report notes that in so far as these venues are concerned, it could seek to impose a "no under 18s" condition if there was evidence that licensing objectives were not being met, but again there is no such suggestion that this is the case.

290. **It seems to me that given the Recommendation was that the Council *take steps* to ensure historic licences were modernised, and that it *should make clear its expectation* that a "no under 18s" policy be adopted, it is being unnecessarily self-critical in suggesting that this Recommendation has not been satisfied. It has made its position quite plain in respect of both, but the licence holders have in each case presented a respectably reasoned argument as to why they do not propose to comply.**

291. I have reminded myself that given it is a general duty of a licensing authority to protect children from harm[288] it has the ability, upon further evidence, to take steps to review any licence.

Recommendation 31

Recommendation 31

Council to review its oversight of restaurant and take-away establishments

- In association with its Night-Time Economy officer, Licensing Team and **WMP**, the **Council** should review information collection and sharing with regard to CSE concerns involving restaurants, takeaways, mobile food outlets and associated residential premises.

292. The Response Report on Recommendation 31[289] suggests that this Recommendation has been implemented completely.

293. In considering this conclusion I have taken into account the following:

293.1. Eatery/Takeaway observation checklist;[290]

293.2. Process flowchart for information sharing;[291] and

293.3. Sample intelligence report.[292]

294. The Council interpreted this Recommendation as requiring relevant teams from the Council, (Environmental Health, Licensing, Trading Standards and Private Sector Housing) to work

[287] [redacted] paragraph 5.5
[288] Licensing Act 2003 s.4(2)(d)
[289] [redacted]
[290]
[291]
[292]

together with WMP to agree a procedure for sharing information and intelligence relating to CSE. That seems to me to be a sensible and practical view.

295. The Response Report notes that the MATES partnership has been in place since 2018 and, as I have noted above in relation Recommendation 29, strategic meetings have been held on a formal monthly basis since February 2022.[293]

296. I have read that sharing of information, observations and intelligence regarding food businesses, as required by Recommendation 31, was discussed by the MATES partners at a strategic meeting with the following results:

296.1. Members of the WMP CE team would be invited to the strategic partnership meetings and intelligence reports submitted as required to the CE team;

296.2. An observation checklist would be developed jointly between WMP and the Council's Food Health & Safety Team, for Environmental Health Officers in the Food, Health and Safety team to complete in conjunction with their inspections of food businesses. Once complete, this observation checklist would be emailed to a single point of contact for the WMP CE team and Problem-Solving Hub. Any relevant intelligence would then be entered onto WMP's intelligence database and disseminated to WMP agreed contacts; and

296.3. Further, any relevant intelligence identified by the Council's Trading Standards, Licensing, Night-Time Economy and Private Sector Housing teams will be entered on to an intelligence report, graded and sanitised, then disseminated to WMP and law enforcement partners. Any CSE relevant intelligence will be sent via the dedicated CE team email address.

297. I am told that these provisions have been put into place and notably that the observation checklist was amended following ILEC consultation.

298. This is an important Recommendation, given that there is no mechanism for the Council to remove a food business operator and nor is there any consideration at national level of a "permit to trade"; the involvement of the police, and information sharing with the police, is therefore key.

299. **I am of the view that the Council was correct to regard this Recommendation as satisfied. The steps taken by all parties show a thoughtful consideration of the issues involved.**

[293] [redacted] paragraph 5.1

Training Recommendations (6, 12, 32, 42)

Recommendation 6

Recommendation 6

Information sharing training to be implemented in order to clarify responsibilities around confidentiality, information sharing and safeguarding.

All organisations with safeguarding responsibilities, to the extent it is not already in place, should:

- Implement an immediate programme of information sharing training for all those dealing with children, or in positions where referrals to Safeguarding is a possibility, to include at a minimum, police officers, PCSOs, social workers, CATE practitioners, youth workers, licensing officers, teachers, school counsellors and nurses, sexual health advisors, GPs, GP practice nurses, A&E doctors and nurses;

- Ensure such training sets out the principles of when information should not be shared and when it must be, including practical exercises; and

- Ensure that the above training is mandatory for any future recruits, and is repeated for existing team members no less than every two years, with training records to be made and retained.

300. The Response Report on Recommendation 6[294] and WMP's IITCSE Overview Report[295] suggest that this Recommendation has not been completely implemented. WMP notes in its report on this Recommendation that:

"[t]*here are a small number of Recommendations that cannot be delivered due to the need for legislative changes or the involvement and support from national agencies. An even smaller number of the Recommendations require some degree of interpretation as to what they require and, in turn, how best to do this*".[296]

301. In considering this conclusion I have taken into account the following:

301.1. College of Policing – Operational module script, information sharing;[297]

301.2. College of Policing – Non-operational module script, information sharing;[298]

301.3. Safeguarding Partnership Threshold of Need conference slides, 13th February 2023;[299]

294 [redacted]
295 paragraph 8
296 paragraph 1.2
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301.4. Summary of information sharing training delivered to education settings;[300]

301.5. Safeguarding Children Board - 7 minute briefing contextual safeguarding document, practice guide and briefing on contextual professional curiosity;[301]

301.6. Integrated Care System NHS Shropshire, Telford & Wrekin course content "Attaining and Maintaining Safeguarding Competences";[302] and

301.7. Telford & Wrekin Council Protecting Personal Information course content.[303]

302. The Response Report notes as a preliminary point that the Council, NHS STW and WMP have made wide use of WMP's specialist trainers to deliver a course entitled "*Raising Awareness of Exploitation and Vulnerability*" to staff as well as local businesses and organisations. The course includes a focus upon sexual exploitation and in particular:

302.1. *"Developing an understanding of indicators that may show within various forms of exploitation";*

302.2. *"Identifying the key considerations necessary when receiving a disclosure and the impact of trauma on any disclosure";*

302.3. *"Understanding the individual's professional accountability and responsibility for sharing information and the legal basis for doing so under the GDPR";*

302.4. *"Recognising the importance of documentation and record keeping in the effective protection of those identified as vulnerable, ensuring non-victim blaming language is used";* and

302.5. *"Understanding the process to get the right help, at the right time, for the identified vulnerable person(s)*".[304]

303. The Council has noted that at the time of publication of the Inquiry Report, it had in place a mandatory online Information Governance course that all staff were required to complete every two years. This course was updated in March 2023 and covers:

303.1. *"Why personal information needs to be protected";*

303.2. *"The Corporate Information Security Policy";*

303.3. *"Data Breaches";*

303.4. *"Sharing Information";*

303.5. *"When mistakes happen";*

300 [redacted]
301 [redacted]
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304 paragraph 5.2

303.6. *"Impacts on those affected by a data breach";*

303.7. *"Impacts on the Council";* and

303.8. *"Impacts on employees."*[305]

304. Having considered the course material[306] I note that it is directed towards ensuring that employees have an understanding of data protection rather than having a safeguarding focus (as it is intended to cover a number of services within the Council). There are two hypothetical scenarios set out in the training to encourage information sharing where appropriate (relating to a CSE case and information that should have been shared with the NRM), which I have been told was intended to provoke thought on, and raise awareness of, CSE. The training is, I understand, still being rolled out, but is 91% complete at the time of publication of this Review.[307]

305. The Council further explained that it considered it would be more effective to include information sharing relevant to safeguarding within the mandatory threshold training for all Safeguarding staff across all agencies. In this way, all agencies involved in the safeguarding of children would have a mutual understanding of how information should be shared between those agencies, and it would also reinforce the fundamental importance of ensuring information is shared as promptly as possible. I am told that this training is mandatory for all Safeguarding employees within the Council and continues to be rolled out amongst these multi-agency services.[308]

306. More pertinently, I am told that the Safeguarding Partnership updated its threshold guidance in February 2023 and a partnership-wide training session took place the same month. Speakers included representatives from Children's Services, Safeguarding and Family Support, Education, the NHS and the police and there were practical exercises including safeguarding scenarios, which included aspects of information sharing. 155 people attended. The training has since been repeated on seven occasions.

307. I have read that so far as schools and colleges are concerned, there is training on GDPR which includes data sharing, but no specific training so far as safeguarding related data sharing is concerned. In 2023, however, schools and colleges were given the following further guidance:

"As part of meeting a child's needs, it is important for governing bodies and proprietors to recognise the importance of information sharing between practitioners and local agencies. This should include ensuring arrangements are in place that set out clearly the processes and principles for sharing information within the school or college and with local authority children's social care, the safeguarding partners and other organisations, agencies, and practitioners as required.

School and college staff should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of

305 [redacted] paragraph 5.5
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children, whether this is when problems are first emerging, or where a child is already known to local authority children's social care.

It is important that governing bodies and proprietors are aware that among other obligations, the Data Protection Act 2018, and the UK General Data Protection Regulation (UK GDPR) place duties on organisations and individuals to process personal information fairly and lawfully and to keep the information they hold safe and secure.

Governing bodies and proprietors should ensure relevant staff have due regard to the relevant data protection principles, which allow them to share (and withhold) personal information, as provided for in the Data Protection Act 2018 and the UK GDPR. This includes:

- *Being confident of the processing conditions which allow them to store and share information for safeguarding purposes, including information, which is sensitive and personal, and should be treated as 'special category personal data'";*
- *Understanding that 'safeguarding of children and individuals at risk' is a processing condition that allows practitioners to share special category personal data. This includes allowing practitioners to share information without consent where there is good reason to do so, and that the sharing of information will enhance the safeguarding of a child in a timely manner. It would be legitimate to share information without consent where: it is not possible to gain consent; it cannot be reasonably expected that a practitioner gains consent; and, if to gain consent would place a child at risk, and for schools, not providing pupils' personal data where the serious harm test under the legislation is met. For example, in a situation where a child is in a refuge or another form of emergency accommodation, and the serious harm test is met, they must withhold providing the data in compliance with schools' obligations under the Data Protection Act 2018 and the UK GDPR".*
- *Where in doubt schools should seek independent legal advice".*

The Data Protection Act 2018 and UK GDPR do not prevent the sharing of information for the purposes of keeping children safe. Fears about sharing information must not be allowed to stand in the way of the need to safeguard and promote the welfare and protect the safety of children". [309]

308. In respect of the police, WMP has noted:[310]

308.1. So far as new recruits are concerned, information sharing training meets the National Curriculum published by the College of Policing ("CoP"). Some material is provided by the CoP to ensure training for police is nationally consistent and compliant with legislation, and is subject to its copyright and as a result I have not been provided with all of this material.

308.2. While "managing information" is a current training requirement for all staff, it is only required to be undertaken as and when the CoP updates the course. Nevertheless, 97% of officers and staff at Telford have completed this course and

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it is proposed that managing information refresher training is now required in-force as part of continuing professional development every two years.

308.3. "Data protection (foundation level)" training is mandatory and must be completed every two years – notwithstanding that, only 72% of Telford officers and staff have completed this course.

308.4. There are several training courses in existence for officers with specialist skills – for example a detective development programme and a specialist child abuse investigators development programme – each of which cover elements of multi-agency working and information sharing. I considered this training to some extent in my Inquiry Report and do not propose to duplicate that here.

308.5. Harm Assessment Unit ("HAU") staff receive an HAU initial training course which requires learning and demonstration of the ability to share information and determine risk associated with public protection and multi-agency working, with particular training given on the purpose and role of HAU staff in multi-agency strategy meetings. Refresher training has now been delivered to all HAU staff and the HAU has adopted Telford's specific threshold guidance for information sharing. I was told that HAU staff are the force experts in safeguarding information sharing.

309. I have considered the CoP operational and non-operational module scripts in relation to information sharing and each is focussed on the legal basis for information collection and sharing. Although both deal with example scenarios, none relates to CSE or deals with information sharing for safeguarding purposes. So far as the material I have not been shown is concerned, I have nevertheless been told that it refers to:

309.1. Data Sharing Code of Practice (presumably, but not specified as such, that issued by the Information Commissioner's Office);

309.2. The Judiciary's 2013 Protocol and Good Practice Model on disclosure of information in cases of alleged child abuse and linked criminal and care directions hearings;

309.3. Home Office publication 'Multi-Agency Working and Information Sharing Project Final Report';

309.4. HM Government Information Sharing Advice for Practitioners providing safeguarding services to children, young people, parents, and carers 2018;

309.5. Information published on Social Care Institute for Excellence ("SCIE") – Safeguarding

309.6. The Bichard Inquiry Report; and

309.7. CoP Approved Professional Practice – Information Management & Information Sharing.

310. While I am told that a number of these materials include guidance as to when information should and should not be shared, it seems to me that this training does not, without more, fulfil the purpose of the Recommendation which was, of course, that those working in

Telford have an understanding of when CSE relevant material, including indicators of exploitation, may properly be shared.

311. In my meetings with stakeholders as part of this Review, I was reassured to know that WMP is alive to this, and recognises that the nationally mandated training needs to be bolstered by additional programmes which it intends to introduce across the force area, and not just in Telford.[311] I have read that:

"[I]*n addition to monitoring completion of relevant training, West Mercia Police are committed to continue to work as a matter of priority with the independent lived experience consultees and the national College of Policing to consider modifications and improvements to national training*".[312]

312. As for NHS staff in positions where referrals to Safeguarding is a possibility, I heard that on an annual basis staff receive update training on information governance, which includes information sharing, as well as nationally provided safeguarding children training, which contains aspects of information sharing for safeguarding purposes. I was also told that training is monitored at every organisation and settings are monitored via contract management. I did not however receive any information on rates of attendance at the training.[313]

313. I was told that the Council and NHS STW will undertake an annual review of relevant information sharing training material and content, and will monitor completion to ensure that all employees are completing mandated training.

314. **This Recommendation made demands across a broad range of stakeholders and it is apparent from the foregoing that responses have varied. That is understandable – WMP, for example, is a very large organisation with obligations to follow national training and, to the extent that it is able to add additional or further training, to ensure that it is deployed across the entire force area, not simply in Telford, and that will take time.**

315. **While it is apparent from my review of responses that all stakeholders have been mindful of the Recommendation, I do consider it is important that each considers carefully first, the extent to which it is relying on existing training resources, rather than tailoring training to the recommendation, and second, that compliance continues to be monitored, enforced, and reported in the JSCERG Annual Report.**

Recommendation 12

Recommendation 12

Training of CATE Team and social workers

The **Council** should ensure that all CATE Team members and social workers in Safeguarding receive regular external training covering:

311 [redacted] pgs 8-9
312 [redacted] paragraph 6.2
313 [redacted]

- The concepts of risk and harm;
- The importance of rigorous recording of information (including detailing the exploitation suffered and naming children and perpetrators).

316. The Response Report on Recommendation 12[314] suggests that this Recommendation has been implemented completely.

317. In considering this conclusion I have taken into account the following:

317.1. Corporate CSE awareness training course content;[315]

317.2. Training attendance records;[316] and

317.3. CSE and NRM Training slides.[317]

318. The Council's Response Report notes, first, that mandatory CSE awareness training – including impact awareness training – is part of the induction training required for all Council employees but recognises the focus of the Recommendation upon CATE and social worker staff. As a result, a trainer was identified with over 30 years' experience and a specialism in child exploitation and awareness of contextual safeguarding concepts. A foundation programme of face to face training was then created for CATE practitioners and Safeguarding social workers. This training, which was mandatory, is intended to be repeated annually and includes consideration of:

318.1. *"Identification of indicators, and recording these readily (rather than waiting for outright evidence), as noted in The Child Exploitation Risk Threshold Indicator - p32 to 36 of the 2023 Telford and Wrekin Threshold Guidance";*

318.2. *"Importance of language in recording; avoidance of victim blaming, considering where recording may also be used or evidenced later, detailing exploitation suffered, avoiding jargon";*

318.3. *"Remaining trauma-informed in recording and approach";*

318.4. *"Push and pull factors";*

318.5. *"The importance of professional curiosity";*

318.6. *"Triangulation of evidence";* and

318.7. *"The Bedfordshire Contextual Safeguarding approach - considering harm outside the home, how parents/carers are referred to and how they might affect a child's risks, framing situations with care."*[318]

314 [redacted]
315 [redacted]
316 [redacted]
317 [redacted]
318 [redacted] paragraph 5.7

319. Further training was provided to CATE practitioners, Safeguarding and Family Connect social workers focussing on the complexity and sophistication of CSE, lived experience of CSE, and use of the NRM. This training was developed with the ILECs in parallel with the review of the Pathway and again delivered face to face. I have read that it is intended that this training will be delivered to a broader group of Council staff, to include any professional who has contact with children to ensure that indicators are recognised across the system as a whole. Again, sessions will be repeated annually.

320. **It seems to me the Council is right to regard this Recommendation as satisfied in full. The new programme of training is thoughtful and comprehensive and plainly represents a very significant investment. The fact that it is a rolling programme gives confidence that the new approach will endure.**

Recommendation 32

Recommendation 32

All schools and colleges to review and refresh training around CSE

Where this is not already happening, **all schools and colleges**, in association with the **Council**, should:

- Commit to annual training of all teachers and staff in CSE awareness;
- Repeat such training at least every two years;
- Set out a programme of age-appropriate CSE awareness raising sessions for their pupils, whether that programme is delivered in the context of PSHE or otherwise; and
- Arrange a CSE awareness raising session for parents, no less frequently than annually, in the opening months of the academic year.

Where the school in question is a primary school, such CSE awareness should be aimed at pupils in Year 5 and above, or, if not felt appropriate, a letter should be sent to all parents explaining why such a programme is regarded as undesirable within the school, and enclosing written information on CSE awareness.

321. The Response Report on Recommendation 32[319] suggests that this Recommendation has been implemented completely.

322. In considering this conclusion I have taken into account the following:

322.1. Example safeguarding audit notes;[320]

322.2. CSE termly briefing for primary schools, 3 July 2023;[321]

319 [redacted]
320 [redacted]
321 [redacted]

322.3. CSE DSL Network for early years Minutes 13 December 2023;[322]

322.4. Minutes for CSE Leads meetings;[323]

322.5. CSE Awareness training notes for staff;[324]

322.6. CSE Awareness training notes for parents;[325]

322.7. Raising awareness of child protection and safeguarding in education training notes;[326]

322.8. Mapping notes against curriculum: Opportunities to teach children appropriate content related to the risks of CSE/child criminal exploitation ("CCE");[327]

322.9. Talk PANTS NSPCC information session notes;[328]

322.10. Talk PANTS NSPCC SEND information session notes;[329] and

322.11. Draft terms of reference for Telford CSE Steering Group, in partnership with NSPCC.[330]

323. The Council's Response Report makes clear that it required all schools to make a commitment to annual delivery of CSE awareness for pupils in year 5 (9 to 10 years old) and above, and for staff and parents.

324. In developing training programmes and raising awareness:

324.1. The Council worked with ILECs in a series of meetings over summer and autumn 2023 to develop core content for DSLs and parents.

324.2. The Education CSE Lead Implementation Officer has worked with the Severn Teaching Schools Alliance to provide training to all head teachers of nursery, infant, junior and primary schools on how to deliver the statutory curriculum in a way which helps raise awareness of CSE.

324.3. The Council has engaged with the NSPCC to deliver its "PANTS" rule to early years, key stage 1 and 2 and SEND pupils.

324.4. The Education Safeguarding Team is working with the NSPCC as part of a partnership campaign to "support in the development, delivery and evaluation of

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a safeguarding campaign across the Telford and Wrekin area which aims to support parents and professionals working with children and young people from 0-18, to help prevent CSE through building their knowledge-base and confidence".[331]

324.5. The Education Safeguarding Team will deliver a range of child protection and safeguarding training to schools and colleges with updated training materials to include the core content for CSE awareness.

325. I have seen a plethora of training materials that have been used for this purpose. I was told that these measures are to be monitored by the Education Safeguarding Team's audit visits, as part of their statutory obligations, which will:

325.1. Test staff awareness of CSE and consider the success of the changes in the curriculum in raising pupils' awareness of CSE; and

325.2. Monitor delivery of awareness raising programmes for parents of school and college pupils and students and that curriculum work with the NSPCC will continue.

326. I saw examples of such audit visits, which audited:

326.1. Whether the DSLs had attended CSE training;

326.2. That all staff understood and recognised CSE and CCE and were familiar with the definitions and indicators;

326.3. Whether there is a proactive approach to minimising the risk of all types of exploitation, including CSE, and that all staff receive relevant training;

326.4. That the curriculum includes a programme of appropriate CSE awareness raising for pupils from year 5;

326.5. That the Headteacher and DSL exchange relevant information with local partners in relation to CSE, as required;

326.6. That the CSE DSL identity and role is known to parents and children; and

326.7. That staff record concerns about a child's welfare, including those relating to CSE.

327. **It seems to me that the Council is right to regard this Recommendation as satisfied in full, and I am gratified to see that no school has thought CSE training was not appropriate. I am also delighted to see how the school statutory audit visits are acting as a monitoring function for implementation of this, and other recommendations, which will ensure that these positive developments are maintained for the long-term.**

[331] [redacted] and [redacted] pgs 8-10

Recommendation 42

Recommendation 42

Quality of CSE training delivered to NHS providers and practitioners

In respect of CSE training, in order to increase the likelihood of training translating into practice, the **CCG** needs to:

- Ensure that the training delivered to providers and practitioners includes training on effective ways of engaging with children and encouraging professional curiosity at every contact;
- Review the content and format of the training to ensure that it does not simply consist of the dissemination of written information;
- Ensure there is creativity in how the training is delivered; for example, practical exercises and/or tests to show understanding, including a minimum pass mark, to ensure the training is embedded in practice; and
- Review the method by which assurance is provided as to the percentage of providers/practitioners that have completed the necessary training; for example, simply because a practitioner was on a distribution list is not sufficient assurance.

328. The Response Report on Recommendation 42[332] suggests that this Recommendation has been implemented completely.

329. In considering this conclusion I have taken into account the following:

329.1. Shropshire Telford and Wrekin Integrated Care System IITCSE Recommendation 42 reply;[333]

329.2. Summary of statutory and mandatory training levels 1-3;[334]

329.3. 7-minute briefings in relation to CSE, professional curiosity and the voice of the child;[335]

329.4. Safeguarding newsletter, Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust, dated 17 May 2021;[336]

329.5. Royal College of Nursing Intercollegiate document "Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff";[337]

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329.6. CSE Standard operating procedure for health practitioners;[338]

329.7. Copy of Shropshire, Telford and Wrekin (STW) pharmacy governance report highlighting CSE training;[339]

329.8. Level 2 Safeguarding Children Training slide deck delivered by health provider trust;[340]

329.9. Example safeguarding dashboard for NHS trusts and other providers which includes the training available, including the new CSE awareness training;[341] and

329.10. Copy of ICB contract requirements for providers.[342]

330. The Council's Response Report notes that:

330.1. An assessment of current training was made as a preliminary step and it was confirmed that all health staff have access to CSE training through distinct levels of safeguarding children training. Additionally, staff were instructed about professional curiosity and engaging with children, though it was accepted that this was at a basic level;

330.2. The existing training material was shared with the ILECs who expressed their views regarding existing CSE training. The Council's CSE training, co-produced with the ILECs, and the "Explore More" guidance then became mandatory for all those working in health commissioned services and contracted services from April 2024, with monitoring happening via contract review meetings;

330.3. As to avoiding training by "information dump" without assurance of completion, while the training will be offered online, both the CSE and safeguarding training contains questions which must be answered to progress, and there is additional, face to face, CSE impact training being offered for specified groups identified by the ILECs, to include sexual health practitioners, school nurses, health visitors, GPs and maternity department staff; and

330.4. Commissioned health providers will continue to ensure learning is delivered in different formats and assurance for this will be monitored via the Safeguarding committee meetings and partnership work.

331. As to ensuring training is embedded in practice, the Response Report notes that this will be monitored in providers' annual reports, numbers of referrals to children's social care for CSE concerns, and provider audits. CSE awareness training has been added to the safeguarding "dashboard" which will be regularly monitored by the ICB to ensure compliance and challenges made at regular meetings where designated nurses attend. CSE

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awareness training is, I understand, to be added to all new contracts commissioned by the ICB, and considered during regular review meetings.[343]

332. **It seems to me that the Council is right to suggest that this Recommendation has been satisfied in full. The evidence I have seen shows an enthusiastic embrace of the opportunity that the ILECs provided to reframe training, and that the resulting training has been firmly embedded in health commissioning, with a common approach by ICB and Council commissioned services; and, of course, given that the ICB's borders are not coterminous, with the Councils to the surrounding areas.**

Schools Recommendations (33, 34, 35)

Recommendation 33

Recommendation 33

Schools and colleges to appoint a CSE lead

All **secondary schools and colleges**, in association with the **Council**, should designate a CSE lead (who should not be the Designated Safeguarding Lead ("DSL")), but whose identity should be known to parents and children, and who must be easily accessible to children. The CSE lead should compile the children at risk report and the mapping report (in accordance with **Recommendation 5**) in consultation with colleagues, including the DSL.

333. The Response Report on Recommendation 33[344] suggests that this Recommendation has been completely implemented.

334. In considering this conclusion I have taken into account the following:

334.1. Job description for CSE DSL Lead Council Officer;[345]

334.2. CSE DSL Role profile;[346]

334.3. CSE DSL list;[347]

334.4. CSE DSL Network terms of reference;[348]

334.5. CSE DSL Network meeting minutes, agendas and presentations;[349]

343 [redacted] pg 11
344 [redacted]
345 [redacted]
346 [redacted]
347 [redacted]
348 [redacted]
349 [redacted]

334.6. CSE Updates by the Education Safeguarding Co-ordinator;[350]

334.7. "Focus on Child Exploitation" – school to parent literature;[351]

334.8. Exploitation Awareness event attendance list;[352] and

334.9. CSE DSL training content and attendance register.[353]

335. I have read that the Council decided that the CSE Lead in a school should be part of the leadership team and be a trained deputy DSL so as better to fulfil the safeguarding element of the CSE lead role and they created a role profile for the job. The role profile suggests that the CSE Leads (now known as CSE DSL) is:

335.1. To be trained as a deputy DSL;

335.2. To publicise their role to the school/college community and be available to pupils/learners and parents/carers;

335.3. To engage with partners to exchange information to react, monitor and protect children better from CSE;

335.4. Work with setting leaders, especially the DSL, to provide annual training to all staff in CSE awareness; to set out a programme of age-appropriate CSE awareness raising sessions for pupils/learners; and arrange annual CSE awareness raising session for parents;

335.5. Maintain a regular attendance at the CSE DSL Network meetings;

335.6. Work with setting leaders to ensure the setting has a written policy in place to govern the recording and sharing of CSE information, and to ensure this is reviewed at least every six months;

335.7. Work with the DSL to monitor the quality of CSE record keeping and actions taken - this may be on the Child Protection Online Monitoring System ("CPOMS") system, or a similar alternative;

335.8. Work with setting leaders, especially health and safety leads and those with responsibility for site security, to undertake an annual site security audit to help to ensure that pupils/learners are protected from potential perpetrators of CSE while at school/college, which includes reporting near-misses to the Council;

335.9. Prepare and share the 'children at risk report' and 'school/college mapping report' with the JCSERG; and

350 [redacted]
351 [redacted]
352 [redacted]
353 [redacted]

335.10. Exchange information with the CATE Team and WMP on contextual and thematic safeguarding updates in accordance with the information sharing pathway.[354]

336. I have heard that all secondary schools and colleges within the Borough, including the independents, have appointed CSE DSLs. The Council intends to monitor the continued presence of CSE DSLs in schools through its statutory Education Safeguarding Audit process (as mentioned above at paragraph 190).

337. Furthermore, the Council has created the "CSE DSL Network" with terms of reference which suggest that the Network will meet regularly so that CSE DSLs may:

337.1. *"Receive training as defined by the Telford & Wrekin Safeguarding Partnership to upskill CSE DSLs to carry out their role effectively";*

337.2. *"Review how the role is publicised to their school/college community and be available to pupils/learners and parents/carers";*

337.3. *"Engage with partners to exchange information to react, monitor and protect children better from CSE";*

337.4. *"Receive and deliver annual training content to all staff in CSE awareness";*

337.5. *"To review the programme of age-appropriate CSE awareness raising sessions for pupils/learners in their school/college";* and

337.6. *"Prepare and share the 'children at risk report' and 'school/college mapping report' with the Joint CSE Review Group and review the evaluation of the children at risk and mapping reports."*[355]

338. The minutes of CSE DSL Network meetings[356] show well attended groups - including presence of CATE and WMP - with regular meetings. The focus of the meetings is said to be the identification of themes and patterns and local threats and risks, rather than being a forum for discussing individual children. In that regard it was, in my view, a very sensible decision that the CATE Team and WMP CE teams were introduced into the group at an early stage, ensuring establishment of valuable lines of communication, bolstering awareness of the nature of their work, as well as making clear the process for referrals.

339. There was CSE DSL training with content developed in association with the ILECs in December 2023.

340. During my meetings with stakeholders I heard that these steps created a solid support system for CSE DSLs:

"…I feel like we have now got a really secure base and cohort and of course colleagues change as well but it's quite easy then to support new people into the network because

354 [redacted]
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we've got such a well-defined job description, we've got a peer network, we've got support groups."[357]

341. I also heard that these steps have resulted in *"an increase in the identification of those vulnerable to CSE".*[358]

342. **This is another Recommendation where I agree with the Council that it has been satisfied in full.**[359]

Recommendation 34

Recommendation 34

Schools to review CPOMS policy and systems for information sharing

In association with the **Council**, **all schools and colleges** using the CPOMS system should ensure that:

- The school or college has a written policy in place to govern the recording of CSE-related information onto CPOMS;
- The policy sets out how information from CPOMS should be shared with partner agencies (namely WMP and Safeguarding) and considers the practicalities for doing so;
- All relevant information is routinely recorded on CPOMS;
- The information should include a statement of what the concerns are, what action was taken, and what follow up was thought to be needed; and that
- A six monthly review is carried out of the information logged on CPOMS, to ensure all relevant information (i.e. information which may have been identified as a possible indicator of CSE) is routinely recorded.

This process should be led by the DSL.

343. The Response Report on Recommendation 34[360] suggests that this Recommendation has been implemented completely.

344. In considering this conclusion I have taken into account the following;

344.1. Template Child Protection and Safeguarding Policy 2023-24;[361]

357 [redacted] pg 4
358 pg 8
359 pg 2
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344.2. Sample school child protection and safeguarding policies;[362]

344.3. Sample of training to support monitoring of safeguarding records in child protection supervision;[363]

344.4. Sample of training for newly appointed DSLs;[364]

344.5. Sample of DSL two yearly refresher training;[365]

344.6. Sample safeguarding audit visits;[366] and

344.7. DSL aide memoire chart - record of six-monthly review of all cases where a concern has been raised about suspected risk of CSE or evidence of known risk of CSE.[367]

345. The Council's Response Report notes that not all schools in the Borough use the CPOMS system – I heard 3% do not[368] – and while the Recommendation was directed at CPOMS schools, the Council has interpreted it in a way which has led to a universal approach. As a result, the Council updated the template child protection and safeguarding policies to include requirements in respect of safeguarding information record keeping and sharing. Additionally:

345.1. Alongside (or in the rare cases in substitution for) CPOMS, a mapping tool has been developed; the intention being that the tool will record any child showing indicators. The mapping tool is monitored daily and discussed at weekly scrutiny meetings and allows access to CATE/WMP CE team information.[369]

345.2. Training has been delivered by the Education Safeguarding Team.

345.3. Monitoring of the initial policy timelines for recording were unforgiving and have been amended.

345.4. DSLs are expected to undertake six monthly reviews of safeguarding records.

345.5. Consistency of recording has become a quality assurance item for governing bodies.

346. Further, I have read that the Education Safeguarding Team's safeguarding audit visits will involve scrutiny of DSL record-keeping as well as a review of school policies in respect of

362 [redacted]
363 [redacted]
364 [redacted]
365 [redacted]
366 [redacted]
367 [redacted]
368 [redacted] pg 11
369 [redacted] pgs 28-32

information recording. Audit visits take place at a minimum on a three-yearly basis but I have read are "*often more frequently based on a risk and needs led response*".[370]

347. **Once again, I am of the view that the Council has fully satisfied this Recommendation and indeed, gone beyond it; it was designed to address schools using CPOMS but the Council's response goes further and provides schools not only with guidance but with an information sharing system that is designed to ensure virtual live monitoring of incoming information.**

Recommendation 35

Recommendation 35

Schools and Colleges to carry out an annual review of site security

In association with the **Council**, **all schools and colleges** in Telford should carry out an annual review to consider the adequacy of the school's site security provision, including arrangements for monitoring and recording any unauthorised access, to ensure that pupils are protected from potential perpetrators of CSE while at school, and to ensure appropriate liaison with WMP or Safeguarding where required.

348. The Response Report on Recommendation 35[371] suggests that this Recommendation has been implemented completely.

349. In considering this conclusion I have taken into account the following:

349.1. CSE guidance note for schools and colleges in respect of use of taxis;[372]

349.2. CSE site security analysis;[373]

349.3. Sample site security audit form and template report;[374] and

349.4. Sample site security visit notes.[375]

350. The Council's Response Report notes that Council officers from Education and Health and Safety worked together with CSE DSLs to develop a site security self-audit for schools and colleges to assess the adequacy of their arrangements. All schools and colleges completed the audit and as a result updated their premises risk assessment with any control measures implemented or further actions required. The Council undertook a full analysis of the security audit returns in August 2023 to consider themes and further developments required. Further measures included, for example, safeguarding audit visits and guidance being offered where the self-analysis revealed gaps. There were additionally sample audits

370 [redacted]2 pg 7 and [redacted] paragraph 6.1
371 [redacted]
372 [redacted]
373 [redacted]
374 [redacted]
375 [redacted]

of schools undertaken by the Education Safeguarding Team – almost one-third of the cohort (30 of 88) being visited in the 2022-2023 academic year,[376] and annual security monitoring will also form part of schools' statutory Safeguarding Audit (as discussed above). Furthermore, schools will be required to review security annually.

351. Consultation with the ILECs about school site security led to the review of procedures for use of taxis to transport children to and from school, with subsequent guidance being issued. Additionally, the Council will conduct spot checks on taxis as part of its school security monitoring.

352. **I consider the Council is right to consider this Recommendation as satisfied. It is impressive that all schools have replied to enquiries and, beyond that, measures have been taken to analyse the results and offer advice and guidance. I am further satisfied that this new process will be properly embedded through use of schools' self-assessment as well as monitoring by way of regular safeguarding audits.**

WMP Recommendations (8, 36, 37, 38)

Recommendation 8

Recommendation 8

Ring-fencing of WMP's CE Team resource

- **WMP** should commit to the continued existence of the CE team within Telford – at no less than its current strength in both numbers and budget (adjusted for inflation), for a period of no fewer than five years from the date of publication of this Report.
- Following the expiry of that period, in the event of no such further ongoing commitment, WMP should state publicly the reasons why, and the proposals for future management of CSE investigations within WMP.
- WMP should publish information regarding the resourcing and workloads of the CE team as part of the Joint CSE Review Group's Annual Report.

353. The WMP Response Report on Recommendation 8[377] and the West Mercia IITCSE Overview Report[378] suggest that this Recommendation has been implemented completely.

354. In considering this conclusion I have taken into account a document described as the "COM Agreement" - a document I am told represents a formal agreement from the Chief Constable, given at the Chief Officer's Meeting ("COM"), to retain the current strength of the Telford CE team. [379]

[376] [redacted]
[377] [redacted]
[378] Paragraph 6
[379] [redacted]

355. The WMP Overview Report notes that the allocation of resources in the Telford CE team, at the time of the Inquiry Report, was two Detective Sergeants, eight Detective Constables, a co-ordinator, and an analyst. That remained the case at the time of my stakeholder meetings in March 2024. I was told that, in order to address the concerns that the team's focus may shift from CSE to CCE, it has been agreed that the team will comprise a dedicated CSE Detective Sergeant and a dedicated CCE Detective Sergeant. I also heard that both Sergeants are able to deal with the other's work in cases of absence and that the cohort of detective constables are tasked according to need; and, further, that recent promotions have been made within the team which guarantees maintenance of specialist knowledge.[380]

356. The COM Agreement, which is dated 19 December 2023 and signed by the then-Temporary Chief Constable, provides:

"*West Mercia Police commits to the continued existence of the Telford & Wrekin Child Exploitation Team, at no less than its strength of July 2022 (in both numbers and budget adjusted for inflation), until at least 12th July 2027. This resourcing level was two sergeants, eight constables, and one CSE co-ordinator.*

At the conclusion of that period, West Mercia Police will review our position and consider whether to renew that commitment. If it is not renewed, we will publicly state the reasons why and what is proposed for management of CSE investigations in Telford and Wrekin.

West Mercia Police will publish information regarding the resourcing and workloads of the CE Team as part of the 'Joint CSE Review Group's' Annual Report." [381]

357. **It seems to me that the commitment made in the COM agreement fully satisfies this Recommendation.**

358. It is convenient to note at this point that I heard during my meetings that there was a suggestion that WMP's Missing Co-ordinator post may change in the future, with that post being fulfilled by an officer rather than civilian staff.[382] It is, of course for WMP to make its own decisions about how posts are filled and the Missing Co-Ordinator post was not the subject of any specific Recommendation in my Inquiry Report, but it was notable during my meetings how valuable both the CATE team and CE team found the Missing Co-Ordinator's work[383] and particularly the fact that it was a full-time post, which meant that issues could be resolved quickly. Whilst it would be a matter of regret, it seems to me, if that post – which has an honourable history in the story of CSE in Telford – became an additional responsibility rather than a dedicated full-time role, I am told that the Missing Co-ordinator role profile now includes responsibility for engagement with care homes, and that there are six such individuals in post across the WMP force area.[384]

380 [redacted]
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Recommendation 36

Recommendation 36

WMP to review use of CSE marker system

WMP should review the use of the intelligence marker system in CSE cases. The review should include:

- An assessment of the suitability of training, and of effectiveness of guidance and procedures for the application of CSE markers; and
- A historic search (to the extent possible) of CSE cases to ensure markers have been appropriately applied.

359. The WMP Response Report on Recommendation 36[385] and the West Mercia IITCSE Overview Report[386] suggest that this Recommendation has not been implemented completely and cannot be implemented in full without wider "*legislative or national*" changes.

360. In considering this conclusion I have taken into account the following documents provided to me by WMP:

360.1. Table of Athena markers;[387]

360.2. Home Office Counting Rules on CSA/CSE crime flags;[388]

360.3. WMP Modern Slavery Audit August 2022;[389]

360.4. WMP CSE Audit August 2023;[390] and

360.5. WMP CSE & CSA keyword audit.[391]

361. WMP has noted, with candour, "*The consistent application of markers to crimes, individuals, and intelligence relating to CSE has proved challenging*"[392], not least because "*CSE is not an offence defined by statute and as such markers are required to identify events or individuals where a link to sexual exploitation of children is suspected*" .[393] WMP states, though, that it recognises the importance of the "*accurate application of CSE flags to crimes*" so that levels of CSE may be determined.

385 [redacted] paragraph 10
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392 [redacted] paragraph 10.1
393 [redacted] paragraph 10.1

362. A detailed analysis of the recording system is beyond the scope of this document; my Inquiry Report dealt in some detail with counting rules and crime recording systems within WMP.[394] It is, however, important to bear in mind the following background as set out by WMP during this Review:[395]

362.1. "Markers" are applied to an intelligence report (referred to as *"information types"*); an investigation (referred to as *"keywords"* or *"crime flags"*); and a person (referred to as "information markers"). "Information markers" should not be confused with a "warning marker", which is information on risks relating to a person only.[396]

362.2. The primary classification recorded on an investigation is the offence crimed as per Home Office Counting Rules ("HOCR"), which provide that the *"CSE crime flag (CSE related offences) is required as CSE is not defined in law as a separate offence. CSE cannot be identified using offence subclasses only as some subclasses could be made up of CSE and non-CSE offences. As such, a 'flag' is the only method for collecting these data".*[397]

362.3. A CSE marker can be added by the person creating the investigation on the system or by the Investigation Management Unit ("IMU"), which assesses crime records and incidents on a daily basis to ensure the quality of recording and to ensure the linking of data for crimes and incidents is maintained at all times and in accordance with National Crime Recording Standards.[398]

362.4. While a marker can be added by the person creating the investigation,[399] it is IMU which has overall responsibility for adding and checking crime flags[400] while officers (and staff)[401] should add information markers.

362.5. CE team co-ordinators also check relevant crimes and add victim or suspect information markers.[402]

362.6. The Intelligence Processing Unit ("IPU") will check markers on intelligence reports.[403]

363. As to a review of the operation of this system, WMP notes that it has undertaken audits across crime types associated with CSE – modern slavery and human trafficking offences,

[394] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cd9fde781c833845d227b0/1657642982025/IITCSE+REPORT+-+VOLUME+THREE.pdf – Chapter 5
[395] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cd9f93d1afb577e0f4d785/1657642904848/IITCSE+REPORT+-+VOLUME+ONE.pdf
[396] [redacted] paragraph 5.2
[397] paragraph 5.3
[398] paragraph 5.4
[399] paragraph 5.4
[400] paragraph 5.6.2
[401] pg 4
[402] paragraph 5.6.2
[403] paragraph 5.4

and child sexual abuse. The audits have shown "*varying levels of compliance*"[404]; and perhaps unsurprisingly "*greatest confidence lies in those crimes where ownership has been assigned to the CE team*".[405]

364. An audit of 100 investigations arising from 41 children referred into CATE between 1 April 2020 and 31 March 2023 (of a total 180 investigations and 70 children) showed the following:

364.1. 82% of the children had relevant information markers added;

364.2. A bare majority (53%) of people identified as potential perpetrators had a subject information marker added;

364.3. The classification "non-crime – CSE" was not being used in the majority of CSE cases; and

364.4. 30% had an NRM referral.[406]

365. A later audit of 150 WMP child sexual offences investigations (30 of them from Telford) recorded between 1 August 2023 and 11 December 2023 showed:

365.1. Six CSE keyword markers had been incorrectly added (4%), four of those from Telford (13%);

365.2. Four CSE keywords had been correctly added (2.6%), three of those from Telford (10%);

365.3. There were six investigations where an NRM referral was missed (these figures are not broken down by local policing area); and

365.4. Warning markers were missed in almost 90% of cases; in CSE cases, the figure was exactly 90%.[407]

366. The Response Report on this Recommendation suggests that these audits show "*keywords/flag were being added in the majority of investigation but showed that further training was required on Information Markers*"[408]. WMP's Overview Report notes that:

"O*ur improvement strategy is to raise the underlying awareness of CSE amongst all operational staff through the provision of awareness training… This will lead to improved application of markers at the earliest opportunity*".[409]

[404] WMP Overview Report paragraph 10.8
[405] WMP Overview Report paragraph 10.4
[406] [redacted]
[407]
[408] [redacted] paragraph 5.11
[409] [redacted] paragraph 10.9

367. As to that training, I have read that there has been a CPD training session on warning markers (though not information markers) for all frontline officers and staff.[410] WMP intends to "*develop a corporate approach*" as to when information markers should be added, and the approach will be disseminated by:

367.1. Force and local area newsletter;

367.2. A short training package ("60 second learning");

367.3. By way of addition to planned CSE training; and

367.4. As part of frontline CPD training.[411]

368. I have been told, though, that WMP's ambition that the IMU should record all crimes is currently stymied by a lack of resources; and that to an extent the IMU is dependent upon the detail available to its staff, which is in turn dependent upon the source of the information, including the Operations and Communications Centre ("OCC"), where staff recruitment and retention has been a difficulty.[412]

369. I heard in my meetings with WMP that its ability to alter the recording system itself is limited – both by the HOCR, understandably, and by the Athena computer system which operates the markers. WMP is just one "Athena force" and changes must be canvassed across all police forces who use the Athena system. I have been told that WMP has successfully requested the addition of a "group based CSE" marker to the system, but further reflection and consultation is needed before wholesale additions are made.[413]

370. **To the extent that WMP does not control the recording environment, I agree that this Recommendation cannot be met without wider change. I also remind myself that the Recommendation was that WMP reviews and audits the use of the marker system, and associated training, which I consider it has done with a high degree of care and diligence.**

371. **While I do not necessarily agree with the positive tone in respect of some of the audits' conclusions, I do accept, first, that this is an area with a degree of subjectivity and accordingly absolute consistency will be difficult to achieve; and second, that WMP's recognition that an appropriate basic knowledge, acquired through training, is key at all levels. WMP has recognised the importance of this Recommendation and I look forward to further development, audit and improvement in the area.**

410 [redacted] paragraph 5.14
411 [redacted] paragraph 6.2
412 [redacted] pg 41
413 [redacted]

Recommendation 37

Recommendation 37

Police officer and staff CSE training to be reviewed

WMP should ensure that:

- All its officers, PCSOs and public facing staff receive, as part of their initial induction and learning, training on CSE;
- All such staff should also receive regular refresher training and updates on CSE to include: the latest known trends around how CSE may be perpetrated; warning signs to look out for; and reminders as to the action to be taken in response to any concerns about CSE; and
- Any such training addresses the appropriate use of language and techniques to encourage victim disclosure and to avoid victim-blaming.

372. The WMP Response Report on Recommendation 37[414] and the West Mercia IITCSE Overview Report[415] suggest that this Recommendation can be implemented in full, although it remains a work in progress in some areas.

373. In considering this conclusion I have taken into account the following documents:

373.1. Police Constable Degree Apprenticeship National Policing Curriculum;[416]

373.2. Degree Holder Entry Programme National Policing Curriculum;[417]

373.3. Police Community Support Officer ("PCSO") National Curriculum;[418]

373.4. PCSO CSE Training Presentation;[419]

373.5. PCSO Training Learning Outcomes;[420]

373.6. Detective Development Programme ("DDP") National Curriculum;[421]

373.7. DDP CE Lesson Plan;[422]

414 [redacted]
415 Paragraph 11
416 [redacted]
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373.8. Professional Curiosity CE Lesson Plan;[423]

373.9. Serious Sexual Assault Investigators' Development Programme ("SSAIDP") National Curriculum;[424]

373.10. SSAIDP Legislation, Policy & Procedure Lesson Plan;[425]

373.11. Specialist Child Abuse Investigators' Development Programme ("SCAIDP") National Curriculum;[426]

373.12. SCAIDP Child Abuse Lesson Plan;[427]

373.13. SCAIDP Terminology Lesson Plan;[428]

373.14. Management of Sexual or Violent Offenders ("MOSOVO") Lesson Plan;[429]

373.15. Harm Assessment Unit Training Aims & Objectives;[430]

373.16. HAU Child Abuse Lesson Plan/HAU CSA Lesson Plan;[431]

373.17. Exploitation & Vulnerability Training Leaflet;[432]

373.18. Exploitation & Vulnerability Lesson Plan;[433]

373.19. WMP Training Proposal for CSE from NWG;[434]

373.20. Commissioned Training Request;[435] and

373.21. Commissioned Training Confirmation.[436]

374. The WMP Response Report notes the extent to which current training requirements include CSE awareness. So far as student officers, PCSOs, and Special Constables are concerned:[437]

423 [redacted]
424 [redacted]
425 [redacted]
426 [redacted]
427 [redacted]
428 [redacted]
429 [redacted]
430 [redacted]
431 [redacted]
432 [redacted]
433 [redacted]
434 [redacted]
435 [redacted]
436 [redacted]
437 [redacted] paragraph 5.2-5.7

374.1. Student officers (both apprentice and degree) receive CSE awareness education as part of the Police Education Qualification framework, including key definitions and importance of indicators;

374.2. PCSOs receive largely the same initial training as student officers in this regard, though given their public facing role, there is an emphasis on indicators rather than investigative skills; and

374.3. Special Constables receive some training delivered as an online course by WMP Exploitation and Vulnerability trainers.

375. Criminal investigation candidates and those who work in the HAU, receive more specialist initial training (in relation to, for example, serious sexual assault and child sexual abuse), whilst staff in the OCC – who take calls from the public – receive initial training from in-house Exploitation and Vulnerability trainers (a previous scheme involving Barnardo's having lapsed). Front counter staff do not receive CSE training.[438]

376. As to ongoing training, I note that 73 frontline officers from Telford received CPD training in CSE and associated issues in 2022 and I heard that "[the Community Policing Team] *all do understand what is CSE, how do you report it*".[439] There is no such CPD or refresher CSE training requirement for OCC staff or front counter staff.

377. WMP has however recognised in the material I have seen that there is a need for a training package to be prepared to be delivered to all frontline officers and staff, and required to be part of CPD; in particular, it has accepted the urgent need for training of those in the OCC. As a result, WMP has commissioned the NWG to create a "train the trainers" package for WMP's Learning and Development Team, and proposes that:

"*…[e]very front-line officer and member of police staff, and all those who have routine contact with the public, will receive this training in the next financial year. The training will begin with members of staff in our Operational Contact Centre, who receive and deal with calls for service from members of the public*".[440]

378. I have seen the NWG proposal[441] which includes the following themes:

378.1. *"Modern Slavery recap highlighting all forms of modern slavery";*

378.2. *"CSE specific focus including different typologies and vulnerabilities";*

378.3. *"Signs and indicators of CSE including a recognition that modern slavery is [sic] often involves different forms of abuse simultaneously (attendees will be supported to consider indicators specific to the environments that they may encounter victims in)";*

378.4. *"Update on current national and international themes";*

438 [redacted] paragraph 5.8-5.15
439 [redacted] pg 18
440 [redacted] paragraph 11.4
441 [redacted]

378.5. *"Impact of modern slavery on the victim including the grooming process and engagement methods that may be effective at different stages to promote disclosure";*

378.6. *"The impact that language has on the victim and the information that they share and how we respond to victims and perpetrators";* and

378.7. *"NRM".*

379. WMP notes additionally that the NWG commission includes an annual review and a CPD event for the Leaning and Development Team, and a more in-depth training package for specialist CE teams.

380. I understand that WMP has discussed the proposed NWG training with the ILECs, who have raised concerns that it is not consistent with training delivered to other agencies in Telford.[442] That may, I suspect, be inevitable when packages are created by different authors; and I remind myself that I recommended that training be reviewed, not that a uniform package is put in place across all agencies.

381. **It seems to me that WMP is right to say that this Recommendation can be implemented in full. That has not yet happened, but it would be churlish of me to complain about that, given the scale of the task; WMP does not just police Telford, and I note that it is necessary to produce a training package that works force-wide and which is delivered force-wide. I do regard it as positive that WMP has identified specific areas of need in its civilian and public-facing staff, and has prioritised their training; as I have pointed out with respect to Recommendation 36, the knowledge of those in the OCC and their ability to ask relevant questions is crucial not only to public confidence but to the future shape of an investigation.**

Recommendation 38

Recommendation 38

Review of WMP complaints handling procedures required

- **WMP** should review its internal complaints handling procedures to ensure that any complaint raised in a CSE matter is acknowledged immediately and dealt with in a timely fashion. If there are any existing timescales for a response, the review should consider whether those timescales are being met, and if not, it must consider why not and how this should be rectified.

- WMP should also ensure that whenever a complaint is raised about an officer or staff member's conduct which relates to a CSE matter, consideration is given to to whether any further training is required on the part of that individual, regardless of any other action that may be taken in relation to misconduct or performance issues.

[442] [redacted] pgs 9-12

- WMP should publish annually, as part of the Joint CSE Review Group Annual Report, a review of complaints or concerns relating to CSE to include themes and lessons learned.

382. The WMP Response Report on Recommendation 38[443] and the West Mercia IITCSE Overview Report[444] suggest that this Recommendation has not been implemented completely, and cannot be implemented fully without "*legislative or national*" changes.

383. In considering this conclusion I have taken into account:

383.1. PSD Flowchart (003);[445]

383.2. Statutory guidance - 2020 | Independent Office for Police Conduct (IOPC); and

383.3. Missing Persons Procedure 2023.[446]

384. WMP's Response Report notes that in dealing with complaints, its Professional Standards Department ("PSD") follows the guidance issued by the Independent Office of Police Complaints ("IOPC"). This guidance is statutory, issued under the Police and Crime Act 2017. WMP states that complaints are dealt with by "*reasonable and proportionate handling of the complaint on a case-by-case basis*" and that it "*makes all efforts to conduct complaint investigations in a timely manner*".[447]

385. WMP does make the point, in relation to CSE complaints, that these are likely to fall outside the less formal procedure known as "*service recovery*", due to the sensitive and often complex nature of CSE related complaints; and while more serious complaints may be dealt with by a local investigating officer, where a crime or a disciplinary offence is alleged, the investigation would be conducted by the PSD. [448]

386. As far as timeliness is concerned, WMP notes that:

386.1. Upon a complaint being logged, the complainant will be contacted by PSD with details of the investigating officer or complaint handler; and if necessary contact will be scheduled at 28 day intervals thereafter; and

386.2. Where a CSE related complaint is connected to an ongoing criminal investigation, the complaint will normally be paused to await the outcome of the criminal process, so as not to prejudice the criminal investigation.[449]

[443] [redacted]
[444] Paragraph 12
[445] [redacted]
[446] [redacted]
[447] [redacted] paragraph 5.4 and 5.12
[448] [redacted] paragraphs 5.19 and 5.20
[449] [redacted] paragraphs 5.24-5.26

387. These are fine statements of intention; WMP has included an analysis of recent complaints so that I may better judge if those best intentions are met.[450] There were recent complaints as follows:

	2020/2021	2021/2022	2022/2023
Number of Complaints	0	0	4

388. I have read that in each recorded complaint, the complaint was properly recorded and 28 day updates took place in all but one case – where the complaint was finalised within the initial 28 day period. None has produced a request for further review by the complainant. It is no part of my current function to consider the detailed facts of the complaints and the underlying police conduct, but it is relevant to remark that it appears from these complaints that WMP has taken account of the issues raised and acted upon them – for example, a complaint about the response to a missing child report led to a referral to the Safeguarding Advice Team within the OCC, consideration of further explanation of the then-new policy involved (the "most appropriate agency" policy) and indeed a review of the policy itself and the procedure for missing young persons.

389. WMP has, refreshingly, noted that it should avoid police vernacular in communications with complainants.[451] Acronyms and abbreviations are, after all, only useful when both parties to a conversation understand what they mean.

390. Finally, in an echo of Recommendation 36, WMP has indicated that the PSD leadership/management team is to ensure that CSE flags are added to relevant complaints on its dedicated computer system.[452]

391. **I take the view that in collating and analysing recent complaints, WMP has reviewed the timeliness of its processes, and satisfied itself of its efficiency - noting that it must act in line with the procedures set out in the Police Act 2017. As to my Recommendation that in the event of a CSE complaint being made out, consideration should be given to further training, I note that "learning" is a potential outcome within the IOPC statutory guidance referenced above;[453] and I do not understand the statutory system to preclude sensible words of advice being given where a complaint is not upheld, but a learning opportunity may have arisen.**

392. I have already dealt with the publication of complaints data in respect of Recommendations 1-5 separately above.

[450] [redacted] paragraphs 5.40-5.82
[451] [redacted] paragraph 12.1
[452] [redacted] paragraph 6.3
[453] [redacted]

PCC Recommendations (40, 41)

Recommendation 40

Recommendation 40

PCC to commit to continued funding of CSE initiatives

The PCC should commit to continued funding of the following initiatives:

- Taxi Marshal scheme
- Street Pastors

393. The OPCC Response Report on Recommendation 40[454] suggests that this Recommendation has been implemented in full.

394. In considering this conclusion I have taken into account the following documents:

394.1. CSP grant offer letter and grant acceptance;[455]

394.2. OPCC Grant application and acceptance – Taxi Marshalls;[456]

394.3. Taxi Marshall qualitative monitoring form;[457]

394.4. OPCC Telford Street Pastors CSP Grant Application Form 2023-2024;[458]

394.5. Telford Street Pastors CSP qualitative monitoring form;[459]

394.6. Safer and Stronger Draft Partnership Agreement;[460] and

394.7. CSE Needs Assessment Terms of Reference.[461]

395. I have noted from the documentation that the PCC committed to funding the Telford Community Safety Partnership ("CSP") for three years at a rate of £158,934 per annum to cover the period 1 April 2022 to 31 March 2025.[462]

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396. In the financial years 2022/23 and 2023/24, £16,000 per year was allocated from CSP funding for the Taxi Marshall scheme and I have seen material which suggests that the same sum would be allocated for 2024/25.[463]

397. In the financial years 2022/23 and 2023/24, £7,100 was allocated from CSP funding for the Telford Street Pastor scheme, and I have seen material which suggests that the same sum would be allocated for 2024/25.[464]

398. The OPCC Response Report stated that "*… we will have a PCC election in May 2024, and a subsequent new police and crime plan. Although the office* [of the PCC] *can recommend continuation of funding for these services, it will ultimately be a decision for whoever is PCC post May.*"[465] As to this, I heard prior to the PCC's re-election that:[466]

398.1. The PCC would support the commitment to 2024/25;

398.2. There was in future the possibility of a grant which was not part of CSP, providing that the local authority made a contribution; and

398.3. Such grant may go to a project other than the Telford Street Pastors; the phrase "Street Rangers" was used as a hypothetical.

399. **Additionally, I have heard representations from some others that the Telford Street Pastors and Taxi Marshalls are, given changing night-time economy patterns, less relevant to CSE than they once were.[467] I need not come to any settled conclusion on the point because this was a very specific Recommendation which I do consider has been fully satisfied by the commitment made to Telford Street Pastor and Taxi Marshall funding from 2022 to date, and indeed by the re-elected PCC's commitment to funding through the financial year end 2024/25. I should note, though, that I would be disappointed if PCC funding were to be reduced because of – or concomitant with - changing the spend from CSP to direct grant, and I would be troubled, given the value of these schemes, if any suggested alternative did not provide equivalent services.**

Recommendation 41

Recommendation 41

PCC Holding to Account ("HTA") Meetings to be improved

The **PCC** and **WMP** should ensure that:

- The Chief Constable provides relevant data and statistics relating to CSE (including risk/threat analysis; case numbers; trends, and the information prepared for the Joint CSE Review Group as per **Recommendation 3** above) and raises any related budgetary concerns at the HTA meetings;

463 [redacted] pg 2
464 pg 3
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467 [redacted] pg 21

- Any complaints or concerns reported to WMP relating to the handling of any CSE cases are shared with the PCC as part of the HTA meetings; and
- Minutes of the PCC and Chief Constable weekly meetings are to be maintained.

400. The OPCC's Response Report on this Recommendation[468] suggests that this Recommendation has been implemented.

401. In considering this conclusion I have taken into account the following documents:

401.1. Holding to Account ("HTA") terms of reference dated 13 March 2024;[469]

401.2. HTA CSE Force Report dated March 2023;[470]

401.3. Process to brief PCC on issues of public confidence;[471]

401.4. HTA Process Review and Recommendations;[472]

401.5. Professional Standards updated to OPCC for Q1 2023/2024;[473]

401.6. Performance Assurance and Accountability Minutes (August 2023);[474]

401.7. Monthly Assurance Meeting Minutes (March 2023);[475] and

401.8. Redacted meeting notes of HTA meeting on 27 June 2023.[476]

402. I understand that the PCC commissioned a review of the HTA process[477] leading to 17 recommendations to be adopted from April 2023 as follows:

402.1. Recommendation 1: The HTA programme should continue to include different meeting types with a specific focus (i.e. thematic, performance, public and virtual). This is with the caveat that appropriate changes will be made to each meeting to improve effectiveness and efficiency.

402.2. Recommendation 2: The HTA programme should be rebranded to ensure appropriate descriptions of different meeting types, and to ensure alignment between internal and external PCC branding. The preferred option is to change

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the name of the meetings, moving from 'holding to account' to 'Assurance and Accountability' meetings.

402.3. Recommendation 3: Formal HTA meetings should take place twice a quarter to include:

- 1 x performance meeting;
- 1 x thematic meeting;
- Any public HTA activity or virtual HTAs in addition to the two quarterly meetings.

402.4. Recommendation 4: Thematic areas included in the calendar for the year should be aligned to the Safer West Mercia Plan ("SWP"), be more focused and less frequent.

402.5. Recommendation 5: WMP and the PCC should have a joint terms of reference setting meeting.

402.6. Recommendation 6: The terms of reference template should be amended to be more focused, reminding the force of their ability to utilise existing reports, briefings and documents wherever appropriate to avoid duplication.

402.7. Recommendation 7: Although WMP should continue to lead on the development of any briefing notes/papers/products, it is recommended that the PCC Policy Team are more actively involved in the process and have regular contact throughout. Final copies of such documents should also be shared with the PCC's office at least 2 weeks before a thematic meeting.

402.8. Recommendation 8: The agenda for performance HTA meetings should be broadened to include a wider view of WMP performance. In particular the agenda should include the following items:

- Chief Constable Assessment of Quarterly Performance;
- Quarterly update on performance/activity related to the national priorities. for policing (new item); and
- Quarterly HMICFRS[478] update (new item).

402.9. Recommendation 9: The HTA activity related to the quarterly performance report should be more focused on exceptions and local priorities (inc. the SWP and budget metrics) to better drive service improvement activity, focusing on three - five key performance areas aligned to SWP/budget metrics, which have not already been covered by the national priorities/HMICFRS agenda items. In addition, consideration should also be given to recognising public priorities and feedback.

[478] His Majesty's Inspectorate of Constabulary and Fire & Rescue Services

402.10. Recommendation 10: The PCC should no longer submit formal questions ahead of the performance meeting. The areas of focus from the quarterly report will be agreed (see recommendation 9 above) and shared in advance (albeit timescales are stated "tbc"). The Chief Constable will be asked to provide an assessment of performance against the areas included on the agenda, and any next steps. Whilst the PCC recognises the proposal within recommendation 5 above to utilise existing products or briefings, there is an expectation that the Chief Constable will present her views and assessment at the meeting itself e.g. presentation. The agenda item paper will be a copy of the unredacted version of the WMP Quarterly Performance Monitoring report.

402.11. Recommendation 11: The proposed two public assurance and accountability meetings/events a year should focus on public priorities, gathered from a variety of areas, to include, but not limited to, the SWP, public engagement, Caseworker data, trends in media reporting and feedback from the Local Policing Community Charter.

402.12. Recommendation 12: The PCC's Communications & Engagement team should undertake a wholesale review of the current public HTA meetings to develop proposals for a new process. Proposals should be informed by the feedback from the HTA process review survey and should aim to increase public participation.

402.13. Recommendation 13: The calendar for the annual HTA programme should be set by the PCC, following engagement with the force.

402.14. Recommendation 14: A set of guiding principles for HTA should be adopted, aligned to the existing PCC and Chief Constable Accountability guidance (attached under background papers). Furthermore, the PCC and CC should ensure that their teams are appropriately briefed on the new process, and these principles, to ensure that existing culture and behaviours are changed. Some initial draft principles for consideration are below:

- Demonstrate behaviours of mutual respect, trust and confidence, in line with the Code of Ethics, the Nolan Principles and the Policing Protocol;
- Work together to establish a shared understanding of, respect for and commitment to the Policing Protocol;
- Establish and agree clear lines of responsibility and accountability;
- Talk regularly and develop ways of working together effectively - both formally and informally;
- Share information openly and transparently;
- Draw on and use your senior teams;
- Recognise and address issues and problems early, particularly those that require clarity of perspective or position;
- Work together to resolve issues at the earliest stage. Consider section 38 as the last resort;

- Adopt candour to ensure that the PCC can achieve appropriate reassurance and that the force commits to being completely open and honest throughout the HTA process, negating the risk of silences to challenging questions; and

- Understanding that the HTA process allows the PCC to ask targeted and challenging questions and should not generate a defensive response.

402.15. Recommendation 15: Draft minutes from each HTA meeting should be produced in a timely manner, along with the development of a new action tracker to actions. These documents should be shared with the force via Teams to enable feedback on minute accuracy to be made (in advance of the next meeting), along with dynamic updates on actions between meetings. Every HTA agenda should include an item at the beginning of the meeting to review progress against the action tracker, along with an item at the end to summarise.

402.16. Recommendation 16: The HTA action tracker should be a quarterly standing agenda item at the West Mercia Governance Board to ensure successful delivery of service improvement activity.

402.17. Recommendation 17: An annual holding to account calendar and agendas for meetings should be published and maintained on the OPCC's website.

403. I take the view that these recommendations are couched in dense – almost impenetrable – language. A careful analysis shows, though, that the HTA process, as it stood, was failing. That the OPCC felt it was necessary to make pleas for *"mutual respect", "candour"*, to *"share information openly and transparently"* and to negate *"the risk of silences to challenging questions*" and "*defensive responses*" is devastating, and speaks of a system that had degenerated into open distrust. I am fortified in that conclusion by my review of minutes of meetings during which insufficiently persistent questioning was inadequately answered,[479] although the OPCC expressed the view that this impression may be due to "*clarity of minutes rather than the actual meetings themselves*".[480]

404. In my meetings I heard a candid acceptance on the part of the OPCC and WMP that the HTA process had not been working as it should, and that historically there had been a reluctance on the part of WMP senior leadership to submit openly to the process. As a result I was particularly pleased to hear from the Temporary Chief Constable his recognition of missteps and of his commitment to the HTA process. I trust that his successor will publicly make the same commitment.[481]

405. So far as the individual parts of Recommendation 41 are concerned:

405.1. I have seen minutes of a monthly assurance meeting dated March 2023[482] in which the PCC was told that "*the analysis to inform strategic focus and form the required annual* [JCSERG] *report will be brought up to date at the end of the*

[479] [redacted] pg 4
[480] [redacted]
[481] [redacted] pgs 5-6 and [redacted] pg 14
[482] [redacted]

financial quarter. There is more work to be done around the performance data to support activity".

405.2. I have also seen a performance assurance and accountability meeting dated August 2023[483] which deals with various performance data but does not mention CSE.

405.3. I have read that as to "*the prioritisation of a data product to improve understanding of CSE*", "*Force updates in relation to this latter action were provided and discussed at HTA meetings in June 2023, August 2023 and October 2023 when the action was closed*"; that the required material had been shared with the JCSERG and that "*a force CSE / CSA dashboard had been developed and was expected to go live early 2024*".[484]

405.4. I have also seen that "[I]*n Quarter 3 2023/24 the PCC's policy team commissioned research focused on IITCSE to inform future HTA activity*" though I have not seen the product of that research.[485]

405.5. I understand that the OPCC identified that following a reorganisation, there remained no mechanism for the PCC to be briefed upon live gross misconduct investigations. As a result it has been recommended that the PCC will receive an existing PSD Chief Officer briefing document on a weekly basis and that in urgent cases direct briefings take place in accordance with existing procedures for incidents and crimes.[486]

405.6. I further understand that the PCC receives a Chief Officer briefing note which provides an overview of notable incidents, offences or events from the previous week, including the following matters potentially relevant to this Recommendation:

388.6.1 High risk missing persons ("mispers"); and

388.6.2 Hearings/PSD referrals (which also includes details of criminal investigations involving officers and staff).[487]

405.7. Finally, I have seen minutes of the weekly meetings between the Chief Constable and the PCC.[488]

406. **In all the circumstances I am of the view that the OPCC has generally satisfied this Recommendation. There has been a wholesale review of the HTA process resulting in meaningful changes and, I am satisfied, commitment on both sides to the new approach. The overall review of practice in the light of the Recommendation has included identification of gaps in the briefing process which have been addressed, and the weekly meetings are now minuted. It does seem**

483 [redacted]
484 [redacted] pg 4
485 [redacted] paragraph 4.1
486 [redacted] pgs 11-12
487 [redacted] pg 5
488 [redacted]

to me, however, that there is a place for CSE reports to be included as a matter of course in the Chief Constable's quarterly performance assessment and the associated performance meetings – which would, I consider, satisfy this Recommendation in full.

407. I should note before leaving Recommendation 41 that I encountered some concern from the ILECs that material from the HTA meetings was difficult to identify or find – and indeed a suspicion that the HTA rebranding was an exercise in hiding that information.[489] I am satisfied that this was not intentionally the case, but this is a lesson that re-namings and re-brandings must be properly communicated to the public if they are to follow how their representative works for them; and in this regard I am reassured by the ready acceptance of the OPCC that its current website is entirely unhelpful, and needs urgent redesign.[490]

Health Recommendations (43 to 47)

Recommendation 43

Recommendation 43

Improvements to trauma-related mental health services for victims and survivors of CSE in Telford & Wrekin

CCG and **NHS England** should consider all avenues to secure an increase in funding for trauma-related mental health services, in particular for victims/survivors of CSE.

408. The NHS STW's Report on this Recommendation[491] suggests that this Recommendation cannot be fully delivered.

409. In considering this conclusion I have taken into account:

409.1. Email from NHS England with finance information;[492]

409.2. Email from ICB commissioners with information regarding finance availability;[493]

409.3. Letter from the ICB to the Safeguarding Partnership to discuss an increase in finance for children's and young people's mental health services within STW footprint;[494]

409.4. Slide deck with scoping and service provision;[495]

489 [redacted] pgs 31-32
490 [redacted] pgs 12-14
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409.5. Email with details of meeting between the local authority, NHS England Midland region and the ICB Safeguarding and commissioners to discuss the Recommendation;[496]

409.6. Email from ICB commissioners confirming interest in new commissioning framework;[497] and

409.7. Information in relation to a public health grant.[498]

410. I understand from NHS STW's report that a scoping exercise was undertaken to establish what services were currently available to children and adults, whether they were trauma-informed and whether the service had a waiting list. The ILECs were asked by NHS STW to comment on existing services and to give views on what was necessary. Discussions then took place with the Council's commissioning services in respect of existing provision and options available. The result was that no suitable trauma-informed service to support CSE survivors could be identified.

411. Following the consideration of what was available, a meeting took place between NHS STW, the Council, ICB commissioning services and NHS England to review possibilities; NHS England Midlands Region and the ICB commissioners for mental health services were approached for additional funding for additional trauma-informed services, but to no avail.

412. However, NHS STW further notes:

412.1. It was able to identify additional funds for the child and adolescent mental health service, to address waiting times;

412.2. A new project, the Women's Health Hubs, is in development using national funding. It is intended that the Hubs will "*will provide essential signposting to women for health conditions, particularly around, pre-conception, menopause and continence*" and the NHS STW says "*[t]he IITCSE report is a key driver for these hubs in the ICS and will be an important point of contact for women*";[499]

412.3. A new commissioning framework is being developed by Barnardo's as a self-assurance tool to evidence a service being trauma informed. This has been discussed with the ICB commissioners who have agreed to review this once it is completed; and

412.4. The Council and ILECs developed a service specification for a new framework to support CSE survivors, as per Recommendation 18, and NHS STW worked with the Council as part of the tender process to support the service.

413. **I take the view that NHS STW may be overly self-critical in regarding this Recommendation to be unsatisfied and undeliverable. The Recommendation, after all, was that it "*should <u>consider</u> all avenues to secure an increase in funding for trauma-related mental health services, in particular for victims/survivors of***

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499 paragraph 5.8

***CSE*" (emphasis added). It has plainly done that. The obviously comprehensive consideration of the matter has not led to any additional services being identified, but NHS STW has not simply reported that conclusion and left the Recommendation there; rather, it has gone on to play a significant role in the Council's review of therapeutic support services and the creation of a new service, as set out above in response to Recommendation 18. It seems to me that this work by the Council, NHS STW and the ILECs has been a model of effective co-operation.**

Recommendation 44

Recommendation 44

The Council to consider increasing capacity for health services to sexually exploited children

The **Council** should review the current capacity (and ability to meet demand locally, compared to the average nationally) of the following services, and where possible commit to a further increase in capacity by 2024:

- Health visitors; and
- School nurses.

414. The Response Report on this Recommendation[500] suggests that the Council has completely implemented it.

415. In considering this conclusion I have taken into account the following:

415.1. Investment bid report in relation to the Healthy Child Programme to the Council's Service & Financial Planning Committee, dated 16 June 2023;[501]

415.2. PowerPoint slide deck to guide ILECs meetings;[502] and

415.3. Report for ILECs meetings in relation to Recommendation 44.[503]

416. The Council's Response Report notes that the capacity for health visitors and school nursing services within the Council's Healthy Child Programme with the NHS was reviewed during 2023. Local capacity was compared with standards and guidance from the relevant professional bodies – namely, the Institute of Health Visiting and the School and Public Health Nurses Association.

417. The result was that staffing capacity within school nursing and health visiting was found to be below the standards set by the professional bodies – though, it is right to note, not

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dissimilar to other local authorities' provision.[504] I have read that a business case was developed to increase health visiting and school nursing capacity and additional investment was approved in June 2023 to provide two additional full time substantive posts – one in the Health Visiting Service and one in the School Nursing Service. There followed meetings with the ILECs to describe and discuss the proposals for the expansion of the services; these meetings led to the decision that the additional school nurse post would also adopt a dedicated CSE Lead role to enhance the health services for sexually exploited children – a role that already exists in Shropshire. It was further decided that the School Nursing Team would receive, as a priority, the CSE Impact Training developed by the ILECs.

418. In terms of further practical results from the recruitment, I also heard that this will:[505]

418.1. Increase the hours of the senior nurse (who currently works term-time) to be available throughout school holidays;

418.2. Allow the proactive offering of Personal, Social, Health and Economic ("PSHE") support to schools, rather than awaiting an invite from them;

418.3. Enable prompt processing and response to Harm Assessment Unit and Accident & Emergency letters when it has been assessed that the intervention of the 0-19 Service would be appropriate for the relevant child or young person. This could provide earlier awareness of risks associated with CSE and therefore contribute to earlier agency involvement;

418.4. Provide continued attendance at CSE panels, to build awareness across the broader team, equipping the staff with the latest intelligence around CSE such as known perpetrators, new grooming techniques etc;

418.5. Provide additional support for the hard to reach communities by cross training other staff to access areas such as traveller sites and residential care homes for children and young people;

418.6. Increase the public health offer into primary schools;

418.7. Promote the school nursing team and the drop-in sessions via attendance at CSE DSL meetings; and

418.8. In general, an increase in capacity will also enable the team to be better equipped to identify indicators of CSE in referrals or during drop ins. This in turn could reduce vulnerability and increase the timeliness of responses and reviews of those individuals demonstrating signs of vulnerability to CSE.

419. I have further read that, in relation to the School Nurse CSE Lead:[506]

419.1. School Nurses with a specialist interest in CSE will take a lead in that area for the service, and professional development will be agreed with the respective Service Manager and line manager;

504 [redacted]
505 [redacted] pg 2
506 [redacted] pg 2

419.2. An action plan with regards to what additional support the CSE Leads need and additional training required will be agreed (and advice will be sought from the ILECS on this plan); and

419.3. Resilience will be built into this CSE role - in the event of absence of the nurse (e.g. long term sickness) the wider School Nursing Team nurses will seek advice as required from the School Nursing Team Leader, the School Nurse who leads on sexual health and wider child exploitation and also the Safeguarding Team as required.

420. **I take the view that the Council is right to regard this Recommendation as satisfied in full; indeed, it is one of those Recommendations where the Council has gone further than asked. Not only has there been a comprehensive review of staffing levels and a very quick response to increase numbers, but sensible use has been made of the ILECs experience and advice to hone the service offered.**

Recommendation 45

Recommendation 45

Guidance for sexual health clinics/to all health providers responsible for giving sexual health advice to be reviewed

Current sexual health guidance issued to practitioners should be reviewed, and kept under review, by the **CCG** to ensure that it:

- Reminds professionals of the need to consider the potential for CSE to be a reason that the child is seeking sexual health support; and
- Clarifies the policies and referral pathways to follow, in the event they have a concern that a child may be being sexually exploited, or at risk of sexual exploitation.

421. The Response Report on this Recommendation[507] suggests that it has been implemented completely.

422. In considering this conclusion I have taken into account a document referred to as "PowerPoint Guidance Summary", which I understand was used for the purposes of the Council's meetings with ILECs to summarise the sexual health service offering, the context for CSE and the summary of the guidance that had been reviewed.[508]

423. The PowerPoint document noted that the main providers of sexual health services are as follows:

423.1. Main Integrated Sexual Health Service - Midlands Partnership Foundation Trust (commissioned by the Council);

507 [redacted]
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423.2. GPs (commissioned by the ICB);

423.3. British Pregnancy Advisory Service ("BPAS") (commissioned by NHS England); and

423.4. School Nurses - Shropshire Community Trust (commissioned by the Council).

424. I have read that sexual health guidance provided to all health providers responsible for giving sexual health advice was reviewed in 2023 and that the results from this review were discussed with the ILECs in a series of meetings in autumn 2023. As a result, the new local CSE guidance, as referred to in respect of Recommendation 42, which included guidance on the revised Pathway and Explore More material, was included as a training requirement in the global package of guidance. The suite of CSE training is therefore mandated in all the contracts that the Council holds for staff providing sexual health services.

425. I have read that further, it has been agreed that sexual health services staff will be prioritised to receive the ILECs CSE Impact Training.

426. **I take the view that the Council is quite right to consider that this Recommendation has been fully satisfied. It has brought local learning into regionally mandated training and ensured continuity by making the requirement part of the contract process.**

Recommendations 46 and 47

Recommendation 46

GPs in Telford & Wrekin to be consulted about CSE data collection

- The **CCG** should consult with GP practices in Telford & Wrekin to consider what can be done to implement a system for flagging CSE concerns on a child's medical records.
- The **CCG** should seek to raise this issue at regional and national meetings, wherever possible.

Recommendation 47

GPs to implement review system for children moving to a different practice

- The **CCG** should ensure that the GP practices introduce a system so that, when a child moves to a different GP practice, the patient records are reviewed and any concerns regarding CSE are flagged to the new GP practice.
- **GP practices** within the borough will be accountable to the CCG to confirm it has a policy in place for such file reviews.

427. NHS STW's Report on these Recommendations[509] suggests that Recommendation 46 has been fully implemented, but that Recommendation 47 cannot be.

428. In considering this conclusion I have taken into account the following:

428.1. Audit into GP coding for children discussed at CATE;[510]

428.2. Draft best practice CSE Coding Guidance;[511]

428.3. Self-assessment audit sent to GPs specific to CSE assurance;[512]

428.4. Slide deck following self-assessment audit of GP letters from CATE;[513]

428.5. GP Safeguarding Newsletter dated 12 August 2023;[514]

428.6. Agenda for NHS England Midlands region Named GP forum to discuss the Recommendation;[515]

428.7. Invite to National Named GP forum where flagging for CSE was discussed;[516]

428.8. Invite to discuss the Recommendation at the NHS England Safeguarding Community of Practice session to be held on 31 January;[517] and

428.9. Sample CATE letter sent to GP with additional information to be added to child/young person's medical records.[518]

429. I understand from NHS STW's Reports on these two recommendations that NHS STW and the CATE Team held discussions to determine the current GP flagging process for children at risk of CSE, and that it was agreed that GPs informed of CATE referrals would be given a code to add onto medical records and would be asked to upload the CATE letter to records. As a result of concerns raised by the ILECs, it was made clear that children would be informed through the CATE Team that their records would be flagged with their GP in this way.

430. Further, best practice guidance was produced for GPs, health professionals and administrative staff to include the importance of using a flag, what do to if a flag is identified, and the different options as to why you may add a CSE flag on a patient's record.[519]

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431. There followed an audit by NHS STW to determine if GPs were receiving the CATE letters and if they were including the codes as intended. The audit covered 52 children and 13 GP practices; all but one practice had added the codes and uploaded the letters.[520] I heard in my meetings that the practice that had not complied then received a named GP visit and there appears to have been training provided to deal with an administrative error. I understand that audits are to be repeated annually.[521] I was told that "[GPs] *have been incredibly receptive"*.[522]

432. I heard in my meetings that GPs have been told in the best practice guide that if any person – of any age – discloses CSE then it should be added to their medical records (subject to their consent if an adult).[523]

433. I am told that the difficulty with Recommendation 47 is that there is – one may think surprisingly – no national formality about handover of patients to different practices or coding for CSE which can move with medical records. As a result, GP practices may not be aware if a child moves to a new practice outside Telford. I have read that in order to address this, and following a meeting with the ILECs, amendments were made by NHS STW to the initial CATE referral letter that is sent to GPs indicating that any new GP should be told of the safeguarding alert/CATE flag and, where applicable, that the child has been referred to the NRM. Moreover, the best practice guidance provides that:

> **"...***when the child/young person who has a CSE code is deregistered or found to be no longer registered…The practice administrator should notify the Safeguarding Lead GP and make a note of the practice the child/young person is transferring to (which may be a different county). Communicate with the practice the child/young person is moving to either by : a letter (electronic or paper) detailing your concerns or a telephone call to the appropriate person in this practice (e.g Safeguarding Lead GP). Record this communication."*[524]

434. **Plainly NHS STW has satisfied Recommendation 46 in full, and has gone beyond it, not simply consulting about a flagging system but crafting it in the light of ILEC input and implementing it.**

435. **As to Recommendation 47, NHS STW has done what it can for intra-Telford transfers and can do nothing about the national position except to lobby for change. I am pleased to note that its representatives have raised the issue about coding children's medical records in regional and national forums and I fervently hope that this Recommendation can bear practical fruit, not only in Telford but beyond; not only for the sake of children moving areas but also for adult survivors, whose attitudes and reaction to healthcare settings may well be affected by their experiences.**

Wider Impact Recommendations (15, 16, 17, 20)

[520] [redacted] pg 7
[521] [redacted] pgs 19-20 and [redacted] paragraph 5.8
[522] [redacted] pg 7
[523] [redacted] pg 9
[524] [redacted] pg 3

Recommendation 15

Recommendation 15

Treating parents as partners

The **Council** should commit to treating parents as partners in CSE cases and should set out publicly what a parent is entitled to expect when their child is being supported by the CATE Team.

436. The Response Report on this Recommendation[525] suggests that it has been completely implemented.

437. In considering this conclusion I have taken into account the following:

437.1. CATE Practitioner Operational Guidance;[526]

437.2. The CSE Pathway;[527]

437.3. Updated Agenda for CSE Risk Panel;[528]

437.4. Parental Feedback report in relation to the CATE service;[529] and

437.5. Parental information leaflet about CATE.[530]

438. The Council's Response Report underlines that as part of the reconsideration of the Pathway in February and March 2023 (as discussed at paragraph 135 onwards above), feedback from parents whose children were at risk of CSE was obtained. Examples of the questions and feedback from a range of parents on the CATE service were as follows[531]:

> ***"1. How well informed did you feel regarding the CATE process and throughout?"***
>
> *"Very informed, no issues, [CATE worker] explained everything to me, told me when the meetings were taking place and what this meant."*
>
> *"[CATE worker] told us everything, I felt really comfortable talking to [CATE worker] and asking questions if I was unsure about anything."*

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"Fully informed, regular contact through phone, text or home visits to explain what was happening and when. Understood process when working alongside a social worker too."

"Yes, I was very informed, and the process went well, the whole process as I saw big improvements with my daughter, I felt the CATE worker really got to know my [child] on a personal level and advised me what to do to support my [child] effectively."

"2. Did you feel your views were listened to in respect of your child?"

"Yes, definitely. [CATE worker] is really approachable and I felt listened to."

"Yes, any concerns I could go to [CATE worker] and she would hear me out any time and responded to me really quickly. [CATE worker] would come out and speak to her about anything I had concerns around to try and understand it."

"3. What do you feel about the impact of the work completed by CATE?"

"I have definitely seen a difference, no more running away which was happening several times a week. [CATE worker] has built a really good relationship with her."

"Yes certainly known the difference, [child] is still very wary about going online and social media, handing [their] number out to anyone. [Child] is certainly more aware of the risks online which is positive."

"I feel that [child] learnt so much and is loads better than where we were with things, more aware. However still has difficulties being vulnerable which I think will be helped by further support from school and the SEND team/potential diagnosis to allow more impact."

"Positive impact there were lots of changes within the relationships within the home environment."

"4. Did you feel the CATE team were able to advocate for your child/family in terms of accessing other services etc?"

"[CATE worker] has been able to advocate well at CORE meetings, I had no idea the type of support that schools should be putting in and trusted school to do so. [CATE worker] informed me of all the things school should/could be doing to support my child. [CATE worker] tells me what we are entitled to, to support or and challenges school/services if needed."

"Yes [CATE worker] was able to inform us of other support services we can access so we had options."

"Yes definitively, having the CATE team involved helped for School to start being more proactive instead of reactive. [CATE worker] has helped to support me to get access to the correct services in order to assess my child whereas school were telling me they had no evidence. It's helped me to feel that I have a voice too."

"Yes, [CATE worker] tried her best there was a lot of people involved at one stage, police, council and school and the worker encouraged us to all work together, if I think how things were when we first started, we have come along way as there was a lot of negativities."

"5. Is there anything you feel that the CATE team could do differently?"

"No I have been more than happy, out of all the services I have worked with [CATE worker] has been able to get through to my child the most."

"No everything was perfect, good experience with [CATE worker] she was so supportive and helpful, we really miss her."

"No everything has been great and everything that was supposed to happen has happened. The main this for us now is getting a diagnosis to support us to know the best way of working with my child."

"It would be nice to have in paper form all the reports and all the discussions with other professionals as there is so much information that there is to take in that it can be missed or forgotten especially when talking with other professionals and trying to remember what support is in place."

439. As a result of the feedback, changes were made to the CSE Risk Panel agenda to include the views of parents. Furthermore, the CATE Operational Guidance was produced, which includes guidance on how to work with parents, including how CATE assessments should include parental views. In order to ensure a better parental understanding of the CATE service and what the offer was to parents and their children, a leaflet for parents[532] was also produced and then reviewed by the ILECs and redrafted as a result to include practical advice, signposting to local and national support, and the contact details for the allocated CATE practitioners and (where appropriate) police officers. This leaflet is now given to parents when their child is allocated a CATE practitioner.[533]

440. I have read that where CSE concerns are present, local independent parental support is now made available to parents at the point their child is referred into Family Connect.

441. I also understand that there is to be a further parental feedback exercise in summer 2024, which will inform the annual update of the CATE Operational Guidance.

442. **I am of the view that the Council is right to regard this Recommendation as implemented in full. The leaflet is a comprehensive and clear statement of what a parent (and child) may expect from CATE. That the Council has not simply reviewed how it deals with parents (per the terms of the Recommendation) but made significant changes, shows a commitment to the spirit of the Recommendation.**

[532] [redacted]

[533] [redacted] paragraphs 5.3-5.5

Recommendation 16

Recommendation 16

Approach to victims/survivors as adults

The **Council** should undertake a review of social care cases to establish whether there is any identifiable bias in respect of parents who are victims/survivors of CSE and actions that have been taken in respect of safeguarding their children, and the reasons for such actions. If the review reveals any patterns, future policies should be reviewed and training provided to ensure no unconscious bias is applied.

443. The Response Report on Recommendation 16[534] suggests that work is ongoing.

444. The Report notes that in considering how to implement this Recommendation, the Council faced the difficulty that it is not straightforward to identify social care cases which involved parents who were victims or survivors of CSE; such detail is not routinely recorded.

445. As a result, work was undertaken to review:

445.1. Operation Chalice material and CATE files with a review sample covering the years 2009-2023, with a view to identifying young people who were sexually exploited and known to have become parents (data set 1); and

445.2. Children's social care records covering the years 2014-2023 (technology limitations explain the different time span) to identify young people whose parents had previously been subject to social care intervention (data set 2).

446. The review[535] was carried out by the Directors of Children's Safeguarding and Family Support and the Service Delivery Manager with responsibility for the CATE Team. The review considered:

446.1. Whether or not the approach to victims/survivors, and their children, was influenced by the fact that they have been, or are, victims of sexual exploitation;

446.2. Whether or not interventions intended to safeguard children were more, or less, robust for those who have a parent, or parents, who have previously been a victim of exploitation or are a victim of sexual exploitation;

446.3. Whether or not practitioners recognised the impacts of CSE on parents and ensured sufficient measures were in place to provide support to them that are aimed at keeping children within their families;

446.4. Whether there was any other evidence of unconscious bias in the treatment of parents who are victims/survivors of sexual exploitation; and

534 [redacted]
535 [redacted]

446.5. Whether or not there was any change in approach to victims/survivors as parents over time with a view to identifying and implementing actions needed to address any unconscious bias.[536]

447. The review found and concluded that:

447.1. There was no identifiable pattern of Children's Services involvement in families where parents had been sexually exploited as children where thresholds for such involvement were not met;

447.2. Whilst there was some evidence of recording the CSE experience of parents in case files when it did not then bear any relevance on the case in question, there was no supporting evidence to suggest that social work interventions were then based upon this recording;

447.3. While there have been some cases where children have been removed from parents who are victims/survivors of CSE, those were child centric decisions based on risk assessments;

447.4. In any case where parents are victims/survivors of CSE, and this is a relevant consideration in terms of involvement with the family, it is important that any support offered is provided in the context of supporting the parent who has experienced CSE so that the family is able to move forwards together towards an outcome where the child is able to stay within the family home;

447.5. Practitioners working with parents who have been sexually exploited as children need to be alert to the possibility that they may be victims of adult sexual exploitation and appropriate support provided; and

447.6. Practitioners should ensure they remain alert to the fact that the position of perpetrator and victim are not mutually exclusive and, where parents are thought to be facilitating the exploitation of children, they may still be victims of exploitation themselves. This consideration should not, however, lead to a lowered view of the risk of harm to any children who have been referred.

448. The review recommended that:

448.1. *"Lived Experience Consultees be asked to deliver lived experience training to ensure background of CSE is always fully explored, not around direct risk of this to children but the emotional impact it has on survivors re identity, confidence, self-esteem, ability to engage with services and similar. Practitioners should then use this learning to when support planning, as failure to do so will result in a significant gap in support. This is a key area of development for the teams moving forward";*

448.2. *"In accordance with the corporate requirement, all staff should undertake unconscious bias training with case file audits continuing to review whether or not there is any evidence of unconscious bias";*

[536] [redacted] paragraph 3

448.3. *"A file review/audit to be undertaken in 2024 focussing upon the impact of the Family Safeguarding Model for families affected by CSE";*

448.4. *"A practice guide in relation to recording CSE on children's case files to be produced with the support of the Principal Social Worker";*

448.5. *"The Joint CSE Review Group to undertake work in respect of the evidence to support the trio of vulnerabilities within children's safeguarding and what action, if any, is required to provide a holistic multi-agency approach to safeguarding children as a result";*

448.6. *"Further learning to be carried out to reinforce the need for practitioners to take a trauma-informed approach when working with families as well as when working with young people in CATE with the impact of CSE being fully considered prior to closure of a young person's files";*

448.7. *"Through the Children Services auditing process, the auditing tool to be updated to enable the monitoring of the findings of this report on an ongoing basis within the Children's Services quality assurance processes. Should any themes be identified through that auditing process the Partnership Team will be required to arrange partnership-wide training. In addition, Children's Services will arrange immediate training to those individuals who need it";* and

448.8. *"To enable wider practice, oversight the learning from this review should be shared with the Council CSP Board and its relevant subgroups."*[537]

449. **This review was a meticulously researched piece of work. It needed consideration of material which was not easy to collate and the facing of conclusions which may have been at times uncomfortable. I consider its methodology was appropriate, its conclusions properly drawn and its recommendations sensible. It follows that I am not concerned, as I heard some were, that the review was internally conducted. Had I considered that an issue, I would have expressed the Recommendation differently.**

450. **I believe the Council has done much to satisfy this Recommendation already, but accept that its work remains ongoing, to ensure it has satisfied itself that the Recommendation has been fulfilled.**

Recommendation 17

Recommendation 17

Counselling for victims/survivors

The **Council** should commit to the provision of contingency funding for continued access to counselling for affected victim/survivors and family members following the publication of this Report.

537 [redacted]

451. The Response Report on this Recommendation[538] suggests that it has been implemented completely.

452. In considering this conclusion I have taken into account various items of correspondence.[539]

453. During the course of the Inquiry the Council commissioned a counselling service, Base 25, to offer its services to those who gave evidence to the Inquiry and/or were affected by the publication of the Inquiry Report. I am told that notwithstanding the terms of this Recommendation, which was intended to ensure continued provision up to and including publication of this Review, there was a suggestion by the ILECs that it had been overtaken by Recommendation 18.

454. **I do not agree with that, and I am pleased to note that the Council did not either, and I have read that the Council is committed to keeping this provision in place until at least six months after the publication of this Review.**

455. **It follows that I take the view that this Recommendation has been satisfied.**

Recommendation 20

Recommendation 20

Council, WMP and CCG to review processes relating to information sharing in respect of risk of HIV

The **Council**, in association with **CCG and WMP**, should review its processes relating to information sharing in the event of discovery of risk of exposure to HIV through a perpetrator of CSE and, if no such document exists, draft a protocol which makes clear:

- when information relating to risk of HIV exposure of children must be shared and with which bodies;
- the legal basis for that sharing, to avoid doubt;
- Which body should take the lead on matters relating to information sharing including identification of at risk contacts.

Furthermore the Council, WMP and the CCG should consider whether their existing individual and joint processes allow for the effective identification of risk of HIV exposure when a complaint is made of (particularly non-recent) exploitation; and if it is considered they do not, to amend those procedures, or to indicate why such procedures cannot be amended to allow such effective identification of risk.

456. The Response Report on this Recommendation[540] suggests that it has been implemented completely.

538 [redacted]
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457. In considering this conclusion I have taken into account the following:

457.1. Risk of HIV Infection Protocol (CSE Related) – Policy for information sharing regarding risk of exposure to (and infection from) HIV in CSE-related circumstances;[541]

457.2. Telford and Wrekin Tripartite CSE related HIV risk of infection Data Sharing Agreement;[542] and

457.3. Process Plan – Persons at risk of HIV infection [CSE related circumstances].[543]

458. The Council's Response Report notes that discussions with WMP, NHS STW and the Midlands Partnership NHS Foundation Trust ("MPFT") began in autumn 2022. It became quickly apparent that positions were entrenched: WMP, for example, was subject to national direction that the police should not request or, even when voluntarily shared, record the HIV status of potential offenders and MPFT was unable to share information without a court order.

459. There were also complications with regard to receiving information that a person may be HIV positive – not least because an individual may seek screening anywhere in the country and there is not a mechanism to share that information with organisations in Telford. As a result, it was considered that the likely mechanism for local organisations becoming aware of HIV status was through local screening.

460. Following these discussions between the parties, the Council drafted the "Risk of HIV Infection Protocol (CSE Related)", the "Telford and Wrekin Tripartite CSE related HIV risk of infection Data Sharing Agreement" and a "Process Plan". These documents were sent to the ILECs for comment, and some concern was raised about sharing of sensitive victim/survivor information.[544]

461. As a result, the Council sought advice from leading Counsel. The advice confirmed the bases for information sharing, confirmed that health professionals are able to share HIV status information and confirmed that the Police are able to share information with partners who are pursuing a legitimate aim. Since then, and duly reassured, all parties have signed the agreement.[545] The relevant parts provide that:

461.1. The Council will take a lead role in bringing together partner agencies to assess risk and consider solutions in HIV cases;

461.2. Where an agency knows that a child has been exposed to risk of HIV there will be consultation with the Council and ICB with disclosure of such details as are necessary for contact with the child or their carer for support and assistance;

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544 [redacted] paragraph 5.6
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461.3. Where exposure risk has been identified then the Council and WMP will identify any people who may have been exposed and MPFT will make appropriate contact; and

461.4. Where a victim is identified as at risk of infection by virtue of CSE related circumstances a court order may be requested for disclosure of perpetrator medical records to identify with certainty the risk posed.

462. I understand that the Council is continuing work to refine the process.

463. **I take the view that the Council is right to say it has fully satisfied this Recommendation. This is a complicated and sensitive area but one of the highest importance. The parties to the agreement are, in my judgment, to be congratulated for their efforts in producing a workable agreement.**

The NRM

Recommendation 39

Recommendation 39

Multi-agency approach to NRM referrals to be reviewed

The **Council** and **WMP** should:

- Review and enhance the current NRM training provision to ensure that all staff who may deal with trafficked children are appropriately trained;
- Ensure that such training includes when a referral should be made, and the appropriate pathways and protocols to be followed in all NRM-qualifying cases;
- Liaise with one another to ensure that each organisation's protocols for NRM reporting is clear; that relevant information is shared; and agreement reached as to which authority should be responsible for making the referral, in circumstances where both authorities are involved.

464. The joint Council/WMP Response Report on this Recommendation[546] suggests that it has been implemented completely.

465. In considering this conclusion I have taken into account the following:

465.1. Exploitation & Vulnerability CPD Training;[547]

465.2. Exploitation & Vulnerability Training Leaflet;[548]

465.3. WMP Modern Slavery and Human Trafficking ("MSHT") Procedure;[549]

546 [redacted]
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465.4. WMP MSHT Audit 2022;[550]

465.5. WMP CSE Telford Audit 2023;[551]

465.6. WMP CSA/CSE Audit 2024;[552]

465.7. NWG Training Proposal for WMP;[553]

465.8. WMP Commissioned Training Report from NWG;[554]

465.9. WMP Commissioned Training confirmation from NWG;[555]

465.10. NRM Co-ordinator Job description;[556]

465.11. Draft workflow for NRM process;[557] and

465.12. Home Office Annex: Key drivers of NRM referral and 2023 statistics.[558]

466. The joint Response Report sets out the following:

"*Through discussion between West Mercia Police and Telford & Wrekin Council and engagement with the lived experience consultants, a new refocused approach to the NRM process has been agreed. Core to this are the following principles:"*

466.1. *"That those who are at risk or a victim of modern slavery is* [SIC] *safeguarded";*

466.2. *"That all those individuals that should have an NRM referral have one"; and,*

466.3. *"That all NRMs are based on the best possible information to ensure that the victim receives the support to which they are entitled".*

"To deliver these principles, the following will be established:"

466.4. *"a NRM Co-ordinator";*

466.5. *"a multi-agency NRM Panel";*

466.6. *"a local NRM pathway";*

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558 [redacted]

466.7. *"a multi-agency NRM awareness and training programme."*[559]

467. I heard that the NRM Panel will provide the Telford & Wrekin Safeguarding Children Partnership CSE and CE Sub-group with an update report every six months, to include NRM statistics and outcomes, which will also then feed in to the JCSERG's Annual Report. The NRM pathway then clarifies roles and responsibilities and relevant timescales.

468. So far as training is concerned, the Council notes that NRM awareness and process guidance is included in its core online CSE programme that was developed with ILECs. Furthermore, the face to face impact training, to which I have made reference, includes material directed to an "*enhanced understanding of the NRM*".[560]

469. WMP has indicated it reviewed its training on the NRM to all frontline officers and staff and confirmed that Continuous Professional Development training, which included the NRM and modern slavery, was delivered to frontline officers in Spring 2022. In relation to the NRM, the training included: what it is, who are the first responders, when it should be used, the need for the NRM to be utilised for children, requirement for a strategy meeting and where to access the on-line form. This training was provided by an Exploitation and Vulnerability Trainer and 73 officers from Telford attended, including patrol, Safer Neighbourhood Teams and Criminal Investigation Departments. Additionally, WMP staff, Special Constables, Cadets and volunteers received the same resource for CSE/CCE/County Lines training covering the NRM, victim blaming language, vulnerabilities, professional curiosity, barriers, trauma, push/pull factors and the relevant pathways.[561]

470. WMP notes that specialist training courses – for example the Specialist Child Abuse investigator Development Programme – include NRM elements.

471. Furthermore, I have read that WMP delivers training on the NRM to partners and other agencies. This is delivered to partners every month/other month. The training is targeted at (as per the PCC's funding requirements): taxis, hotels, night time economy, religious organisations, sports clubs, retail, universities, police officers/staff, council, care homes, secondary/sixth form/colleges/other provisions for education, support agencies, health sector and others deemed relevant. Between April 2020 to December 2022, they have delivered training to 23,696 delegates.[562]

472. As to effectiveness of the process, WMP conducted a Modern Slavery Crime Audit[563] in August 2022 over incidents and crimes recorded since January 2022. It covered the WMP force area, rather than just Telford. The audit noted that of 92 child criminal exploitation incidents (child sexual exploitation was not separately dealt with) a review of strategy meeting minutes showed "*none identified a requirement for an NRM referral to be carried out*" – conclusions which, in my view, seem odd. Furthermore, the conclusions relating to modern slavery incidents determined that, of 82 modern slavery crimes, an NRM referral was completed for 70 of them, meaning 12 referrals had not been completed. The audit did note the following areas where improvement was necessary:

559 [redacted] paragraphs 5.1-5.2
560 paragraph 5.10
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472.1. Improve staff knowledge for recording modern slavery crimes/incidents and NRM process;

472.2. Delay in crime recording for NRMs submitted by specialist police departments; and

472.3. Improvement of staff awareness that all modern slavery crimes require a NRM.

473. A further audit was carried out by WMP a year later. The source material for analysis was provided by the Council and related to cases dealt with by CATE. 100 cases, relating to 41 children, were reviewed and of these only 12 had NRMs submitted. The joint Response Report suggests that "[t]*his showed an improving picture in the submission of NRMs*" – a conclusion that, while technically correct, seems to me to be overly positively expressed.[564]

474. A further CSE audit carried out by WMP in January 2024, dealing with 30 Telford cases and 150 across the force area, noted of NRM referrals "[t]*he audit found 6 investigations which involved elements of trafficking and modern slavery where an NRM referral should have been considered but wasn't. 2 of these Investigations identified a missed crime of modern slavery*". It is not clear from this analysis whether CSE cases were included in the definitions of trafficking and modern slavery. [565]

475. WMP has accepted "*further training on NRM referrals is required as the audits show NRMs are still being missed/not considered. NRM training will be included within the CSE Training due to be rolled out to all frontline staff/officer in April 2024*".[566]

476. As regards the Council's NRM referrals, national data published by the Home Office for the calendar year of 2023,[567] confirms that 33 referrals were made by the Council during that year (30 of which were being investigated by WMP and three by West Midlands Police). This is in comparison to 13 in 2021 and eight in 2022, indicating that the Council's referral rate had increased. In addition, the Council's own data for the calendar year 2024 shows that 41 referrals have been made to date (with the national data showing that 18 referrals were made in the first quarter of this year). This data does confirm that indeed more referrals are now being made.

477. I accept that the Council and WMP will see children in different circumstances and that comparing their NRM referrals statistics is not easy. While the CATE Team does now refer every child it supports, WMP has taken the view that it cannot properly adopt the same approach.

478. However, I also note the importance of the NRM to victims/survivors, which was outlined to me during the Inquiry, and during this Review; it was acknowledged that whilst the system may have its flaws, "*it is all* [victims/survivors] *have to be able to access certain types of support*".[568] I am heartened, therefore, to see that both the Council and WMP have committed to the creation of a jointly funded NRM co-ordinator post, with a multi-agency NRM panel to agree a new NRM pathway, oversee referrals and ensure information is shared between relevant agencies.

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564 [redacted] paragraph 5.14

565 [redacted]

566 [redacted] paragraph 51.6

567 https://www.gov.uk/government/statistics/modern-slavery-nrm-and-dtn-statistics-end-of-year-summary-2023

568 [redacted] pg 15

479. **In the circumstances, I take the view that this Recommendation will be fully satisfied upon the NRM panel coming into operation and appointment of the NRM co-ordinator.**

Section 6

Conclusions

480. As I said in my press statement when releasing the Inquiry Report – and as mentioned at the beginning of this Report at paragraph 4 - my fervent hope was that all stakeholder organisations would be encouraged to reflect on the findings made in relation to each of them; that they would approach these with a ready acceptance of the mistakes that were made, and would embrace the Recommendations with an open mind, recognising the opportunity these provided for them to improve their practice in relation to CSE in Telford.

481. I am pleased to say that this two year review has confirmed to me that all organisations, without exception, have met my expectations in this regard; and in some cases, have gone beyond what I had expected. I regard the decision by the Council to work closely with the ILECs to be both a brave and revolutionary one. Inviting the ILECs to be an integral part of both the Council's and the JCSERG's response to the Inquiry Report necessarily meant inviting their direct challenge and scrutiny of every step taken by the Council and its partner organisations. As I commented earlier in this Report at paragraph 13 this was not something suggested by me, either informally or formally, as part of the Recommendations. The fact that this relationship grew organically, to the stage where latterly the Council were meeting with the ILECs for a full day every week, is testament not only to its significant commitment to the implementation of the Recommendations, but also to the value the ILECs provided in this endeavour.

"[We] *cannot fault the Council, anybody in the Council for lack of engagement, lack of consultation and lack of commitment… they have been absolutely cracking".*[569]

Recommendations 1 to 5: Establishment and operation of the Joint CSE Review Group

482. I explained at paragraph 124 above, in relation to the first five Recommendations, that these were intended to be the foundation upon which change in Telford would be built. I am pleased to report that the change appears to have been fundamental, and successful, insofar as it has led to the first proper co-ordinated attempt to bring key stakeholders together to collate, share and publish CSE data. In my view, a framework has been created for data sharing and analysis which I hope will lead to a greater public understanding of the nature and extent of CSE within Telford.

483. I repeat, as I did earlier in this Report, the feedback that:

"*The value of the Annual Report cannot be underestimated in that it gave a new insight into CSE in the borough and, as such, will shape policy across all partner organisations for future years."* [570]

484. In relation to **Recommendations 1 to 5**, I consider each to have been implemented, and in some cases with work going beyond what I had set out in the Recommendation itself.

[569] [redacted] pg 29
[570] [redacted] paragraph 5.16

485. I have accepted that there are certain constraints on the extent to which all data, in particular certain sensitive police information, can be shared. However, inter-agency at least, data is being shared to the extent that it is both appropriate and important to do so, and I am hopeful that even if certain data cannot be shared, the collation and analysis should continue.

486. I have also accepted the approach taken to the engagement with school CSE Leads and that the information sought via the questionnaire adequately covers the terms of **Recommendation 5**.

487. In summary, I consider **Recommendations 1 to 5** have been met, and I applaud all stakeholder organisations for their combined work in fully engaging with the establishment and operation of the JCSERG, and recognising its importance in responding to the Inquiry.

The CATE Recommendations (7, 10 and 13)

488. In relation to the protection of CATE funding and resourcing for the future (**Recommendation 7**), it seems to me that the Council has given as complete a commitment as it reasonably can, and I am pleased to see that this features in the 2023 JCSERG Annual Report.

489. The CATE Pathway itself has been reviewed as required in **Recommendation 10**, in concert with the ILECs. Despite some challenges along the way, continuing efforts on all sides led to the creation of the "Explore More" document, which is now being used by Family Connect to support any practitioner working with children in better understanding the issues that may indicate they are being exploited. The same collaborative approach has been adopted in relation to the associated Pathway guidance material, and I said above at paragraph 144 that the Pathway as it now stands demonstrates an admirable openness by Telford's professionals to listen to the experiences of those who know exploitation, and there is a commitment to ensuring the Pathway is reviewed annually.

490. Insofar as **Recommendation 13** and the case file audits are concerned, the Council engaged the services of the NWG, and whilst the audit did identify room for improvement in some areas, the conclusions of their review identified a strong CATE Team that had a "*palpable enthusiasm and passion*" for its work. Most laudatory of all, it found that the work being done by the Council in relation to its Pathway and engagement with both the NRM and the NWG, "*will reference as good practice to other local authority areas".* [571]

Structural Recommendations (9, 11, 14, 18, 19, 21, 22)

491. Readers of the Inquiry Report may recall that I was quite critical of the way in which the Council's governance and oversight structures often stood in the way of action being taken, with rigid criteria being applied across various different groups and pathways which were overly complex and unhelpful. In line with this, **Recommendation 9** required the Council to review its sub-groups. I am pleased to report that it appears the Council has carefully considered its structure, and has removed an upper tier of bureaucracy with the Safeguarding Partnership Executive and ensured independent scrutiny by ensuring that independent chairs do not chair more than one board. It has sought greater focus with the

[571] [redacted] paragraph 5.1

inception of thematic groups and specifically retained the Exploitation and Neglect groups, underlining the importance of these areas.

492. As regards adulthood transition, I noted in my Inquiry Report that this represented a notorious cliff-edge for far too many young people in Telford. I have noted in this Report the significant work undertaken by the Council in seeking to address this, where possible, in response to **Recommendation 11**, with appropriate panel oversight and signposting to support. The involvement of housing and the changes to the Post-17 Transition meetings are, I believe, positive developments which I hope will make a difference to those young people making their way into adulthood.

493. Another issue that was raised in my Inquiry Report was the lack of information sharing between schools and the Council. I was pleased to see the new CSE Information Sharing Agreement implemented, which sets out a legal basis (not dependent upon consent) for sharing information and provides for a two-yearly review of its operation by the CSE DSL Network. I am also encouraged by the fact of the safeguarding audit visits conducted by the Education Safeguarding Team of all schools and colleges in the Borough,[572] which will, amongst other things, look at how they have used the information received. The fact that all schools, including independent schools, have signed the agreement and this new system has been welcomed and embraced by a large majority of teachers in the area, leads me to conclude that **Recommendation 14** has also been met.

494. The Council has also sought to augment its therapeutic support services, in line with **Recommendation 18**, and in concert with NHS STW's Safeguarding Nursing team. Whilst the new services have only just been through the contracting stage, and so the success of these is still to be seen, I am of the view that the Council has sought to create a support service which I hope will be of great value to those affected, directly and more broadly, by CSE.

495. The same can be said of the Council's approach to its Youth Services, in response to **Recommendation 19**. Following its consultation with young people and the ILECs, and following establishment of the Youth Partnership Board and introduction of a Youth Development Officer, the Council has created an imaginative structure, which I hope will provide a strong youth offer within Telford both now and in the future.

496. As regards reporting of concerns, the Council reflected on the comments made in my Inquiry Report about the barriers to reporting, including that this was not truly anonymous. The work done in response to change this, as set out above at paragraphs 213 to 220, clearly proved beneficial, as analysis carried out in Family Connect during the development of the new anonymous reporting system showed that anonymous reporting – including of CSE - by other means was increasing, reinforcing the need for the revamp of the online system. I recognise that technological changes are often very complicated and often costly to implement, so I am delighted at the efforts made to introduce these changes in response to **Recommendation 21**.

497. Lastly, in terms of complaints and **Recommendation 22**, the Council responded to the Inquiry's Recommendation by introducing a new policy, in consultation with the ILECs, for handling CSE complaints which fell outside statutory procedures. The policy recognises the need for confidentiality in CSE cases and also provides details of support services and advocacy services that complainants may find helpful. In particular, the policy requires a

[572] In line with its obligations to do so under s157 and s175 of the Education Act 2002

uniform process for dealing with all complaints relating to CSE. I appreciate, as I must, that the Council must also abide by its obligations under the newly-developed national Complaints Handling Code, however the Council's decision to introduce its own additional guidance in respect of CSE complaints shows an innovative and flexible approach, which is to the Council's credit.

Licensing Recommendations (23 to 31)

498. I made a number of individual Recommendations in relation to the Licensing regime in Telford, following the issues identified in my Inquiry Report about matters such as cross-border licensing and whether, for example, seeking a common pricing structure may help to address issues in this regard. It is of course the case that many of the parameters that govern the taxi licensing regime in Telford are matters that are controlled at a national level, and as such there is a limit to what the Council is able to do in isolation. I acknowledge that, as a result, there are certain Recommendations I made in my Inquiry Report that cannot currently be fulfilled in their entirety.

499. Whilst a common pricing structure is clearly not possible, I am pleased that in response to **Recommendation 23** the Council has at least attempted to address this with its neighbouring authorities, and that it has nevertheless sought to improve information sharing by way of the monthly multi-agency enforcement meetings, which I note results in the sharing of information between local authorities regarding neighbour-licensed drivers.[573]

500. The Council has also made proper efforts to seek to share the contents of its taxi driver training course with other local authorities (**Recommendation 24**), albeit this has not been taken up.

501. In relation to complaints and reporting of concerns (**Recommendation 25**), I was pleased to read about the introduction of new stickers with QR codes, and that these have been rolled out to LSAVI premises as well as in taxi cabs. Efforts to ensure all media communications are in plain English, and using innovative channels such as Tik Tok, show that the Council has thought broadly about how it can ensure complaints and concerns can be reported quickly, easily and effectively. Where complaints relate to individual taxi drivers (**Recommendation 26**), it is satisfying to note that data is being analysed by the Licensing Committee, and fed through to the JCSERG so that any safeguarding complaints are being reviewed for CSE, and that it is intended such reports will continue to be collated and presented to the Licensing Committee every year.

502. My concerns around the sharing of safeguarding information for the purposes of taxi licensing were captured in **Recommendation 27**, and I was pleased to note that as required, the Council drafted a consolidated information sharing policy and a safeguarding flowchart, which require more detailed checks to be undertaken on application or renewal of a taxi licence. The policy clarifies what is expected and when, and it seems the sharing of relevant data (or its absence) is now firmly embedded.

503. I am equally pleased by the success of the pilot introduction of CCTV into taxi cabs in response to **Recommendation 28**, and that in March 2024, with the benefit of CSP funding, 25 taxis were running CCTV with a waiting list in place for further installations.

573 [redacted]

The groundswell of support from both drivers and members of the public, as set out in the Council's response to this Recommendation, leads me to the conclusion that this should be another case for nationally mandated standards in this regard.

504. Insofar as the role of WMP in licensing is concerned (**Recommendation 29**), I note above at paragraphs 276 to 278 that following a joint review, the Police and Licensing agreed that more co-ordinated activity was required and there has been an increase in joint operations to effect random stops and enforcement exercises. I was pleased to read about the creation of the Taxi Forum initiative, for the police and Licensing to work together with drivers and operators to raise awareness and respond to feedback. I am also comforted by the introduction of a named officer who holds the title of Licensing/ Multi-Agency Targeted Enforcement Strategy Officer and who holds responsibility within WMP for the operations and associated briefings relating to taxi enforcement.

505. As regards **Recommendation 30**, and the review of historic premises licences, I accept that no complaints or issues were identified which suggested operators were not meeting their licensing obligations, so as to require a formal licence review or variation. I also accept the difficulties with the approach to imposing a no under-18s licensing condition, and there needs to be a clear reason to do so within the confines of the current premises licensing regime. That said, I do consider that a process should be put in place to ensure the position is reviewed regularly so that if any licence review is instigated these conditions are considered and, if necessary, applied at that stage.

506. **Recommendation 31** similarly looked at information sharing with regard to CSE concerns involving restaurant and take-away establishments. I note that this topic already represents part of the MATES meetings, but that through those meetings the approach to these venues has been reviewed, and as a result a new observation checklist has been prepared to be used by Environmental Health Officers in the Food, Health and Safety team to complete in conjunction with their inspections of food premises. Once complete, this observation checklist would be emailed to a single point of contact for the WMP CE team and Problem-Solving Hub, and any relevant intelligence would then be entered onto WMP's intelligence database and disseminated to WMP agreed contacts to be taken forward. I consider this an important development, as there is no mechanism for the Council to remove a food business operator and nor is there any consideration at national level of a "permit to trade". The involvement of the police, and information sharing with the police, is therefore key to ensuring as much as possible can be done to follow up on, or identify, CSE concerns or complaints in relation to food and beverage premises.

507. The Council's Licensing Team, uniquely, did not meet serious criticism in my Inquiry Report. Rather, I was concerned that it had not been supported by local decisions and by national policy. So far as national policy is concerned, I remain of the view that aspects of taxi licensing, in particular, undermine rather than promote best practice. In this Review I found the Licensing Team to be committed to public safety. I find their efforts to implement the Recommendations so far as possible, and to have conversations with partners about those that were more troublesome, admirable.

Training Recommendations (6, 12, 32, 42)

508. These Recommendations made demands across a broad range of stakeholders and responses have varied. That is understandable – WMP, for example, is a very large organisation with obligations to follow national training and, to the extent that it is able to

add additional or further training, it needs to ensure that it is deployed across the entire force area, not simply in Telford, and that will take time.

509. It is important that I set out here again the extent to which the ILECs have been crucial to the preparation and delivery of training for the Council and NHS STW, and they have thereby transformed practitioners' understanding of the many issues surrounding CSE. It is my firm hope that other stakeholders are also able to derive such benefit from full engagement with the ILECs. This Review has underlined the obvious point that if lived experience is thought to have value for stakeholders dealing with Telford's problems - and I consider it plainly does - then it is to those individuals who stakeholders should turn.

510. While it is apparent from my review of responses that all stakeholders have been mindful of the Recommendations, and that in many cases the roll out of training is still ongoing, I do consider it important that each one considers carefully first, the extent to which it is relying on existing training resources, rather than tailoring training to the Recommendation; and second, that compliance continues to be monitored, enforced, and reported in the JSCERG Annual Report.

Schools Recommendations (Recommendations 33, 34 and 35)

511. As regards schools, I was very pleased to note that in response to **Recommendation 33**, all secondary schools and colleges within the Borough, including independents, have appointed CSE DSLs, and that the Council intends to monitor the continued presence of CSE DSLs in schools through its statutory Education Safeguarding Audit process. The creation of the CSE DSL Network is another very welcome development, and the minutes show good attendance at meetings, where the focus is on the identification of themes, patterns and local threats and risks, rather than discussing individual children, which I think is to its credit.

512. It is apparent that the new DSL system has been wholeheartedly embraced - the CSE DSLs I met were overwhelmingly positive about the new system. Interestingly, although my Recommendation did not seek to impose CSE DSLs in primary schools, I heard that at least one primary school has voluntarily adopted the role.

513. In considering the steps taken by the Education team, I reflect on the fact that teachers are uniquely well placed to see what is happening to children out of the home setting, and the findings in my Inquiry Report that teachers were alive to concerns about CSE in the 1990s, but lacked a forum for raising those concerns. In this regard, **Recommendation 34** required schools and colleges to review the use of the CPOMS system, consider policies for how to record and share information with partner agencies in relation to CSE concerns, and any such information on CPOMS should be reviewed every six months. In response, the Council has updated its child protection and safeguarding policies to include requirements in respect of safeguarding information record keeping and sharing. Additional training has also been delivered to all schools by the Education Safeguarding Team, and a mapping tool has been developed, to record any child showing indicators of CSE. Audits carried out every three years (or sooner) by the Education Safeguarding Team will, I am told, also involve scrutiny of DSL record keeping and review.[574]

[574] [redacted] pg 7 and [redacted] paragraph 6.1

514. In **Recommendation 35**, I asked schools and colleges to carry out an annual review of site security, in an effort to address unauthorised access and to protect pupils from perpetrators who may seek to target children on or outside school premises. In response, Council officers from Education and Health and Safety worked together with CSE DSLs to develop a site security self-audit for schools and colleges to assess the adequacy of their arrangements. All schools and colleges completed the audit and as a result updated their premises' risk assessments. The Council undertook a full analysis of the security audit returns in August 2023 and some further measures were identified. Consultation with the ILECs also led to the review of procedures for the use of taxis to transport children to and from school, with subsequent guidance being issued.

515. In conclusion, therefore, I am of the view that the Council and Education Safeguarding Team have implemented all Recommendations in relation to schools, and indeed in some respects have exceeded my expectations.

WMP Recommendations (8, 36, 37 and 38)

516. Similar to the CATE Team, an important Recommendation in my Inquiry Report was that a commitment should be made by WMP to ringfence its CE team resource at no less than its existing strength (at that time) – both in terms of numbers and budget (**Recommendation 8**). At the time of publication, the CE team comprised two Detective Sergeants, eight Detective Constables, a co-ordinator, and an analyst. That remained the case at the time of my stakeholder meetings in March 2024, however structural changes had been made within the team such that the two Sergeants are aligned one each to CSE and CCE – to ensure equal focus remains on both types of exploitation – albeit both sergeants are equipped to deal with the other's work as required. I was also very pleased to note that recent promotions have been made, which guarantees consistency of specialist knowledge within the team. In a similar way to the Council, WMP has also indicated its commitment to maintain the resourcing at the current level, until at least 12 July 2027 – five years on from the Inquiry Report – and after which time it will be reviewed; if it is not renewed at the same level, a public statement will be made setting out the reasons why.[575]

517. **Recommendations 36 and 37**, which related to a review of the use of WMP's CSE marker system and of its CSE training, were perhaps the two most challenging Recommendations. I recognise this, given the fact that both of those issues fall within a much wider, nationally mandated system of crime recording and officer training, which cannot be changed unilaterally at the behest of WMP. That said, it was clear from the Inquiry findings that WMP needed to review what steps could be taken to improve practice within the force. I have set out in the body of this Report, at paragraph 361 onwards, the considerable review carried out by WMP of the different ways in which information types, crime flags and warning markers can or should be used in relation to CSE. This has included carrying out an audit of 100 investigations arising from 41 children referred into CATE between 1 April 2020 and 31 March 2023,[576] and another of 150 WMP child sexual offences investigations (30 of them from Telford) recorded between 1 August 2023 and 11 December 2023.[577]

575 [redacted]
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518. These audits showed that "*keywords/flag were being added in the majority of investigation[s] but showed that further training was required on Information Markers*".[578] WMP explained that it intends to address this by the provision of further training to all operational staff,[579] and I have noted that this is to include a mixture of updates to planned CSE and frontline CPD training; newsletters; and "60-second learning" training modules.[580] The greater challenge is, however, in seeking to roll the training out timeously across all relevant frontline and civilian staff force-wide. Equally, WMP is hamstrung by being one of a number of 'Athena' forces, meaning that any changes to the Athena computer system itself must be canvassed across all police forces who use the Athena system. That said, WMP has successfully requested the addition of a "group based CSE" marker to the system, which represents progress.[581]

519. As regards staff training, WMP provided me with a wealth of information around the various different training courses that are required of staff (civilian and operational), and specifically the more specialist initial training that is given to criminal investigation and HAU staff (in relation to, for example, serious sexual assault and child sexual abuse).[582]

520. In addressing the Inquiry's findings on training, from the material I have seen, WMP has recognised that there is a need for a further training package to be prepared and delivered to all frontline officers and staff, and an urgent need for training of those in the OCC who receive and deal with calls from members of the public. As a result, WMP has commissioned the NWG to create a "train the trainers" package for WMP's Learning and Development Team. This includes an annual review and a CPD event for the Leaning and Development Team, and a more in-depth training package for specialist Child Exploitation teams.

521. It must be recognised, that whilst WMP's response to **Recommendation 37** remains a work in progress, WMP does not just police Telford, and it is necessary to produce a training package that is delivered force-wide. WMP has identified specific areas of need in its civilian and public-facing staff, and has prioritised their training, and I am confident that WMP will continue to work hard to ensure its training programmes are updated and rolled out as quickly as possible.

522. Finally, in response to **Recommendation 38**, by collating and analysing recent complaints, WMP has reviewed the timeliness of its processes, and satisfied itself of the efficiency of its complaints process. I note that the relevant complaints data is shared with the JCSERG, and complaints data was also shared with me for the purposes of my Review.[583] This included an example of where a complaint about the response to a missing child report led to a referral to the Safeguarding Advice Team within the OCC, consideration of further explanation of the then-new policy involved (the "most appropriate agency" policy) and indeed a review of the policy itself and the procedure for missing young persons. I regard this as a very positive development.

523. As I have noted in the opening sections of this Report, WMP apologised for the failures of the past very quickly. I consider it was less quick to begin meaningful implementation of

578 [redacted] paragraph 5.11
579 [redacted] paragraph 10.9
580 [redacted] paragraph 6.2
581 [redacted]
582 [redacted] paragraphs 5.8-5.15
583 [redacted] paragraphs 5.40-5.82

the Recommendations, but it committed fully to the process from January 2023.[584] I recognise of course that WMP is, like all police forces, subject to very close scrutiny and must follow strictly mandated national procedures – training and information systems being the obvious examples. I also recognise that it is difficult to make local changes when policing should be uniform force-wide. It is therefore reasonable to expect that further work will be required for implementation. It is also reasonable, in my judgment, to expect WMP to retain a corporate memory of its failings and a commitment to ensuring that any future innovations are in the spirit of these Recommendations and, in Telford, focussed on effective multi-agency working.

PCC Recommendations (40 and 41)

524. In my Inquiry Report, I made a Recommendation that the PCC should commit to the continued funding of both the Taxi Marshal and the Street Pastors schemes in Telford (**Recommendation 40**). I also recommended that, in providing statutory oversight of policing, the PCC also needed to improve its HTA meetings with WMP's Chief Constable to ensure that relevant data and statistics relating to CSE, and any complaints or concerns relating to WMP's handling of CSE cases, are discussed at those meetings, and that the minutes of the meetings are maintained and published (**Recommendation 41**). I am pleased to note that, in terms of the continued funding of the Taxi Marshals and Street Pastors, the re-elected PCC has made a commitment that this will be maintained through the financial year end 2024/25, and I would hope that these and any other similar initiatives will attract funding in the future, whether that be via the CSP or direct funding grants.

525. As regards HTA meetings, following a detailed review of the process, there was a candid acceptance on the part of both the OPCC and WMP that the HTA process had not been working as it should. I heard historically there had been a reluctance on the part of WMP senior leadership to submit openly to the process. As a result I was particularly pleased to hear from the Temporary Chief Constable his recognition of missteps and of his commitment to the HTA process.[585]

526. The decision to change the name of the meetings from HTA meetings to "Performance Assurance and Accountability" meetings, without public explanation, did cause some suspicion that the HTA rebranding was an exercise in hiding that information.[586] However, I am satisfied that this was not the intention, and there has been a wholesale review of the HTA process which has resulted in some meaningful changes and, importantly, commitment on both sides to the new approach. I would, however, like to see CSE reports included as a matter of course in the Chief Constable's quarterly performance assessment and the associated performance meetings with the PCC – which would, I consider, satisfy Recommendation 41 in full.

Health Recommendations (43 to 47)

527. I made five Recommendations relating to health services in Telford, where I found improvements could be made in relation to CSE victims/survivors.

584 [redacted]
585 [redacted] pgs 5-6 and [redacted] pg 14
586 [redacted] pgs 31-32

528. In **Recommendation 43** I asked the CCG (as it was previously) and NHS England to consider all avenues to secure an increase in funding for trauma-related mental health services. Following engagement with the ILECs and a meeting between key stakeholders in health services to consider what was available and review possibilities, NHS England Midlands Region and the ICB commissioners for mental health services were approached for additional funding for additional trauma-informed services, but to no avail. However, I was told about new projects and frameworks that have commenced – for example a Women's Health Hub to provide support and signposting – which are looking at other ways to improve the variety of mental health support available to victims/survivors.[587] I am pleased that, despite being unable to secure additional specific funding, NHS STW has gone on to play a significant role in the Council's review of therapeutic support services and the creation of a new service, as set out in response to Recommendation 18, and this has demonstrated the value in effective cross-agency co-operation.

529. The same can be said in relation to the Council's work with the health visiting and school nursing teams, in response to **Recommendation 44**, where I believe there has not only been a comprehensive review of staffing levels and a very quick response to increase numbers, but sensible use has been made of the ILECs experience and advice to hone the service offered.

530. As regards sexual health guidance, this was reviewed in 2023 following **Recommendation 45**, and the results were discussed with the ILECs in a series of meetings in autumn 2023. As a result, the new local CSE guidance (which included guidance on the revised Pathway and Explore More material) was included as part of the suite of CSE training that is mandated for all staff involved in all the contracts that the Council commissions to provide sexual health services. Those staff members will also be prioritised to receive CSE Impact Training, which is to be delivered by the ILECs. By so doing, the Council and health services have brought local learning into regionally mandated training and have ensured continuity by making completion of the training form part of its sexual health services contract process.

531. I also made specific Recommendations in relation to the role played by GPs and the need to consider what could be done to flag CSE concerns on a child's medical records (**Recommendation 46**). Following a meeting between NHS STW and the CATE Team, it was agreed that where GPs were informed of CATE referrals a code would be given to them to add onto the child's medical records, and best practice guidance was produced for GPs to include the importance of using a flag, and what do to if a flag is identified.[588] A follow-up audit of 13 GP practices noted that all but one had dealt with the referral-flagging and had uploaded the letters to the medical records as intended, which I find a reassuring outcome.[589]

532. **Recommendation 47** has proven more problematic, however, as it required GPs to implement a system to review child patient records when they move practice, with a view to flagging any CSE concerns identified. This is because there is no national coding system (similar to police information markers, for example) which would mean the code introduced and applied by GPs in Telford would automatically be transferred across to a new GP

587 [redacted]
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589 [redacted] pg 7

practice residing outside of the region. However, I am of the view that NHS STW has taken this Recommendation as far as it can, by seeking to include in its best practice guidance that when a child with the designated CSE code is deregistered, the Safeguarding Lead GP should be notified and should either write to, or call the new practice to share the concerns, and ensure this is also contained in the patient notes.[590]

533. Plainly, this is another area that needs national consideration in order to have the greatest impact upon the ability of GPs to monitor and share concerns about children who are victims, or potential victims, of CSE in their area.

Wider Impact Recommendations (15, 16, 17 and 20)

534. In my Inquiry Report I sought to make wider Recommendations which related to the treatment of, or impact upon, CSE victims/survivors and their families. I asked the Council to commit to treating parents of victims/survivors as partners, and ensure parents are aware of what to expect when their child is being supported by the CATE Team (**Recommendation 15**). The Council addressed this via its amendments to the Pathway,[591] by updating its guidance for practitioners,[592] and by producing new parental information leaflets.[593] The leaflet is a comprehensive and clear statement of what a parent (and child) may expect from CATE. The Council has not simply reviewed how it deals with parents (per the terms of the Recommendation); it has made significant changes, which shows a commitment to the spirit of the Recommendation.

535. Similarly, in **Recommendation 16**, I asked the Council to review whether there is any identifiable bias in respect of parents who are victims/survivors of CSE, and actions that have been taken in respect of safeguarding their own children. I am told that this continues to be a work in progress, as it was not possible to identify such social care cases on the basis of current information held and recorded. A historic audit of a sample of Operation Chalice cases was carried out instead, with a view to identifying whether any assessments or interventions in relation to the children of some victims/survivors was appropriate. The conclusion was that there was no case where the CSE circumstances of a parent were said to be a reason for any intervention with a child.[594] As stated at paragraphs 449 and 450 above, I believe the Council has done much to satisfy this Recommendation already, but accept that its work remains ongoing, to ensure it has satisfied itself that the Recommendation has been fulfilled.

536. In **Recommendation 17** I required the Council to commit to the provision of contingency funding for continued access to counselling for those affected by CSE following publication of the Inquiry Report. I am pleased that the services of Base 25 have been maintained throughout the past two years following publication of the Inquiry Report and will continue for a further six months following publication of this Report.

537. Finally, I asked the Council, CCG (now NHS STW) and WMP to review the processes and protocols relating to information sharing in the event that a risk of victim/survivors exposure to HIV from a CSE perpetrator came to light (**Recommendation 20**). Following

590 [redacted] pg 3
591 [redacted]
592 [redacted]
593 [redacted]
594 [redacted] paragraphs 1.2 and 1.4

detailed consideration between partner agencies, the Council drafted a "Risk of HIV Infection Protocol (CSE Related)", the "Telford and Wrekin Tripartite CSE related HIV risk of infection Data Sharing Agreement" and a "Process Plan"[595] and all relevant parties have signed up to the protocol and data sharing agreement. I consider this a significant step forward, in what is a complicated and sensitive area, but one of the highest importance.

The NRM (Recommendation 39)

538. I asked, by way of **Recommendation 39**, that both WMP and the Council review and enhance their current NRM training provision so that all staff are aware of when referrals should be made and how to do so; and that the organisations work together to ensure relevant information relating to referrals is shared. I accept that the Council and WMP will come across children in different circumstances, and when it comes to CSE and the NRM there has clearly been a difference in approach to the way in which referrals have been made by each. While the CATE Team now refers every child it supports, WMP has taken the view that it cannot properly adopt the same approach, and statistics from one audit provided by WMP revealed that only 12 out of 100 cases had NRMs submitted.[596] I was provided with various other audits carried out by WMP and training materials relating to the NRM, which demonstrated that WMP is continuing to look at improvements in its referrals, and it has accepted that "*further training on NRM referrals is required as the audits show NRMs are still being missed/not considered. NRM training will be included within the CSE Training due to be rolled out to all frontline staff/officer in April 2024*".[597]

539. I have seen national data published by the Home Office for the calendar year of 2023[598], which confirms that 33 referrals were made by the Council during that year (30 being investigated by WMP and 3 by West Midlands Police). This is in comparison to 13 in 2021 and 8 in 2022. In addition, the Council's own data for the calendar year 2024 shows that 41 referrals have been made to date (with the national data showing that 18 referrals were made in the first quarter of this year). This data does confirm that awareness of the NRM referrals has improved, and that indeed more referrals are now being made.

540. Both the Council and WMP have also committed to the creation of a jointly funded NRM co-ordinator post, with a multi-agency NRM panel to agree a new NRM pathway, oversee referrals and ensure information is shared between relevant agencies. In the circumstances, I take the view that this Recommendation will be fully satisfied upon the NRM panel coming into operation and appointment of the NRM co-ordinator.

Overall Conclusions

541. As I indicated at paragraph 7 of this Report, while some may have expected me to delve back into the wider Terms of Reference of the Inquiry, and seek to re-investigate areas which I previously dealt with in the Inquiry Report, that is not my remit here. The aim of this Review is solely to look at the progress of implementation of the Recommendations, not to investigate new concerns or investigate other matters as may relate to CSE in Telford, as tempting as that made be.

595 [redacted]
596 [redacted] paragraph 5.14
597 [redacted] paragraph 51.6
598 https://www.gov.uk/government/statistics/modern-slavery-nrm-and-dtn-statistics-end-of-year-summary-2023

542. Overall, I have found that, in line with my expectations as set out in the Recommendations section of the Inquiry Report,[599] all key stakeholders have demonstrated that steps have been taken, and are being taken, in respect of each relevant recommendation, and where steps have not been taken, they have given good reasons as to why not.

543. As regards the implementation of the individual Recommendations, taking these in the order they appear in this report, a summary of the status of each is as follows:

The First Five Recommendations	Recommendations 1 to 5	• Implemented
The CATE Team Recommendations	Recommendations 7,10,13	• Implemented
Structural Recommendations	Recommendations 9, 11, 14, 18, 19, 21,22	• Implemented
Licensing Recommendations	Recommendations 23 to 31	• Recommendations 24 to 29 and 31 implemented • Recommendation 23 unable to be implemented • Recommendation 30 in progress
Training Recommendations	Recommendations 6, 12, 32, 42	• Recommendations 12, 32 and 42 implemented • Recommendation 6 in progress
Schools Recommendations	Recommendations 33, 34, 35	• Implemented
WMP Recommendations	Recommendations 8, 36, 37, 38	• Recommendation 8 implemented • Recommendation 37 in progress • Recommendations 36 and 38 unable to be implemented
PCC Recommendations	Recommendations 40, 41	• Implemented
Health Recommendations	Recommendations 43 to 47	• Recommendations 44 to 46 implemented • Recommendations 43 and 47 unable to be implemented
Wider impact Recommendations	Recommendations 15, 16, 17, 20	• Recommendations 15, 17 and 20 implemented • Recommendation 16 in progress
The NRM	Recommendation 39	• Implemented

[599] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cd9f93d1afb577e0f4d785/1657642904848/IITCSE+REPORT+-+VOLUME+ONE.pdf – at page 132 of Volume 1, paragraph 4

544. As identified above, out of the 47 Recommendations made I am very pleased to report that I consider 38 have been implemented in full, with a further four in progress. Insofar as those Recommendations that were unable to be implemented, this equates to five of the 47, and I accept the reasons given to me for a failure to implement – which is that each relies upon wider legislative or national change stretching beyond the capabilities of the local organisations alone. In such cases, whilst the Recommendation itself may not currently be capable of implementation, I am content that stakeholders have tried to address these where possible, and I am confident that they will continue to consider these as part of their practice in future.

545. In the Foreword to my Inquiry Report I noted that:

"If there is an overarching theme to be identified, I consider it is that concern and action about CSE came from individuals within organisations, rather than from the organisations themselves."[600]

546. This process of reviewing progress against Recommendations has led me to a different, and happier, view – namely, that the organisations that comprise the key stakeholders, and above all the Council, have demonstrated dedication to implementing the Recommendations in a way that will lead to an enduring change of approach.

[600] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cd9f93d1afb577e0f4d785/1657642904848/IITCSE+REPORT+-+VOLUME+ONE.pdf

Section 7

The Future

547. As I acknowledged in Chapter 1 of the Inquiry Report,[601] Telford is not the first town to have been blighted by CSE. Like Rochdale, Oxford and others, the name Telford became a shorthand in public discourse for CSE. Following the publication of the Inquiry Report, I expressed the view that these "pariah towns" were not a category of uniquely unfortunate places but rather that CSE had occurred, and will occur, in other towns across the country. The patterns of CSE may change in future; what will not change is the necessity for the concerns of parents, teachers, youth workers, social workers, the police and citizenry as a whole to be recognised, acknowledged and acted upon by those agencies charged with protecting children.

548. Addressing CSE is not simply a matter for towns, councils and communities. My discussions with stakeholders confirmed that there remain difficulties with national policy at a conceptual level, in relation to the way in which the legislation and guidance relating to CSE seek to define it, and in particular its place in relation to child criminal exploitation and modern slavery.[602] These matters, requiring the national Government's attention - and, some suggest, revision of legislation, policy and guidance - plainly fall outside the scope of my original Inquiry, still less this Review.

549. I am, however, pleased that both the Council and WMP, as lead stakeholders, have acknowledged and raised other issues of national concern – notably in relation to taxi licensing and crime recording and statistics – and have indicated that they will continue to lobby for change.[603] NHS STW, too, has adopted ILEC comments and now continues to make submissions to the relevant national bodies as to how national policy and guidance might better serve victims and survivors of CSE.[604]

550. That said, Telford's journey is not over: as mentioned in the Conclusions section of this Report, some Recommendations remain in progress, and whilst this Inquiry will not be holding a further review, **I hope that with the establishment of the JCSERG and the standing obligation to publish an annual report, the key stakeholders in Telford will continue to be held accountable for how they detect, prevent, and respond to CSE.**

551. In seeking to ensure this happens, and to preserve the valuable work done to date, I have set out below some future actions that I recommend the JCSERG consider:

Recommendation/Area	Future Action
Recommendation 3 Prevalence and mapping data	This Recommendation did not, as I note at paragraph 115 above, require that prevalence and mapping reports be published; only that they be prepared for the purposes of the JCSERG. Ultimately, whether the

[601] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cd9f93d1afb577e0f4d785/1657642904848/IITCSE+REPORT+-+VOLUME+ONE.pdf - Volume 1 page 158 at paragraph 127
[602] [redacted] pgs 7-8
[603] [redacted]
[604] [redacted] pgs 13-14

Recommendation/Area	Future Action
	JCSERG chooses to publish this data is a matter for it to decide, with the specialist knowledge and expertise of its constituent parts. However, I consider that the analysis should continue to be prepared for consideration by the JCSERG itself, and that consideration should be given as to whether it may be possible to publish the data in a way that does not cause concern, and which does serve to underline that CSE is not just a problem in particular areas, even if prevalence varies by area.
Recommendation 6 Information sharing training	I have set out in paragraphs 314 and 315 above that whilst I understand the demands that amendments to training can make on large organisations, and that in many cases the roll out of training is still ongoing, it is important that each stakeholder considers the extent to which it is relying on existing training resources, rather than tailoring training to the Recommendation, and that compliance with the Recommendation continues to be monitored, enforced, and reported in the JSCERG Annual Report.
Recommendation 36 CSE markers	I have accepted at paragraph 370 and 371 above that there are certain elements of the crime recording environment that WMP does not control, and also that this is an area with a degree of subjectivity upon the receipt of a crime report. Accordingly, I acknowledge that absolute consistency will be difficult to achieve. However, WMP has recognised the importance of this Recommendation and has indicated that work is ongoing in this area. I wish to underline the importance of this Recommendation to the overall work of the JCSERG, and I therefore hope that, whilst difficult and time consuming, WMP continues to review the CSE marker systems and value its importance in the future.
Recommendation 30 Premises licence renewals	Whilst I accept that there is little the Council can do in respect of licensed premises unless a review of the licence is triggered, I do consider that it would be a proportionate step for the Council to consider implementing a process to ensure that if any licence review is instigated, then the appropriateness of additional licence conditions is considered and, if necessary, applied at that stage.
Recommendation 37 Police officer and staff training	WMP has identified specific areas of training needed for its civilian and public-facing staff, and has prioritised their training. As I have pointed out in this Report with respect to Recommendation 36, however,

Recommendation/Area	Future Action
	the knowledge of those in the OCC and their ability to ask relevant questions is crucial not only to public confidence but to the future shape of an investigation, and so, in my view, their training should also be prioritised.
Recommendation 41 HTA/ Performance Assessment meetings between the PCC and Chief Constable of WMP	Given the significant history of CSE in Telford, and based on my views expressed at paragraph 406 above, I think it would be beneficial for CSE reports to be included as a matter of course in the Chief Constable's quarterly performance assessment and the associated performance meetings with the PCC.

552. The success of the JCSERG as a multi-agency group dedicated solely to addressing CSE is, I would hope, clear for all to see from this Review. My hope is that it continues to be supported at a high level by key stakeholders to ensure that the focus on CSE is not lost. I have commented above on the equal success of the governance and oversight structure put in place by the Council for implementation of the Recommendations. Whilst those structures have clearly been effective, it is not for me to determine whether the SIG and the POG should continue as they currently exist following this Review or what, if anything, should replace them. **However, thought must be given to how oversight and review of the JCSERG is maintained. I hope that this is a matter that the JCSERG itself will consider and report on, in its next Annual Report.**

553. With this Review, the Independent Inquiry into Telford Child Sexual Exploitation is reaching its conclusion. It is over five years since it was commissioned, and in some cases[605] many decades after the exploitation suffered by the victims and survivors. While I consider the Inquiry, including this Review, has allowed me to meet my original Terms of Reference as comprehensively as I might have hoped, it is for others to determine whether this process has achieved what was needed. I hope that the public in general, but more specifically the victims/survivors of CSE in Telford, feel some sense of reassurance that this Inquiry has done all it possibly can to bring the stories of some of those affected by CSE in Telford to light; to identify past mistakes; and to highlight failings where these have been found, across all organisations responsible for detecting and responding to CSE.

554. Inquiries are often criticised for the lack of any mechanism to ensure implementation of their recommendations. This Inquiry is different. I am fortunate that, in conducting this Inquiry, I have been afforded the opportunity to return and review the implementation of Recommendations; something that was reflected in comments from stakeholders I spoke to:

"I think having the review has been helpful in focus of minds."[606]

[605] see individual Case Studies section in Volume Four Chapter 8 https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cd9ff9ba1c7b03a9af9c11/1657643011239/IITCSE+REPORT+-+VOLUME+FOUR.pdf

[606] [redacted] pg 20

555. I have no doubt that the existence of this Review will have provided impetus to take action, and a deadline to aim for.

556. I have, however, been struck throughout this Review by a pervasive enthusiasm for the way the Council has gone about implementing the Recommendations, and by tangible pride in the result. This is but one quote, from one professional I heard during this Review, but its tenor was reflected across all key stakeholders in Telford:

"[This Inquiry]*, obviously it came from a dark negative place but it's been a positive journey, the way things have developed and to be part of it as well*".[607]

557. I said at the start of the Inquiry, in the Foreword to my Inquiry Report:

"If there is an overarching theme to be identified, I consider it is that concern and action about CSE came from individuals within organisations, rather than from the organisations themselves."[608]

558. I have seen something different on this return to Telford. I have seen a Council that recognises the stain of the past, but does not attempt to ignore it or erase it; rather to learn from it, to engage its partners and to ensure that the next generations of Telford's children will be safer than the last. Telford may be regarded as having been a "pariah town", but I consider at the conclusion of this Review that it is now an admirable model - for holding up a mirror to itself by commissioning this Inquiry; investigating what has gone wrong; why and how; and learning from this and taking bold action, with the most important of objectives – safeguarding children from CSE.

[607] [redacted] pg11

[608] https://static1.squarespace.com/static/5cc814eee8ba44aa938d883c/t/62cd9f93d1afb577e0f4d785/1657642904848/IITCSE+REPORT+-+VOLUME+ONE.pdf

Appendix A

Recommendations from the Inquiry Report

Recommendations

1.	**Establishment of a 'Joint CSE Review Group'** The **Council** and **WMP** should take the lead in establishing a joint group, and shall identify and include other key stakeholder authorities, to include education and health sectors and such third sector agencies as the Council and WMP as lead agencies deem appropriate. The Joint Group's function will be to meet every six months, in order to: • Consider data and information gathered – such data to include: the incidence, trends and locations of CSE within the borough; missing persons/truancy data; referral numbers and investigations/complaints; licensing and night-time economy information; and any other data considered relevant; • Analyse such data and information in order to provide a reliable set of statistics against which the threat/risk and prevalence of CSE can be measured, and any apparent increase or decrease in the number of CSE cases considered; • Maintain minutes of each meeting, with appropriate action plans attached; and • Publish a report setting out the results of the analysis and accounting to the public for the action being taken in response – as set out in **Recommendation 2**. ***Relevant chapters: All chapters***
2.	**'Joint CSE Review Group' to publish an annual CSE Report** The **Council** and **WMP** should lead the 'Joint CSE Review Group' in publishing an annual report, titled "Joint CSE Review Group Annual Report" (or similar). This report should include, at a minimum: • The output of the statistical analysis carried out in accordance with **Recommendation 1;** • Current staffing numbers/caseload ratios within the WMP CE Team and the Council's CATE Team; • The extent of collaboration and support sought from third sector organisations, including transparency about the level of funding ring-fenced for such support; • Details of steps taken in relation to CSE training and awareness campaigns; • Details of PCC funded resources and initiatives relevant to CSE; • Statistics regarding the number of NRM referrals; • Updates as to work undertaken to improve relevant services to children within the health and education sectors; and • A summary of any complaints received by any of the member authorities regarding the handling of a CSE matter. Each member organisation should publish a copy of the report on its website. ***Relevant chapters: All chapters***

Recommendations

3.	**WMP to prepare mapping and prevalence data to be shared with the Joint CSE Review Group** In line with **Recommendations 1 and 2:** in advance of each Joint CSE Review Group meeting, and for the purposes of its Annual Report, **WMP** should prepare the following: • An analysis of the incidence of, and its response to, CSE within Telford (a "prevalence report"). Subject to the need to protect the integrity of ongoing investigations and policing tactics, this should include reference to the numbers of complaints, reports, investigations, arrests, charges and conviction rates, as well as geographical distribution of CSE 'hotspots' within Telford. • A CSE activity analysis (a "mapping report") based on intelligence received from its own sources (including that collated via the 'Joint CSE Review Group'), in order to ensure that an ongoing and targeted approach to CSE is maintained. Copies of the prevalence report and mapping report should also be shared with the PCC in line with **Recommendation 41.** ***Relevant chapters: Chapters 2 and 5***
4.	**Council to prepare CATE data to be shared with the 'Joint CSE Review Group'** In line with **Recommendations 1 and 2:** in advance of each 'Joint CSE Review Group' meeting, and for the purposes of its Annual Report, the **Council** should prepare the following: • An analysis of its response to CSE within Telford & Wrekin to include numbers of CSE cases dealt with by Safeguarding processes, those dealt with by CATE processes, and to detail how many are new cases, how many are active, and how many have been closed. ***Relevant chapters: Chapters 2 and 3***
5.	**Schools and colleges to prepare data to be shared with the 'Joint CSE Review Group'** **Secondary schools and colleges** should prepare the following, in association with the **Council:** • A six-monthly CSE statement (to be submitted prior to the six-monthly 'Joint CSE Review Group' meeting) giving details of specific children showing indicators which may be indicative of CSE (the "children at risk report"), whether or not that behaviour merits immediate referral to CATE or Safeguarding; and • A further six-monthly report (to be submitted prior to the six-monthly 'Joint CSE Review Group' meeting) containing such information as may allow effective mapping of CSE ("school mapping report"), including but not limited to, ages of children involved, the place of exploitation where known, their general places of residence, and any information which may establish the identities of perpetrators. • The above information should also include statistics and information relating to any missing from school episodes/ truancy records, in order to agree any steps that should be taken in relation to children that are shown to have regular difficulty attending school. The children at risk report and the mapping report should be shared with the CATE Team, which in line with **Recommendations 1 and 2** will share the reports with the 'Joint CSE Review Group' meeting for the purposes of its Annual Report. ***Relevant chapters: Chapter 3***

Recommendations

6.	**Information sharing training to be implemented in order to clarify responsibilities around confidentiality, information sharing and safeguarding** **All organisations with safeguarding responsibilities,** to the extent it is not already in place, should: • Implement an immediate programme of information sharing training for all those dealing with children, or in positions where referrals to Safeguarding is a possibility, to include at a minimum, police officers, PCSOs, social workers, CATE practitioners, youth workers, licensing officers, teachers, school counsellors and nurses, sexual health advisors, GPs, GP practice nurses, A&E doctors and nurses; • Ensure such training sets out the principles of when information should not be shared and when it must be, including practical exercises; and • Ensure that the above training is mandatory for any future recruits, and is repeated for existing team members no less than every two years, with training records to be made and retained. ***Relevant chapters: Chapter 3, 5 and 7***
7.	**Ring-fencing of CATE Team resource** • The **Council** should commit to the continued existence of the CATE Team within Telford at no less than its current strength in both numbers and budget (adjusted for inflation), for a period of no fewer than five years from the date of publication of this Report. • Following the expiry of that period, in the event of no such further ongoing commitment, the Council should state publicly the reasons why, and the proposals for future management of children at risk of CSE. • The Council should ensure that (i) CATE practitioners are protected from abstraction to cover other work; and (ii) practitioner caseload remains no higher than the current level. • The Council should publish information regarding the resourcing and workloads of the CATE Team as part of the 'Joint CSE Review Group's' Annual Report. ***Relevant chapters: Chapter 3***
8.	**Ring-fencing of WMP's CE Team resource** • **WMP** should commit to the continued existence of the CE Team within Telford – at no less than its current strength in both numbers and budget (adjusted for inflation), for a period of no fewer than five years from the date of publication of this Report. • Following the expiry of that period, in the event of no such further ongoing commitment, WMP should state publicly the reasons why, and the proposals for future management of CSE investigations within WMP. • WMP should publish information regarding the resourcing and workloads of the CE Team as part of the 'Joint CSE Review Group's' Annual Report. ***Relevant chapters: Chapter 5***

Recommendations

9.	**Council should review its subgroups** • The **Council** should review the number, membership and remit of all groups and subgroups – internal and with partners - dealing with CSE. • Group membership should be limited, to ensure effective meetings, and be open to those most qualified to bring value - not be based simply on seniority. • Strategic meetings should always include a practitioner – someone working directly with children and their families. ***Relevant chapters: Chapter 3***
10.	**CATE Pathway to be reviewed** • The **Council** should carry out an immediate and thorough review of the published CATE Pathway to ensure that it sets out, with clarity, the model of response, intervention and support to be expected where a child has been sexually exploited, or is considered at risk of future sexual exploitation, including the circumstances in which a child on the child protection pathway can obtain CATE support, and vice versa. • This review should include consideration of current research and national best practice. • The CATE Pathway should be reviewed annually to ensure that it remains fit for purpose. ***Relevant chapters: Chapter 3***
11.	**Implementation of an adulthood transition meeting** The **Council** should commit to immediate implementation of an adulthood transition meeting as part of the CATE Pathway for cases where a CATE child transitions to adulthood. ***Relevant chapters: Chapter 3***
12.	**Training of CATE Team and social workers** The **Council** should ensure that all CATE Team members and social workers in Safeguarding receive regular external training covering: • The concepts of risk and harm; and • The importance of rigorous recording of information (including detailing the exploitation suffered and naming children and perpetrators). ***Relevant chapters: Chapter 3***

Recommendations

13.	**Case File Review/Audit** The **Council** should commit to an annual external audit of no fewer than ten randomly selected CATE case files and of no fewer than ten randomly selected Safeguarding case files relating to children who have been exploited or are at risk of exploitation, to ensure proper emphasis is established and maintained. The **Council** should also ensure that: • Safeguarding and CATE Team members focus appropriately on contextual safeguarding and not simply upon child behaviour modification; and • The extent and quality of information sharing is properly assessed. ***Relevant chapters: Chapter 3***
14.	**CATE's information sharing protocols with schools to be reviewed** The **Council** should review the information sharing protocols in place with schools, and update them as necessary to ensure that the CATE Team shares information with schools that identifies CSE threat levels, trends and groups as well as individuals; with a view to allowing schools to react, monitor and protect children better. ***Relevant chapters: Chapter 3***
15.	**Treating parents as partners** The **Council** should commit to treating parents as partners in CSE cases and should set out publicly what a parent is entitled to expect when their child is being supported by the CATE Team. ***Relevant chapters: Chapter 3***
16.	**Approach to victims/survivors as adults** The **Council** should undertake a review of social care cases to establish whether there is any identifiable bias in respect of parents who are victims/survivors of CSE and actions that have been taken in respect of safeguarding their children, and the reasons for such actions. If the review reveals any patterns, future policies should be reviewed and training provided to ensure no unconscious bias is applied. ***Relevant chapters: Chapters 3 and 9***
17.	**Counselling for victims/survivors** The **Council** should commit to the provision of contingency funding for continued access to counselling for affected victim/survivors and family members following the publication of this Report. ***Relevant chapters: Chapter 3***

Recommendations

18.	**Council to review annually all CSE therapeutic support services** The **Council** should annually review its CSE therapeutic support offering, to include services it provides directly and services it commissions, to ensure that: • The offering is sufficiently broad in scope, encompassing mental health support and specialist trauma based support; • The support is available for victims/survivors as children, when transitioning to adulthood, and ongoing support for victim/survivors in adulthood, including a focus on relationships and parenting; • Such support is sourced from a range of providers, including national and local third sector groups; • The support offering as a whole is clearly signposted to CSE victims/survivors and their families; and that • The allocated budget is sufficient for need. The review should be published annually as part of the 'Joint CSE Review Group's' Annual Report. ***Relevant chapters: Chapters 3 and 9***
19.	**Youth support** The **Council** should commit to collaborating with those bodies best able to offer replacement for community support services for children - for example, youth club provision - no longer provided by the Council. ***Relevant chapters: Chapter 3***
20.	**Council, WMP and CCG to review processes relating to information sharing in respect of risk of HIV** The **Council**, in association with the **CCG and WMP,** should review its processes relating to information sharing in the event of discovery of risk of exposure to HIV by a perpetrator of CSE and, if no such document exists, draft an infection protocol which makes clear: • When information relating to risk of HIV exposure must be shared and with which bodies; • The legal basis for that sharing, to avoid doubt; and • Which body should take the lead on matters relating to information sharing, including identification of at risk contacts. Furthermore the Council, WMP and the CCG should consider whether their existing individual and joint processes allow for the effective identification of risk of HIV exposure when a complaint is made of (particularly non-recent) exploitation; and if it is considered they do not, to amend those procedures, or to indicate why such procedures cannot be amended to allow such effective identification of risk ***Relevant chapters: Chapter 3***

Recommendations

21.	**Council should refresh its system for reporting of concerns** • The current website based system for reporting of concerns via Family Connect requires registration. This could serve as a barrier to reporting. • The **Council** should institute and publicise a system whereby such concerns can be reported truly anonymously via a number of channels, whether by whistle-blowers or members of the public. ***Relevant chapters: Chapter 3***
22.	**Council to review its CSE complaints procedure** The **Council** should carry out a full review of its complaints process, insofar as this relates to the handling of CSE cases. This should include: • Preparing and publishing a comprehensive complaints procedure for complaints relating to CSE which should be readily accessible and published on its website; • Setting out a uniform process for dealing with all complaints relating to CSE, led by a named team within the Council; • Establishing a suitable repository for all complaints relating to CSE, so that all documents relevant to a complaint including, ultimately, its outcome, are readily accessible; • Ensuring that all staff, in particular CATE practitioners, are suitably trained so as to identify complaints, or feedback from service users which is not in the form of a complaint but which suggests cause for concern; • Signposting to assistance which can support individuals with the process and substance of a complaint; and • Publishing annually, as part of the Joint CSE Review Group's Annual Report, a summary of suitably anonymised CSE complaints and a review of complaints or concerns relating to CSE to include themes and lessons learned. ***Relevant chapters: Chapter 3***
23.	**Licensing information sharing with neighbouring authorities** The **Council** should seek to agree with its neighbouring authorities a stricter information sharing agreement, a joint enforcement protocol and a common licensing pricing structure. ***Relevant chapters: Chapter 4***
24.	**Taxi driver training** The **Council** has an established CSE training programme for taxi drivers; this course should be offered, at a cost, to drivers licensed elsewhere. In the interim, the Council should publicise the high standards that Telford licensed taxis are already required to meet and raise awareness of how to recognise a locally licensed taxi. ***Relevant chapters: Chapter 4***

Recommendations

25.	**Council to review and improve its complaints process for public complaints or concerns in relation to licensing and/or taxi drivers** The **Council** should: • Review the ways in which the public can report licensing complaints, to include consideration of instant reporting by way of text or online services; • Publicise its role in taxi regulation, the need for the public to report concerns, and the ways in which concerns can be reported, to include prominent advertising in night-time economy 'hotspots' and a requirement for in-taxi notices; and • Ensure a continuing programme of public awareness raising the requirement for licensed drivers to display their licence, so as to address 'badge-swapping'. ***Relevant chapters: Chapter 4***
26.	**Council to collate data relating to complaints against taxi drivers** The **Council** should publish annually, as part of the 'Joint CSE Review Group's' Annual Report, a taxi licensing review to include: • How many complaints it has received about taxi drivers; • How many of those complaints related to drivers licensed by the Council; • How many complaints related to sexual behaviour, including use of sexualised language or harassment, and of those, how many related to complaints involving such behaviour towards children; and • How many complaints resulted in action by the Licensing Team, and what action resulted. ***Relevant chapters: Chapter 4***
27.	**Council to implement a protocol for the sharing of safeguarding information for the purposes of taxi licensing** The **Council** should draft and publish within six months of this Report a protocol for the sharing of safeguarding information for the purposes of taxi licensing, setting out: • The procedures by which, on receipt of a new application, renewal, or a complaint about a driver, information will be requested by the Licensing Team from Safeguarding, WMP, neighbouring local authorities and such others as are deemed appropriate; and • The circumstances in which the Licensing Team will share information with Safeguarding, WMP, neighbouring local authorities and such others as are deemed appropriate, upon the receipt of a complaint and, if applicable, later imposition of a sanction against a taxi driver. ***Relevant chapters: Chapter 4***
28.	**Council to explore implementation of CCTV in taxis** • The **Council** should explore the possibility of installing CCTV in taxis. It should begin by carrying out a full consultation amongst interested parties, in the borough and in the region. • The Council should consider any funding applications that may be available to assist in this regard. ***Relevant chapters: Chapter 4***

Recommendations

29.	**WMP role in taxi licensing enforcement to be reviewed** • **WMP** should carry out a review of its current involvement in joint taxi licensing enforcement exercises in order to ensure that the exercises are sufficiently regular and rigorous, and that any information or intelligence of concern relating to CSE activity is captured and acted upon. • This should include considering which officers are involved in such enforcement exercises, and that those officers are of an appropriate rank and level of training. • If not already in place, a named officer should be designated to liaise with colleagues in the Council's Licensing Team to ensure appropriate sharing of information relating to taxi drivers who may pose a risk/concern. ***Relevant chapters: Chapter 4***
30.	**Council to review historic premises licences** • The **Council** should take steps to ensure that appropriate conditions are applied in respect of any premises operating under a historic licence; and • Whatever the terms of a historic licence, the Council should make clear its expectation that any nightclub should operate an '18 or over' entry policy. ***Relevant chapters: Chapter 4***
31.	**Council to review its oversight of restaurant and take-away establishments** • In association with its Night-Time Economy officer, Licensing Team and **WMP**, the **Council** should review information collection and sharing with regard to CSE concerns involving restaurants, takeaways, mobile food outlets and associated residential premises. ***Relevant chapters: Chapter 4***
32.	**All schools and colleges to review and refresh training around CSE** Where this is not already happening, **all schools and colleges,** in association with the **Council**, should: • Commit to annual training of all teachers and staff in CSE awareness; • Repeat such training at least every two years; • Set out a programme of age-appropriate CSE awareness raising sessions for their pupils, whether that programme is delivered in the context of PSHE or otherwise; and • Arrange a CSE awareness raising session for parents, no less frequently than annually, in the opening months of the academic year. Where the school in question is a primary school, such CSE awareness should be aimed at pupils in Year 5 and above, or, if not felt appropriate, a letter should be sent to all parents explaining why such a programme is regarded as undesirable within the school, and enclosing written information on CSE awareness. ***Relevant chapters: Chapter 3***

Recommendations

33.	**Schools and colleges to appoint a CSE Lead** All **secondary schools and colleges** in Telford, in association with the **Council**, should designate a CSE Lead (who should not be the Designated Safeguarding Lead ("DSL")), but whose identity should be known to parents and children, and who must be easily accessible to children. The CSE Lead should compile the children at risk report and the mapping report (in accordance with **Recommendation 5**) in consultation with colleagues, including the DSL. ***Relevant chapters: Chapter 3***
34.	**Schools to review CPOMS policy and systems for information sharing** In association with the **Council, all schools and colleges** in Telford using the CPOMS system should ensure that: • The school or college has a written policy in place to govern the recording of CSE-related information onto CPOMS; • The policy sets out how information from CPOMS should be shared with partner agencies (namely WMP and Safeguarding) and considers the practicalities for doing so; • All relevant information is routinely recorded on CPOMS; • The information should include a statement of what the concerns are, what action was taken, and what follow up was thought to be needed; and that • A six monthly review is carried out of the information logged on CPOMS, to ensure all relevant information (i.e. information which may have been identified as a possible indicator of CSE) is routinely recorded. This process should be led by the DSL. ***Relevant chapters: Chapter 3***
35.	**Schools and Colleges to carry out an annual review of site security** In association with the **Council, all schools and colleges** in Telford should carry out an annual review to consider the adequacy of the school's site security provision, including arrangements for monitoring and recording any unauthorised access, to ensure that pupils are protected from potential perpetrators of CSE while at school, and to ensure appropriate liaison with WMP or Safeguarding where required. ***Relevant chapters: Chapter 3***
36.	**WMP to review use of CSE marker system** **WMP** should review the use of the intelligence marker system in CSE cases. The review should include: • An assessment of the suitability of training, and of effectiveness of guidance and procedures for the application of CSE markers; and • A historic search (to the extent possible) of CSE cases to ensure markers have been appropriately applied. ***Relevant chapters: Chapters 2 and 5***

Recommendations

37.	**Police officer and staff CSE training to be reviewed** **WMP** should ensure that: • All its officers, PCSOs and public facing staff receive, as part of their initial induction and learning, training on CSE; • All such staff should also receive regular refresher training and updates on CSE to include: the latest known trends around how CSE may be perpetrated; warning signs to look out for; and reminders as to the action to be taken in response to any concerns about CSE; and • Any such training addresses the appropriate use of language and techniques to encourage victim disclosure and to avoid victim-blaming. ***Relevant chapters: Chapter 5***
38.	**Review of WMP complaints handling procedures required** • **WMP** should review its internal complaints handling procedures to ensure that any complaint raised in a CSE matter is acknowledged immediately and dealt with in a timely fashion. If there are any existing timescales for a response, the review should consider whether those timescales are being met, and if not, it must consider why not and how this should be rectified. • WMP should also ensure that whenever a complaint is raised about an officer or staff member's conduct which relates to a CSE matter, consideration is given to whether any further training is required on the part of that individual, regardless of any other action that may be taken in relation to misconduct or performance issues. • WMP should publish annually, as part of the 'Joint CSE Review Group's' Annual Report, a review of complaints or concerns relating to CSE to include themes and lessons learned. ***Relevant chapters: Chapter 5***
39.	**Multi-agency approach to NRM referrals to be reviewed** The **Council** and **WMP** should: • Review and enhance the current NRM training provision to ensure that all staff who may deal with trafficked children are appropriately trained; • Ensure that such training includes when a referral should be made, and the appropriate pathways and protocols to be followed in all NRM-qualifying cases. • Liaise with one another to ensure that each organisation's protocols for NRM reporting is clear; that relevant information is shared; and agreement reached as to which authority should be responsible for making the referral, in circumstances where both authorities are involved. ***Relevant chapters: Chapter 3, 5 and 6***
40.	**PCC to commit to continued funding of CSE initiatives** The **PCC** should commit to continued funding of the following initiatives: • Taxi Marshal scheme; and • Street Pastors. ***Relevant chapters: Chapter 4 and 6***

Recommendations

41.	**PCC Holding to Account ("HTA") Meetings to be improved** The **PCC** and **WMP** should ensure that: • The Chief Constable provides relevant data and statistics relating to CSE (including risk/threat analysis; case numbers; trends, and the information prepared for the 'Joint CSE Review Group' as per **Recommendation 3** above) and raises any related budgetary concerns at the HTA meetings; • Any complaints or concerns reported to WMP relating to the handling of any CSE cases are shared with the PCC as part of the HTA meetings; and • Minutes of the PCC and Chief Constable weekly meetings are to be maintained. ***Relevant chapters: Chapter 6***
42.	**Quality of CSE training delivered to NHS providers and practitioners** In respect of CSE training, in order to increase the likelihood of training translating into practice, the **CCG** needs to: • Ensure that the training delivered to providers and practitioners includes training on effective ways of engaging with children and encouraging professional curiosity at every contact; • Review the content and format of the training to ensure that it does not simply consist of the dissemination of written information; • Ensure there is creativity in how the training is delivered; for example, practical exercises and/or tests to show understanding, including a minimum pass mark, to ensure the training is embedded in practice; and • Review the method by which assurance is provided as to the percentage of providers/ practitioners that have completed the necessary training; for example, simply because a practitioner was on a distribution list is not sufficient assurance. ***Relevant chapters: Chapter 7***
43.	**Improvements to trauma-related mental health services for victims and survivors of CSE in Telford & Wrekin** **CCG** and **NHS England** should consider all avenues to secure an increase in funding for trauma-related mental health services, in particular for victims/survivors of CSE. ***Relevant chapters: Chapter 7***
44.	**The Council to consider increasing capacity for health services to sexually exploited children** The **Council** should review the current capacity (and ability to meet demand locally, compared to the average nationally) of the following services, and where possible commit to a further increase in capacity by 2024: • Health visitors; and • School nurses. ***Relevant chapters: Chapter 7***

Recommendations

45.	**Guidance for sexual health clinics/to all health providers responsible for giving sexual health advice to be reviewed** Current sexual health guidance issued to practitioners should be reviewed, and kept under review, by the **CCG** to ensure that it: • Reminds professionals of the need to consider the potential for CSE to be a reason that the child is seeking sexual health support; and • Clarifies the policies and referral pathways to follow, in the event they have a concern that a child may be being sexually exploited, or at risk of sexual exploitation. ***Relevant chapters: Chapter 7***
46.	**GPs in Telford & Wrekin to be consulted about CSE data collection** • The **CCG** should consult with GP practices in Telford & Wrekin to consider what can be done to implement a system for flagging CSE concerns on a child's medical records. • The **CCG** should seek to raise this issue at regional and national meetings, wherever possible. ***Relevant chapters: Chapter 7***
47.	**GPs to implement review system for children moving to a different practice** • The **CCG** should ensure that the GP practices within the borough introduce a system so that, when a child moves to a different GP practice, the patient records are reviewed and any concerns regarding CSE are flagged to the new GP practice. • **GP practices** within the borough will be accountable to the CCG to confirm it has a policy in place for such file reviews. ***Relevant chapters: Chapter 7***