Shropshire Safeguarding Community Partnership

Annual Report 2021-22

Annual Report

2021 – 2022

Contents

Foreword	3
Introduction	7
What we achieved this year	8
What we know about crime, adult safeguarding, children at risk in Shropshire	25
Impact on adults and children and their families in practice	39
Hearing the voice of children and families, adults with care and support needs and victims of crime	44
Our Approach to Learning and Development Changes to published arrangements	45
Independent Scrutiny	
The effectiveness of these arrangements in practice	51
What we want to achieve next year	54
Closing Scrutiny statement	56

Foreword by Key Partners

Tanya Miles
Executive Director of People,
Shropshire Council

Each year, our Shropshire Safeguarding Community Partnership produces and publishes an annual report highlighting our work together as partners to make Shropshire a safer place for our residents. The annual report provides an opportunity to recognise our partnership strengths, delivery against our priorities and reflect on where we need to focus our work to ensure we continue to prevent, reduce, and remove harm.

During 21/22, the partnership remained focussed on our safeguarding priorities, continuing to maintain a high standard of work during the second, and very challenging year of covid as variants saw the number of cases rise and the earlier part of the year was spent under continuing restrictions that affected all partners. Organisations continued to experience issues around recruitment, retention, and resilience.

In this reporting year Shropshire Council saw an increase in contacts to adult and children services.

We saw a 23% increase in adult safeguarding contacts since last year however only a small number became safeguarding concerns and an even smaller number, safeguarding plans. This tells us that the majority of people in the adult safeguarding process were helped to stay safe.

We also saw a small increase in contacts COMPASS but it's the overall complexity we have seen rise as individuals and families struggle with the impact of COVID. The main reason for safeguarding children was and continues to be neglect which is why this must remain as a priority going into 22/23. There were also concerns over the rise in child exploitation in Shropshire.

As a partnership, we must continue to understand the very real risks of exploitation to prevent and reduce the risk of this form of abuse, building on the good work started in this reporting period.

As a partnership we work on the principle of involving individuals and families as much as possible and this is evident in our audit work and in the various reviews undertaken this year. Listening to the voice of the person remains a key focus area and it's great to report that 93% of adults were asked what outcomes they would like to be achieved as part of the safeguarding enquiry process. This indicates a strong emphasis on making safeguarding personal.

Shropshire
Fire and Rescue Service

Guy Williams

Head of Service Delivery, Shropshire Fire and Rescue Service

Working together as a team is fundamental to firefighting. Very rarely do we (Fire and Rescue) operate in isolation or alone. This approach builds relationships, trust and allows us to understand our collective strengths, weaknesses and how to realise opportunities and meet challenges.

This operational conditioning should be no different to the mindset and culture that drives the Partnership and our various teams that address community risk and safeguarding.

The Partnership is evolving into a team that understands the strengths and limitations of its partners. Key to our effectiveness will be as a partnership, our ability to get people working together. Having a multi-agency team approach to individual cases and crisis will ensure the most appropriate plan is actioned that incorporates the best of all of us.

With such a team approach at all levels we have a far greater chance of succeeding and improving the lives of those who need our support, help and attention. To be successful we need to be in the room or out in the field but we need to be a collective not a collection of individuals.

Shropshire Fire and Rescue Service like the Partnership, will continue to learn where the opportunity presents and will put the communities of Shropshire before our own corporate reputation as continuous improvement by making Shropshire safer is our commitment to the public.

Stu Bill

Superintendent, West Mercia Police

West Mercia Police are proud to be members of Shropshire Safeguarding Community Partnership.

The work evidenced in this report, ranging from tackling vulnerabilities in the community, improving our data quality and developing our response to domestic abuse, show the commitment across the collective members to deliver for our community.

Of course, there continues to be areas for improvement, many of which are identified through learning briefings. This is why reflecting on this annual report is vital to ensure energy, focus and scrutiny is directed to maximise our potential.

The service remains as committed as ever to this cause and looks forward to working collaboratively to make Shropshire a safer place to live, work and visit.

Shropshire, Telford and Wrekin
Clinical Commissioning Group

Alison Bussey

Executive Director of Nursing & Quality, Shropshire, Telford & Wrekin Clinical Commissioning Group

This report provides a way to both describe and evaluate the work done in 2021-2022. It is an important tool in demonstrating our accountability to the people of Shropshire and I hope it is read with interest and challenge by all those groups and individuals with a stake in this vital work.

The period under focus was a time prior to me joining our safeguarding partnership and I have personally found it helpful to have this reference point. Safeguarding children and adults and driving our community safety work means we really need this report. It seeks to take account of the issues we have faced; explain how we performed and vitally identify how we must keep pushing this work forward in each and every year.

It is right that the work to safeguard adults and children and help build safer communities is undertaken through a partnership approach. In this report you will see some of the work that takes place to protect individuals as well as our communities and how the Partnership seeks to enhance the skills of those who do this work, improve those safeguarding arrangements and also recognise the further learning that takes place to improve practice and multi-agency working.

As the report shows, this is unfinished business and we are very much aware of the ongoing work needed to address such massively impacting issues as domestic abuse, child neglect, the concerns faced by adults with care and support needs and community cohesion in the face of crime and anti-social behaviour.

I hope you find this report informative. If you are reading it as a professional it is important to thank you for the work you do and to urge your ongoing efforts, if you are reading it because you are interested in this work thank you for your interest and to remind you as a Partnership, we remain committed to engaging with our communities and your feedback will be gratefully received.

George Branch

Head of Service, West Midlands Probation Region, Hereford, Shropshire and Telford Probation Delivery Unit

Preventing re-offending and making communities safer is critical to Shropshire Safeguarding Community partnership.

The mandate for reducing reoffending was passed to local areas with the introduction in April 2010 of a statutory duty for Community Safety Partnerships to formulate and implement a strategy to reduce reoffending. This duty requires local areas to fully understand their offender profiles, the ways in which mainstream services can be more inclusive and supportive of the needs of offenders, identify gaps in provision and where resources should be targeted to reduce reoffending.

Throughout 2021 -2022 we have sought to identify crime trends and offending patterns to effectively put together a plan of action. The partnership has worked tirelessly in developing comprehensive data sets and though the work is ongoing we are starting to make some inroads with the help of our partners.

The last 12 months have been particularly challenging but within Shropshire we had a joint strategic approach to COVID-19 recovery with our partners. We are committed to working with both statutory and non-statutory partners to address the key issues that specifically impact the Shropshire area. Hate crime, anti-social behaviour, accommodation, and mental health have been consistent themes alongside the new Integrated Offender Management national refresh to ensure that those people on probation who commit the most offences are managed across agencies to reduce their risk of reoffending.

We have particularly strong partnerships with the Offices of the Police & Crime Commissioner, and we are building partnerships with the NHS through the Liaison and Diversion scheme.

We will sustain strategic partnerships to maintain collaborative work, improving appropriate and timely data sets as well as undertake audits and learning briefings for partners to address and prevent reoffending.

Information about Shropshire

Shropshire Council

census 2021

First release – June 2022

Shropshire's total population

323,600
a 5.7% rise from 306,100 people in 2011 (England 6.6% rise)

Population Density

Shropshire: 1 person per hectare
England: 4.3 people per hectare

Number of households

139,600 households an increase of 9,900 or 7.6% since the Census 2011. (England 6.2% increase)

Gender split

Male 159,700 (49.4%)
163,900 (50.6%) Female

Population by Age

Age	Shropshire	England
0 - 14	48,000 (14.8%)	9,838,700 (17.4%)
15 - 64	193,700 (59.9%)	36,249,800 (64.2%)
65 and over	82,000 (25.3%)	10,401,200 (18.4%)
85 and over	10,800 (3.3%)	1,370,400 (2.4%)

Aged 65 and over

In Shropshire

82,000 People aged 65 and over rising from 63,300 in 2011, a 29.5% rise. Compared to a 20.1% rise in England.

Source: Office for National Statistics, Licensed under the Open Government Licence, crown copyright 2022.

Introduction

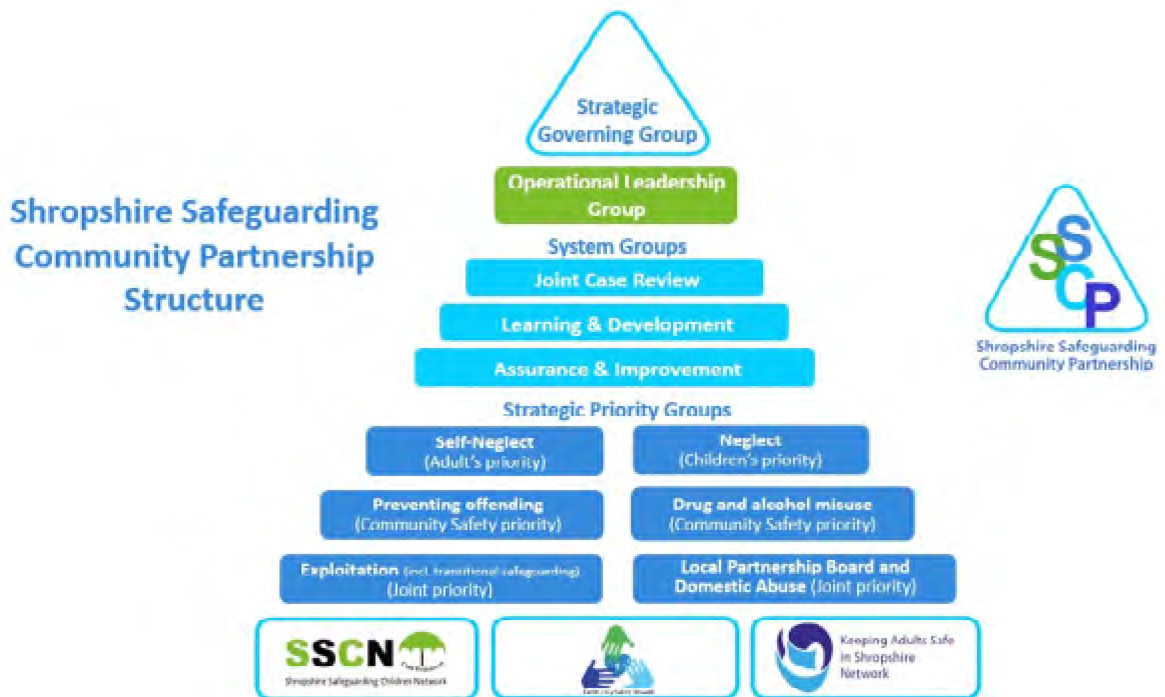
This report fulfils the statutory duty to produce an annual report for both Adult and Children's safeguarding arrangements. Whilst there is no requirement on the Community Safety Partnership to publish an annual report about its activity, Shropshire Safeguarding Community Partnership chooses to ensure its community safety work is reflected in this publicly available report. It provides an opportunity to report to the public and all partners about decisions made and actions taken, by the Responsible Authorities for Community Safety.

The purpose of this report is to provide assurance that Shropshire Safeguarding Community Partnership has plans in place to address our strategic and "business as usual" priorities to safeguard our communities.

It explains what has been achieved in this financial year and what we plan to do in 2022-23.

In our report for 2020-21 we said our joint priorities were Domestic Abuse, Exploitation and Transitional Safeguarding (the period of moving from Children's Services into adulthood). Our Transitional Safeguarding priority now sits under the work of our Exploitation Group.

This is how we are now structured:



What we achieved this year

In our report for 2020-21, we said we our Joint Case Review Group would achieve the following:

- **Evidence how we embed learning**

  Our update – we carried out agency audits against The Myth of Invisible Men and The Child Safeguarding Practice Review Annual Report 2020's six practice themes to ensure that national learning was shared and embedded within organisations.

  Learning briefings were produced for all Statutory Case Reviews which were sent to agencies via the Partnership newsletter and the website. Agencies confirmed that these are shared with staff with some agencies using them to deliver learning sessions through team meetings.

  Multi-agency action plans were developed for each case with identified learning and actions for improvement. Agencies are requested to provide regular updates on progress and evidence the impact of the changes made.

  Statutory partners reviewed the recommendations from the National Analysis of Safeguarding Adult Reviews April 2017-March 2019 Report and produced an action plan to monitor the embedding of this national learning at a local level.

- **Ensure that the voice of the community is heard when working to safeguarding both adults and children**

  Our update – in 2021 the Partnership received a referral for consideration of a Safeguarding Adult Review from the person's family. The Partnership accepted this and a decision was made to undertake the requested review. This raised the question, why had agencies had not made a referral themselves?

  We have added a question to our information gathering form to ask agencies if they can evidence that they were able to hear the experience of the community as part of their work.

Other achievements for this group include:

- We continually review and revise our documentation for case reviews to ensure that it is fit for purpose and gives us the quality information we need. Our generic referral form has been separated out into a form for each type of case review to avoid confusion and simplify the process for the agencies completing them.
- During 2021-2022 we have:
  - Undertaken 3 Rapid Reviews
  - Initiated 3 Safeguarding Adult Reviews
  - Initiated 1 Domestic Homicide Review
  - Published the G Children Serious Case Review
  - Continued to undertake 11 statutory case reviews which are on-going

In our report for 2020-21, we said we our Assurance and Improvement Group would achieve the following:

- **Carry out an inspection style multi-agency audit in readiness for a Joint Targeted Area Inspection[1]**

  Our update – this was not completed during this year however, we started the planning on 23rd March 2022 for this exercise to take place in May 2022. We will explain how this went in our next report.

- **Have all partners contribute fully to providing data for the neglect, exploitation, adult and children's datasets**

  Our update – We continue to work with partners to pull together a comprehensive data set, recognising that some data is not currently available within systems.

1- Joint inspections of local services by Ofsted, Care Quality Commission, HM Inspectorate of Constabulary, Fire and Rescue Services and HM Inspectorate of Probation

- **Produce a data report that analyses neglect, exploitation and adult and child safeguarding**

  Our update – Capacity has led to a delay in implementation of this action, however it remains a priority for partners to inform planning moving into 22/23

Other achievements for this group include:

Agencies completed a Section 11[2] audit and the results were analysed and reported in June 2021. While some supporting documents provided an improved quality assurance, however this will remain a priority for 22/23 to continue to demonstrate examples of practice being embedded.

A peer review was undertaken in Autumn 2021 to provide assurance to the partnership about compliance with Section 11 standards and to share learning.

The two standards chosen for the peer review were 'Recruitment and Selection' and 'Listening to Children and Young People'. The general feedback from the peer review process was as follows:

It was a good experience as it was good practice to review how each agency approaches recruitment

Services are very self-critical, and it can be a good motivation for the workforce to receive comments from outside agencies.

The experience highlighted what areas of change would have to be addressed in order to be considered as an 'Outstanding' organisation. The experience helps partners to learn much more about the wider partnership.

The peer review provided partners with a good opportunity to take a step back and review the work that they, and others, do.

Agencies showed interest in reviewing submissions from agencies that had demonstrated 'Outstanding' practices that they may take influence from.

2 - Section 11 of the Children Act 2004 - Places duties on a range of agencies to ensure their functions are discharged having regard to the need to safeguard and promote the welfare of children.

One partnership wide action was identified, to highlight the need for Safer Recruitment Training for partner agencies.

- We built the Care Act Compliance (Safeguarding Adults) Audit tool into the online auditing system and agencies undertook their self-assessment audits. The responses will be analysed and findings reported in next years' annual report.
- We published our 'Approach to Information and Insight' document and applied the 'Litmus Test[3]' to our core and strategic priority datasets.
- We agreed the Multi-Agency Case File Audit Process under the new Partnership arrangements and started a schedule of audits through the Strategic Priority Groups, the findings of which are reported throughout this report.

In our report for 2020-21, we said our Learning and Development Group would achieve the following:

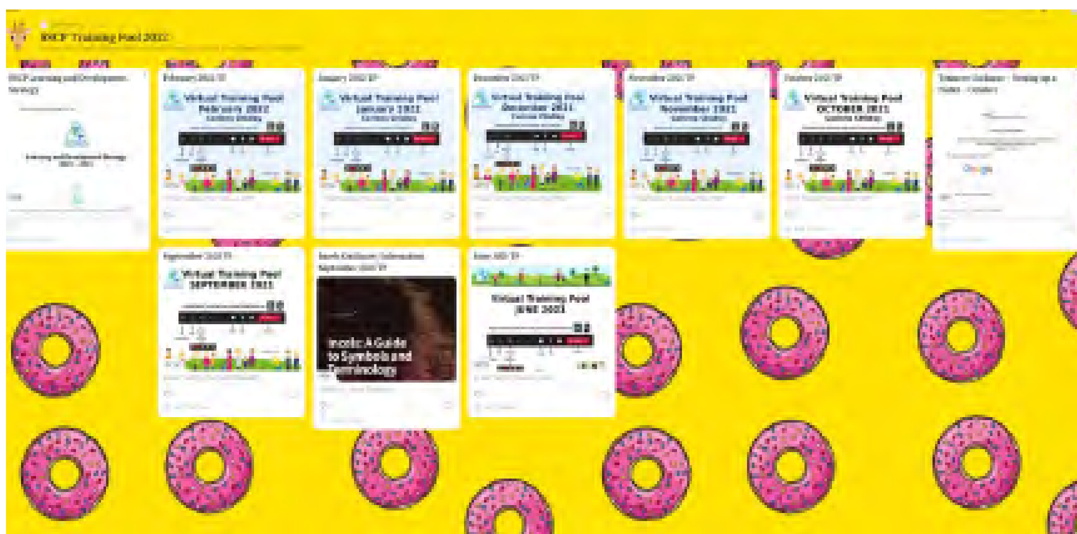
- **Provide a multi-agency Learning and Development programme which is accessible and quality assured**

  Our update – our learning and development programme is up and running and you can find more detail about this later in the report.

  Our update – the trainers in SSCP training pool who contribute their valuable time to help us deliver our training programme meet with our Learning and Development Coordinator on a monthly basis. They are provided with up-to-date information about the sessions they deliver and are taught new technical skills so that courses whether delivered on-line or face-to-face are interactive and engaging.

Padlet is an online noticeboard and is used to share information with the members of training pool and anyone who attends one of our training sessions.

This is what a Padlet looks like.



3 - Litmus Test – a set of five standards to determine the need to collect data against a data measure.

- **Ensure learning from statutory case reviews is included in learning and development activity.**

  Our update – Key information from Learning briefings are embedded within training delivery and included in the resources for multiagency learners to share within their organisations

Other achievements for this group include:

- Multi-agency Learning and Development Strategy was published which included an observation template.
- The group met quarterly with good attendance and engagement, with regular task and finish groups that progressed specific areas of work. Action tracker, business plans and the multiagency training offer were updated after every meeting
- Training continued to be delivered online in virtual classrooms

In our report for 2020-21, we said we our Domestic Abuse Group would achieve the following:

- Review the Terms of Reference to ensure the group acts as:
  - Strategic Priority Group for the Shropshire Safeguarding Community Partnership
  - Domestic Abuse Local Partnership Board for Shropshire Council
  - Multi-Agency Risk Assessment Conference governance group

  Our update – Our terms of refence for this group have been changed and were agreed by Partners at the Operational Leadership Group on 24th January 2022.

- **Conduct a multi-agency case file audit of repeat domestic abuse cases into Children's Social Care.**

  Our update – This audit took place in September 2021. Two learning briefings were produced as a result and shared widely across the partnership.

Briefing ONE

1. Context setting – the audit

The Local Domestic Abuse Partnership Board and Domestic Abuse Group carried out a multi-agency case file audit which focused on repeat referrals into Children's Social Care.

Two cases were audited and thirteen agencies were represented.

2. Context setting – family one

This was a family including 4 children who were open to Children Social Care due to risks of domestic abuse towards the Mother from the Father (previously) and a known male recently.

The is Mother an adult with complex needs and has experienced repeat incidents of domestic abuse.

3. Context setting – family two

This was a family including 3 children (1 unborn), who were open to Children Social Care due to risks domestic abuse towards the Mother from the Fathers and multiple known males.

The Mother is an adult with complex needs, she has been living in a refuge due to recent incidents of domestic abuse.

4. Domestic Abuse Act 2021

The Act places a duty on local authorities to provide safe accommodation to victims of domestic abuse and gives "priority need" to those who are homeless as a result of experiencing domestic abuse.

Ensure practitioners are aware of the above duty.

5. Domestic abuse pathway

As soon as practitioners have concerns that an individual is at risk of domestic abuse then they should implement the Domestic Abuse Pathway

Domestic Abuse Pathway

6. DASH-RIC

The Domestic Abuse Stalking Harassment Risk Indicator Checklist should be completed in all domestic abuse situations not just when referring cases to for Multi-Agency Risk Assessment Conferences.

Guidance can be found Safelives DASH-RIC

7. Be trauma informed

When working with individuals that have experienced harm they may exhibit some challenging behaviour. This maybe a trauma response.

Being trauma informed will help you to support them. Resources are available here that may help you What is Trauma?

8. Did I or didn't I?

Make sure that risk information is shared with all involved agencies so that they are aware of any changes and can make sure people are safe and crimes are prevented and detected.

Multi-agency case file audit
Learning briefing
Domestic Abuse 2021-2022

Briefing TWO

9. Judgement and bias

Professional judgements and unconscious bias influence the services and responses individuals receive.

It maybe impacting how practitioners are working with and talking about individuals. Practitioners should use supervision to reflect on their practice and seek support.

10. Is it or isn't it?

Where someone declines support, but a risk to them remains, practitioners should consult with other agencies and review what risk management actions may still need to be taken; even if they are not going to remain involved with the service.

Refer to the Adults working with risk document and Childrens threshold document.

11. Working with risk guidance

Ensure that all staff working with adults are aware of and working to the Working with risk guidance.

12. Mental capacity and alcohol

When assessing mental capacity and there is evidence that the individual is a dependant drinker, consider: Alcohol Change UK (2021): How to use legal powers to safeguarding highly vulnerable dependant drinkers in England and Wales

13. Mental capacity and coercion

When assessing mental capacity and there is evidence that the individual is the subject of coercive or controlling behaviour; consider: RIPFA Guidance (2018): Mental Capacity and Coercion

14. Supervision

Support practitioners to recognise and acknowledge any unconscious bias and how this may impacting their response to individuals they are working with.

Provide learning opportunities which explore trauma informed approaches to working with complex individuals.

15. Good practice example 1

This audit highlighted the good practice of:

Multi-agency information sharing; particularly in relation to the protection of children.

16. Good practice example 2

This audit highlighted the good practice of:

Relationship-based practice which enabled the voice and lived experience of the Mother, Grandmother and Children to be heard and responded to.

Multi-agency case file audit
Learning briefing
Domestic Abuse 2021-2022

- **Conduct a review of the existing Domestic Abuse Pathway which takes account of:**
  - Multi-Agency Risk Assessment Conference protocols
  - Domestic Abuse Statutory Guidance (once published)
  - Assessment of and response to risks by those that perpetrate and those at risk of domestic abuse
  - Learning from the multi-agency case file audit

  Our update – We are pleased to report that this work started in February 2022. The final pathway will be published later in 2022 it will be on our website and shared widely across the partnership.

Other achievements of the group include:

- The Multi-Agency Risk Assessment Conference operating protocols and reporting templates were reviewed and signed off by the group
- As per the Domestic Abuse Act (2021) the group function was changed and so now acts as the Local Domestic Abuse Partnership Board and the terms of reference have been changed to reflect this
- Shropshire Council have employed an experienced Domestic Abuse Development Officer who will be able to drive forward the work of this group and support the implementation of the statutory requirements laid out in the Domestic Abuse Act (2021)
- Funding was made available through the Home Office for a perpetrator programme and a successful bid was made from the Richmond Fellowship who begin their 18-month programme alongside Shropshire Domestic Abuse Service for low to medium risk perpetrators of domestic abuse.

In our report for 2020-21, we said we our Neglect Group would achieve the following:

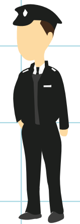
- **Ensure more professionals are using the Practitioner's Support Pack and the tools it provides to improve the outcomes of children being impacted by neglect**

  Our update – this continues to be both a challenge and a priority for this group as some organisations are struggling to work out how they can use the tools provided in their busy environments where they sometimes only see children and young people for short periods of time. Organisations finding this particularly difficult include West Mercia Police who are in people's home for a limited period of time and Accident & Emergency Departments who treat children and young people in emergency situations and do not visit families' homes.

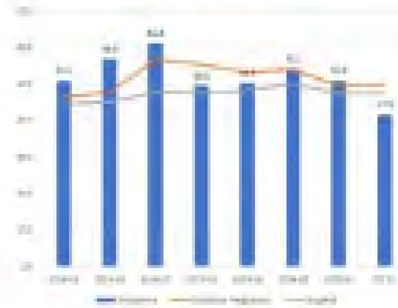
In order to promote the use of the document and evidence its use, from December 2021, the group decided to start every meeting with hearing from a range of teams and staff who describe how the Practitioner Support Pack is being used in their practice. This continues to be the way we start every meeting. Shropshire Council's Targeted Early Help Team we the first to make their contribution.

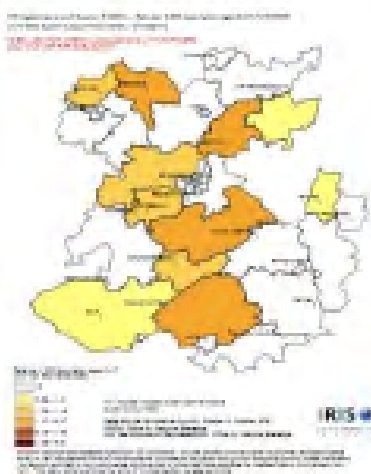
- **Use the neglect profile data to focus resources on geographic areas of greatest concern**

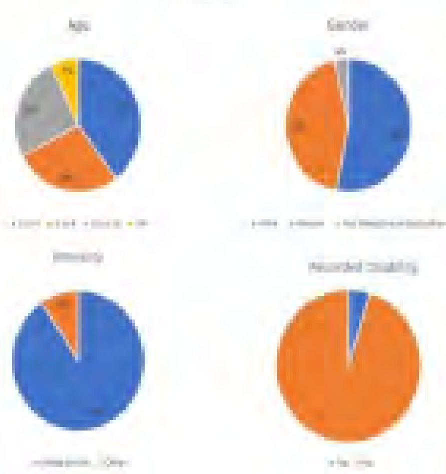
Our update – This work on this started in this year but is still under development. The profile continues to be developed and the group are considering how to target resources on the affected geographical areas. We know that our proportion of Child Protection Plans about Neglect have fallen below our statistical neighbours and the national average.

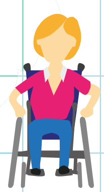


Child protection plans – category of abuse





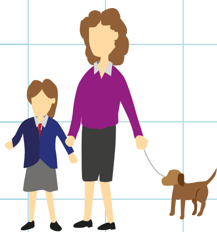


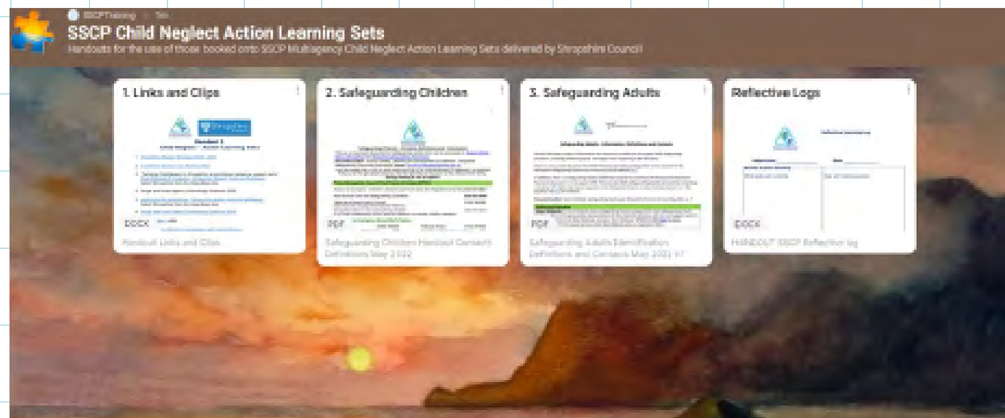


- **Provide action learning sets to improve the practice of front-line staff when children being impacted by neglect**

  Our update – Action Learning Sets give practitioners the opportunity to come together, to explore challenges that they face when working with children who experience Neglect, reflect and learn from each other, and find ways to move forward with the children and families they are working with.

  Although one Action Learning Set was planned to be delivered in this reporting year.

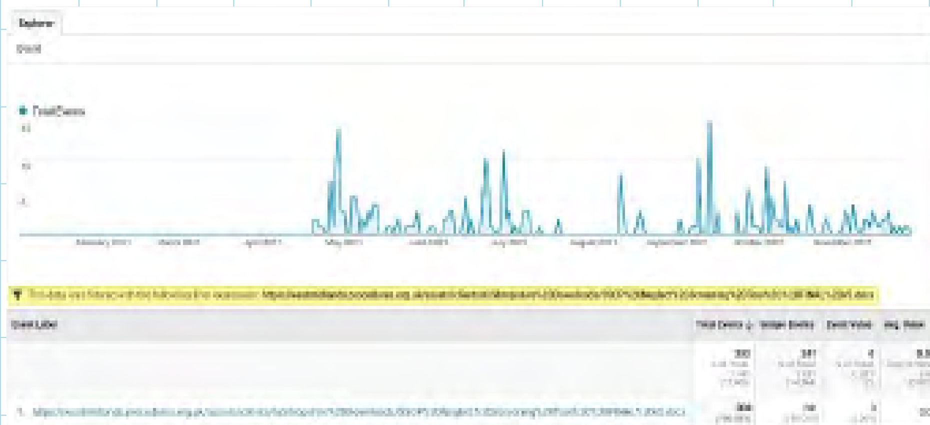




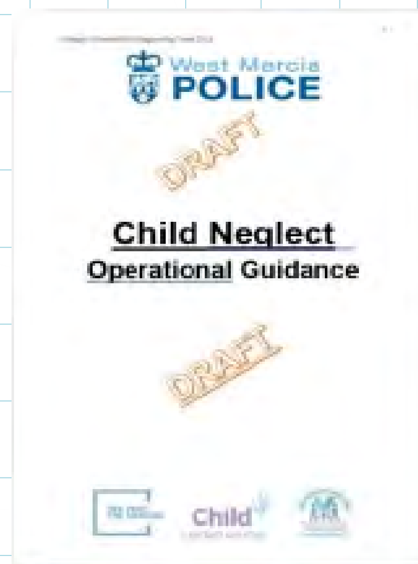
Other achievements for this group include:

- A multi-agency case file audit took place in May 2021. The findings included:
  - the Neglect Screening Tool and GCP2 should be being used more in practice
  - opportunities need to be being created to speak to children back their views wishes and feelings and these need to be recorded
  - supervision and training should be used to build the confidence of staff to have difficult conversations with parents

- The monitoring of the Neglect Screening Tool downloads tells us there aren't as many staff as we'd like using this tool to assist their practice to respond to child neglect.

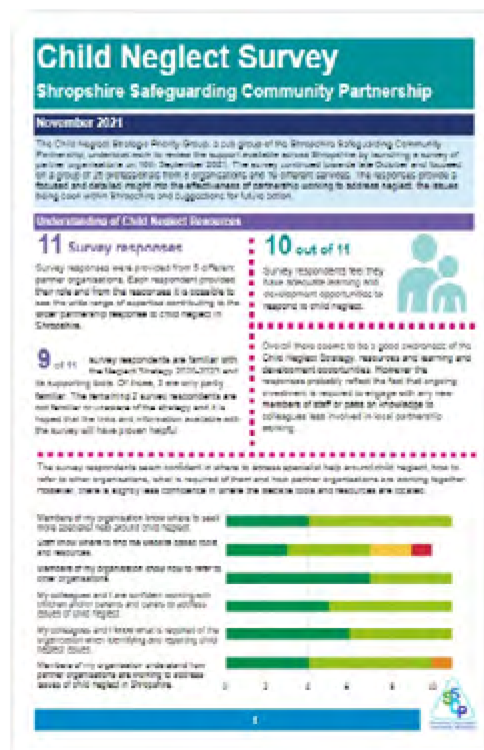


- West Mercia Police created their own toolkit for responding to child neglect in partly because they work across four local authority areas and need the force to be consistent in their approach. Partners in the group provided feedback on their toolkit which includes links to the Practitioner Support Pack and our Neglect Screening Tool.



- A survey was circulated to members of the group that posed series of questions including:
  - How familiar are you with the Neglect Strategy 2020-2023 and its supporting tools?
  - Do you feel you have had adequate learning and development opportunities to know how to respond to child neglect?
  - Which forms of child neglect are you seeing through your work in Shropshire?
  - What services do you provide that allow you to identify and respond to issues of child neglect, and where in Shropshire are they provided?
  - What work do you do within your service to prevent child neglect developing in the first instance?

In our December 2021 meeting, the results were presented to the group. We were able to demonstrate there was overall awareness of the work of the group, the Neglect Strategy and the tools to support their work. However, there was less clarity about what services were provided and where and what organisations were doing to prevent child neglect happening in the first instance. Because of this, the survey will be re-issued next year with a focus on these two areas.


Child Neglect Survey

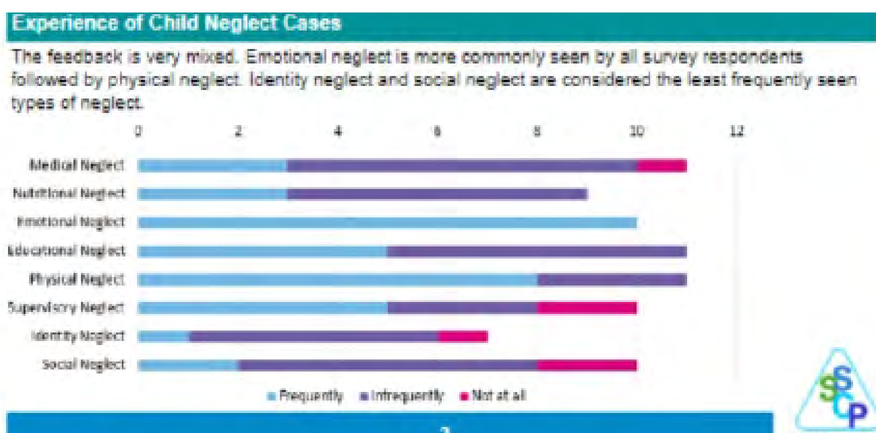
Shropshire Safeguarding Community Partnership

November 2021

11 Survey responses

10 out of 11

9 of 11



Concerns and Social Issues

Top issues of concern:

- Parents not recognising neglectful behaviour
- Parental commitment to change
- Complex family circumstances/ multiple concerns
- Parental aggression/domestic abuse
- Food insecurity and financial hardship
- Anxiety, self harm, mental health
- Substance misuse
- Delayed child development
- Child exploitation

The comments from the 11 survey respondents suggest most (at least 7 of the 11) have concerns relating to existing issues or concerns that social and economic conditions will cause many of the problems of child neglect to further increase.

Example comments:

- *"Engagement.. aggression.. sometimes it is difficult to engage with parents and to gain access to the home."*
- *"We have noticed increased levels of aggression in homes due to tensions. We are concerned about social isolation of children. Poverty and hardship is an issue, especially for children who are being schooled from home. We are aware of an increase in anti-social behaviour amongst teenagers in Shrewsbury.... We are aware of an increase in young people with mental health issues and young people being assessed under the Mental Health Act."*
- *"Impact on mental health (parental and young people's), increase in substance misuse, we are seeing an increase in poor home conditions."*
- *"Financial hardship impacting upon parental mental health which in turn affects children & young people's emotional well-being and lived experience. Increase in self harm and suicide ideation in children & young people. Rise in push/ pull factors re: child exploitation."*
- *"Food poverty is a key issue. More families are accessing foodbanks. Steep rise in cases of anxiety... pupils not able to access school due to anxiety issues. Ongoing concerns regarding criminal exploitation and domestic abuse."*

- Awarding the contract for the publication of a co-produced poster campaign to increase the awareness of children, parents and professionals about child neglect

In our report for 2020-21, we said we our Exploitation Group would achieve the following:

- **Ensure there is a multi-agency response to all adults who are at risk of or being exploited that complements the existing adult safeguarding process in Shropshire**

  Our update – On 10th June 2021, the first multi-agency meeting took place to discuss how we were going address this issue. Those involved agreed to pilot an Adult Exploitation Allocation Meeting. This decision came about as a result of the recognition that in Children Services there was a recognised multiagency process for discussing Children at risk of Exploitation, but this did not exist for adults.

The weekly pilot allocation meetings ran for three months between February and April 2022. We will report on the outcome of this work in next year's annual report.

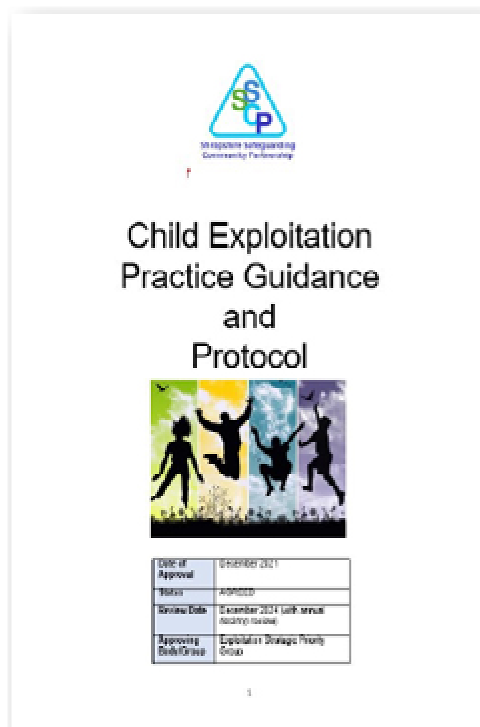
- **Review the effectiveness and impact of the existing Child Exploitation Pathway in identifying and responding to Child Exploitation in Shropshire; taking account of actions within our local Child J Child Safeguarding Practice Review, learning from other relevant Rapid Reviews, Local Child Safeguarding Practice Reviews and national report findings**

  Our update – In May 2021, we held a learning event for practitioners involved with Child J. The aims of the session were to:

  - Refresh our understanding of the Child Exploitation Pathway and Tools
  - Disseminate the learning from Child J and the "It was Hard to Escape" Report

- Explore what is meant by "critical moments", consider how to intervene
- Ask practitioners who are working with children at risk of exploitation:
    - how well they are identifying and responding to critical moments and having difficult conversations?
    - what support they need to improve?
- Gain feedback from practitioners on the Child Exploitation Pathway to inform its review

In December 2021, the Exploitation Group approved the Child Exploitation Practice Guidance and Protocol.



- **Ensure the revised national Prevent Referral Form is on all partnership web pages**

  Our update – this was done and can be found here.

Other achievements for this group include:

- Promoted Child Exploitation Awareness Day: 18th March 2022
- Organisational self-assessment against:
  - National Child Safeguarding Practice Review Panel report 'It was hard to escape' (2020)
  - Solihull Safeguarding Adults Board Safeguarding Adult Review (Rachel)
- Receiving regular updates relating to how we tackling exploitation locally including from:
  - Adult Safeguarding
  - Child Exploitation panel
  - Serious Organised Crime Joint Action Group[4]
  - Channel Panel[5]
- Promoted Anti-Slavery Day on which was held on 18th October 2021 by producing a newsletter about this subject which has had 1,288 views
- Reviewed the learning and development offer

Achievements for the Self-Neglect Group include:

- Holding its first meeting on 13th October 2021
- Agreeing terms of reference for the group
- Discussing Shropshire's response to self-neglect and how that was working in practice
- Promoting National Safeguarding Adults Week

4 – A multiagency meeting held to tackle organised crime led by the Police
5 – A multiagency meeting held to discuss people at risk of being drawn into terrorism and provide them with appropriate support

Achievements for the Drug and Alcohol Misuse Group include:

- The Drug & Alcohol Toolkit that supports reduction of exclusions shared with Head Teachers to review their school policies
- We have revised the 'Safeguarding children affected by someone else's drug and alcohol misuse' guidance
- Stronger working relationships have been developed with the voluntary sector to maximise recovery through community based and localised support
- We have consulted on the Shropshire Drug and Alcohol Strategy
- We have considered the National Strategy 'From Harm to Hope' and what this means for our local governance structure.
- We have held discussions about what the learning and development offer for multi-agency practitioners in relation to drugs and alcohol should look like.
- In March 2022 a Multi-Agency Case File Audit was undertaken on the theme of continuity of care for drug and alcohol users on leaving prison. One audit of practice was graded as 'Good', one 'Good with elements of Outstanding' and one 'Good with elements of Requires Improvement'. The findings included:
    - Taking time to make every contact count.
    - Find out if the service user can read and write.
    - Prison leavers can see their children if risk assessed to do so safely.
    - Ensure that assessments are reviewed regularly to reflect both negative and positive progress that prison leavers are making in the community.
    - Ensure that staff are supported to finding the best ways to engage with prison leavers who need support with their drug or alcohol misuse.
    - Agencies need to develop a process to ensure health workers/GP's are informed of the risk an individual may present. Risk assessments should be shared where appropriate.

The full learning briefing is available on the Shropshire Safeguarding Community Safety website.

Achievements of the Executive/Operational Leadership Group

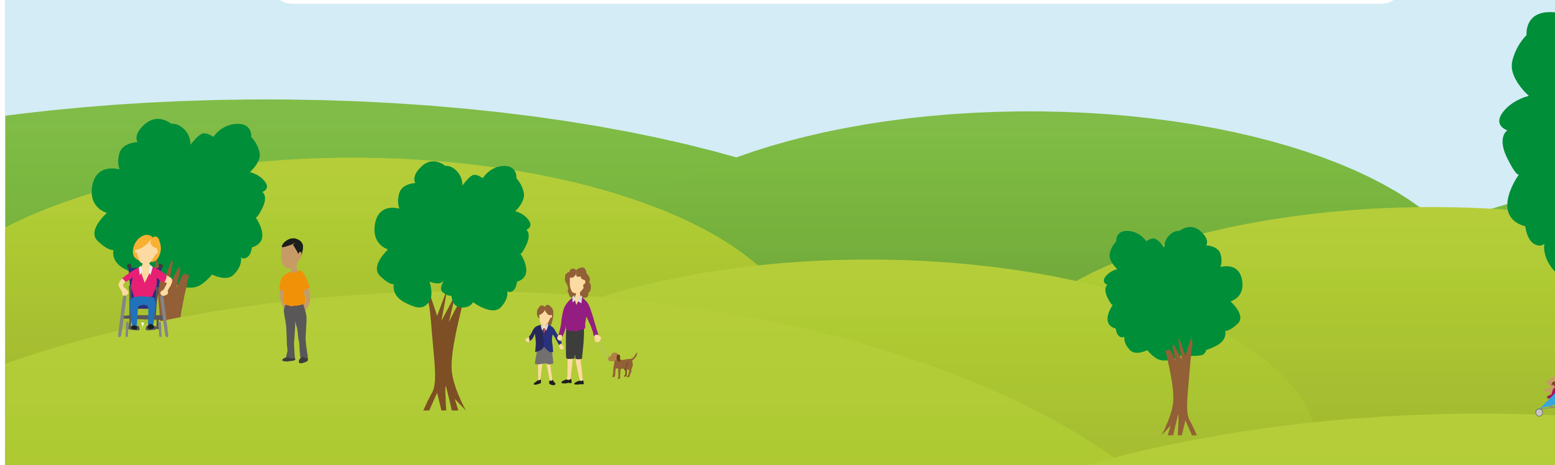
During this year, the group changed its name to Operational Leadership. This was to avoid confusion with Directors working across Social Care and Health becoming known as Executive Directors. Achievements for this group include:

- Producing a Multi-Agency Case File Audit process and agreed the case audit progamme for the year
- Agreeing our approach to the use of social media
- Reviewing the Business Plans from other groups in the structure to ensure they are completed and everyone is aware of the work being done across the Partnership
- Starting discussions about the Partnership's approach to violence reduction
- Received the Child Death Overview Panel's Annual Report
- Considered and commented on the Police and Crime Commissioner draft Crime Plan
- Considered and commented on the National Child Safeguarding Practice Review Panel Annual Report 2020
- Providing a regular opportunity to raise any practice issues or service delivery changes because of the impact of COVID-19
- Commissioned the production the Student Health Guide, a magazine for young people that bought information about sexual health, anxiety, depression, relationships, hygiene, bullying, anti-social behavior and crime.
- Provided feedback on new and revised regional procedures
- Signed off new and revised Shropshire procedures, including the Children's Threshold document

SSCP/Strategic Governing Group

During this year, the group changed its name to Strategic Governing Group. This was because of feedback received from partners about confusion between using the abbreviation SSCP for the name of the group and the wider Partnership. Achievements for this group included:

- Receiving presentations about the externally scrutiny items of:
  - CHILD NEGLECT THROUGH THE COVID-19 PANDEMIC 2020-2021 REPORT
  - LEARNING FROM NEGLECT SUPERVISION WORKSHOPS MARCH 2021
- Scrutinised and requested changes to the Neglect Group's Business Plan
- Scrutinised the Domestic Abuse Group's Business Plan
- Promoted awareness of the Everyone's Invited website and considered the implications for Shropshire
- Received a report on the COVID-19 dataset from 2020/21
- Considered setting the budget for 2022/23. This remains unresolved due to financial pressures.
- Received an assurance report about the Shrewsbury and Telford Hospital 2wNHS Trust and the Section 31 notice from the Care Quality Commission
- Received a briefing about preparing for an Ofsted inspection
- Considered a presentation about; the findings of the Wood Review, the Children's National Panel Annual Report 2020 and the What Works For Children's Social Care analysis of Children's Safeguarding Partnerships' annual reports
- Signed off Statutory Case Reviews
- Discussed the challenge of populating the multi-agency dataset due to partners not providing data or analysis of what is provided
- Discussed concerns relating to provision of support to young people with mental health problems and planned a challenge event to address this
- Received a presentation from the Clinical Commissioning Group about Deaths of People with Learning Disabilities from COVID-19
- Received an update from the Clinical Commissioning Group the response to the Ockendon Report



What we know about crime in Shropshire, children at risk and adult safeguarding

Crime in Shropshire

The information below explains crime in Shropshire. When reading this information, it's important to remember that Shropshire remains a safe place to live.

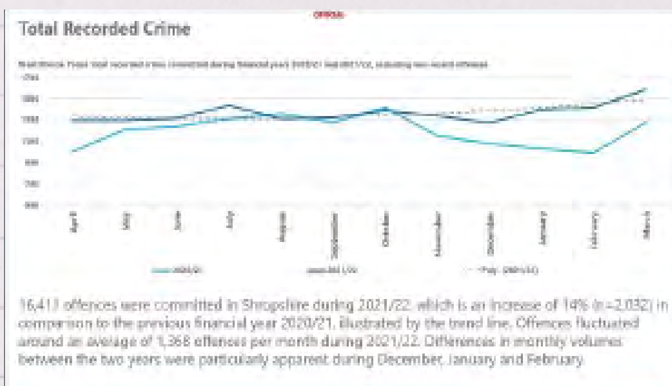
The information provided comes from a report produced by partnership analysts working with the Police.

We thank them for allowing us to share their work.

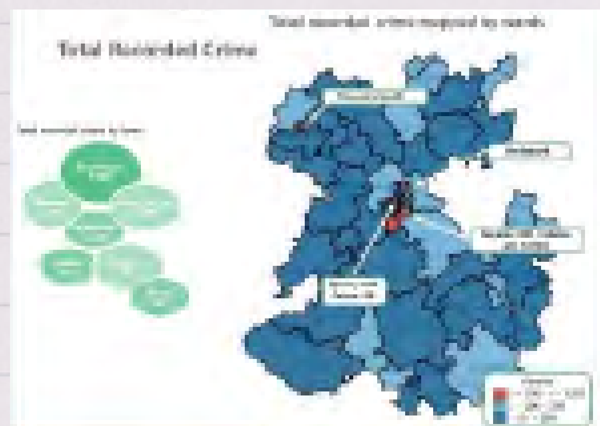
Shropshire Community Safety Partnership
Annual Overview 2021/22
ADDITIONAL INFORMATION

1 April 2021 – 31 March 2022

West Mercia POLICE



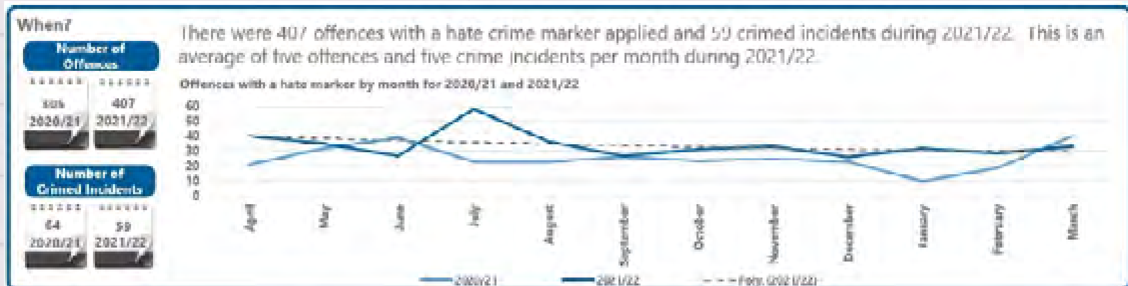
16,413 offences were committed in Shropshire during 2021/22, which is an increase of 14% (n=2,032) in comparison to the previous financial year 2020/21, illustrated by the trend line. Offences fluctuated around an average of 1,368 offences per month during 2021/22. Differences in monthly volumes between the two years were particularly apparent during December, January and February.



Total Recorded Crime by Type

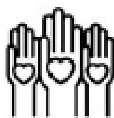
Offence	Total	Percentage	Rate per 1,000 population
Violence without injury	5,084	31%	15.7
Violence with injury	2,192	13%	6.8
Other crimes against society	2,122	13%	6.57
Criminal damage & arson	1,879	11%	5.81
All other theft offences	1,478	9%	4.57
Shoplifting	1,082	7%	3.3
Vehicle offences	725	4%	2.2
Burglary – residential	639	4%	1.98
Other sexual offences	436	3%	1.35
Burglary - business and community	351	2%	1.09
Rape	139	1%	0.4
Bicycle theft	109	1%	0.34
Personal robbery	85	1%	0.3
Theft from person	74	0%	0.2
Business robbery	11	0%	0.03
Homicide	3	0%	0.01
N200 modern slavery non-crime incident	2	0%	0.01
Total	**16,411**	**100%**	**50.8**

Hate Crime in Shropshire

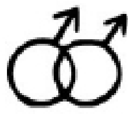


Hate Crime by Type

Hate related offences and incidents by type 2021/22 (n=511)



Racist 60%
(n=308)

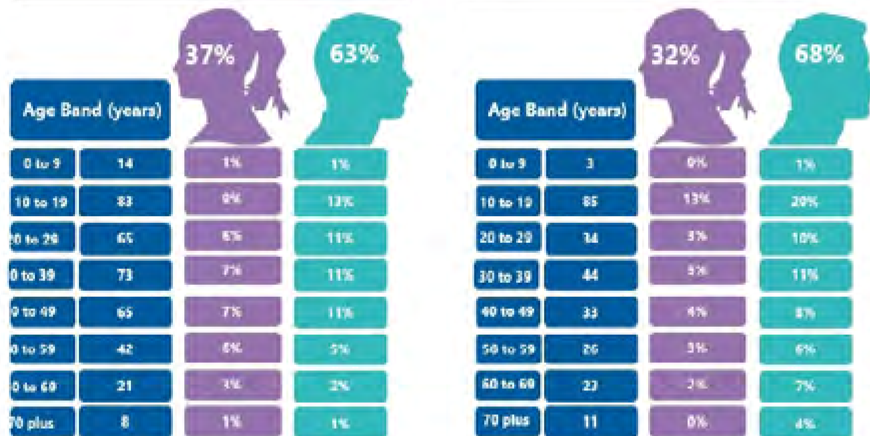


Homophobic 19%
(n=98)

Disablist 14%
(n=69)

Religious 4%
(n=19)

Transphobic 3%
(n=17)



Victims:

Age Band (years)		37%	63%
0 to 9	14	1%	1%
10 to 19	83	9%	12%
0 to 29	65	6%	11%
0 to 39	73	7%	11%
0 to 49	65	7%	11%
0 to 59	42	6%	5%
0 to 69	21	3%	2%
0 plus	8	1%	1%

Suspects:

Age Band (years)		32%	68%
0 to 9	3	0%	1%
10 to 19	85	13%	20%
20 to 29	34	3%	10%
30 to 39	44	5%	11%
40 to 49	33	4%	8%
50 to 59	26	3%	6%
60 to 69	23	2%	7%
70 plus	11	0%	4%

Victims and suspects of hate related offences and crimed incidents are broken down by gender and age band. Percentages show the proportion of victims or suspects according to gender and age band as a percentage of the total number of individual victims or suspects.

Hate Crime – where is it happening?

Offences and crimed incidents were mapped (n=458). Eight incidents were not mapped due to a lack of geographic data.

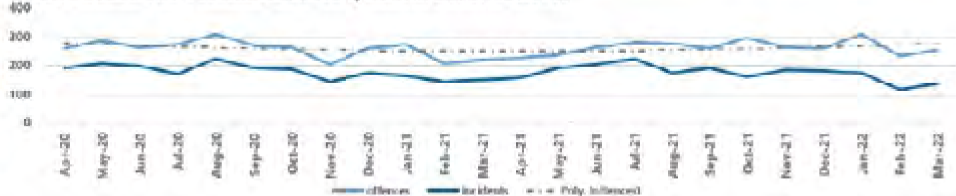
Domestic Abuse in Shropshire

Domestic Abuse

In 2021/22, there were 3,155 offences and 2,102 crimed incidents with domestic abuse markers. This was an average of 263 offences per month. Trends have remained relatively stable over the past two years for both crimes and incidents.

Number of Offences	
3,091	3,155
2020/21	2021/22

Number of Incidents	
2,144	2,102
2020/21	2021/22



How? A keyword search was used on the 5,257 crimed incidents and offences with domestic abuse markers to identify the nature of domestic abuse. Offences and crimed incidents may have recorded more than one keyword.

Emotional abuse was detailed in 30% of all incidents and crimes (n=1,571).

Key word search of domestic abuse offences for 2021/22

Emotional **30%** (n=1,571)

Punch **15%** (n=763)

Kick **10%** (n=529)

Choke **0.4%** (n=19)

Domestic Abuse – who is affected?

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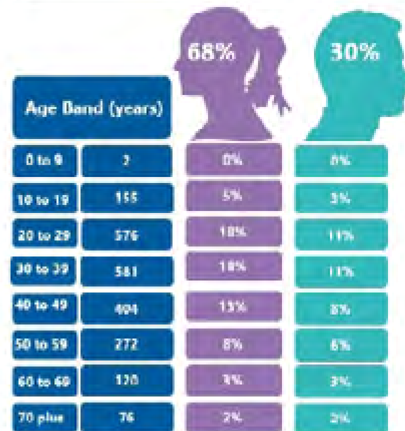
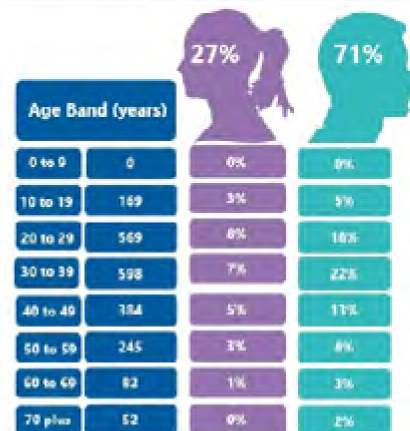
Age and gender of **VICTIMS** of domestic abuse offences and crimed incidents in 2021/22. Percentages shown are of total victims (n=2,186).



Age Band (years)		68%	30%
0 to 9	2	0%	0%
10 to 19	155	5%	3%
20 to 29	576	18%	11%
30 to 39	581	18%	11%
40 to 49	404	13%	8%
50 to 59	272	8%	6%
60 to 69	120	3%	3%
70 plus	76	2%	2%

Age and gender of **SUSPECTS** of domestic abuse offences and crimed incidents in 2021/22. Percentages shown are of total suspects (n=2,090).



Age Band (years)		27%	71%
0 to 9	0	0%	0%
10 to 19	169	3%	5%
20 to 29	569	8%	18%
30 to 39	598	7%	22%
40 to 49	384	5%	17%
50 to 59	245	3%	8%
60 to 69	82	1%	3%
70 plus	52	0%	2%

Victims and suspects of hate related offences and crimed incidents. Broken down by gender and age band. Percentages show the proportion of victims or suspects according to gender and age band as a percentage of the total number of individual victims or suspects.

Domestic Abuse – where does it happen?

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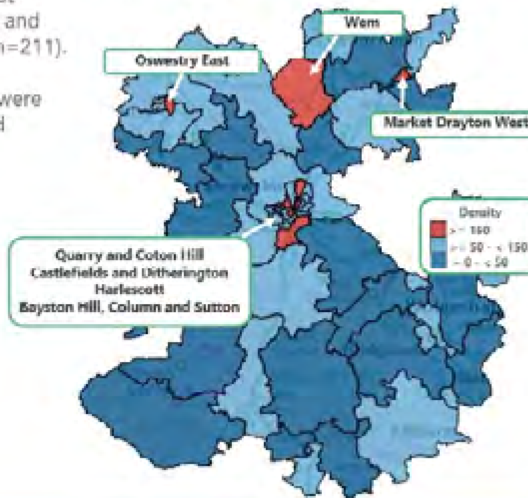
The location of offences and incidents with a domestic abuse marker were mapped (n=5,257). Domestic abuse was most prevalent in Shrewsbury. The greatest volume of offences and incidents were in Bayston Hill, Column and Sutton Ward (n=211).

Other wards with high volumes of offences and incidents were Oswestry East (n=206), Market Drayton West (n=198) and Castlefields and Ditherington (n=190).

Ten wards with the highest volume of domestic abuse related offences and incidents in 2021/22

Wards	Total	Percentage
Bayston Hill, Column and Sutton ED	211	4%
Oswestry East ED	206	4%
Market Drayton West ED	198	4%
Castlefields and Ditherington ED	190	4%
Harlescott ED	181	3%
Quarry and Coton Hill ED	170	3%
Wem ED	156	3%
Monkmoor ED	155	3%
Oswestry South ED	146	3%
Whitchurch North ED	142	3%



Domestic Abuse – what happens when it's reported?

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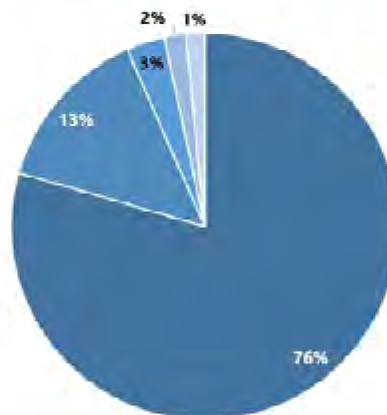
145 offences are still under investigation, pending an outcome and are therefore excluded. Analysis based on the remaining 3,010 offences, of which 95% (n=2,869) have an outcome in one of five categories shown in the chart.

Outcomes for domestic abuse related offences in 2021/22

- Named Suspect identified: evidential difficulties prevent further action; victim does not support (or has withdrawn support from) police action
- Named Suspect identified: victim supports police action but evidential difficulties prevent further action
- Charge/summons
- Evidential Difficulties Victim Based – Named suspect not identified: The crime is confirmed but the victim either declines/ or is unable to support further police investigation to identify the offender.
- Charge/Summons – alternate offence



Drug Offences in Shropshire

Drug Offences

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What?

Number of Offences: 537 (2020/21), 405 (2021/22)

There were 405 drug offences in 2021/22 a decrease of 25% (n=132) compared to the previous year.

Most frequent types of drug offences in 2021/22

- 34% n=136 – Possession of cannabis
- 15% n=60 – Possession of crack/cocaine
- 3% n=12 – Possession of heroin
- 16% n=64 – Trafficking crack/cocaine

Recording of possession of drugs is often as a result of stop and search, therefore, the actual picture of drug use within Shropshire is likely to be much broader.

Where?

Wards

Quarry and Coton Hill Ward had the largest volume of drug offences in 2021/22, which comprised 16% of offences across Shropshire (n=63).

Towns

Drug offences were concentrated in Shrewsbury, the location for 62% of all offences (n=250).

Drug offences by town 2021/22

Shrewsbury 250

Violence With Injury in Shropshire

Violence With Injury

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What happens?

Number of Offences: 1,713 (2020/21), 2,192 (2021/22)

There were 2,192 violence with injury offences in 2021/22, representing an increase of 28% (n=479) compared to the previous year.

The largest volume of offences were assault occasioning actual bodily harm (ABH) (79%, n=1,739).

Violence with injury offences by offence group 2021/22

Offence Group	Total	Percentage
Assault occasioning actual bodily harm (ABH)	1,739	79%
Owner or person in charge allowing dog to be dangerously out of control injuring any person or assistance dog	106	5%
Wounding with intent to do grievous bodily harm (Indictable)	96	4%
Minor wound without intent (s20)	60	3%
Administer poison/noxious thing to injure/annoy (Indictable)	57	3%
GBH serious wound without intent (s20)	48	2%
Attempted - Wounding with intent to do grievous bodily harm (Indictable)	31	1%
Other offences	57	3%

Where does it happen?

Wards

Quarry and Coton Hill Ward had the largest volume of violence with injury offences in 2021/22, which comprised 12% of offences across Shropshire (n=273).

Towns

Violence with injury offences were concentrated in Shrewsbury, the location for 48% of all offences (n=1,050).

Violence with injury offences by town 2021/22

Shrewsbury 1,050

Violence With Injury

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Why does it happen?

The 2,192 violence with injury offences committed during 2021/22 had 4,027 markers applied as more than one can be applied to each offence.

Violence with injury offences key word markers in 2021/22 (n=4,027)

Most serious violence with injury offences in 2021/22 by type

How was the injury inflicted?

A keyword search was used on offences to understand the form that the violence took. Note, more than one keyword may be recorded against an offence.

Where physical violence was involved, punching was most common, involved in 32% (n=701) of offences.

A weapon was used for 95 offences (4%) primarily sharp objects such as knives or blades (n=71), the offences where weapons are involved are likely to result in the highest levels of harm.

Anti-Social Behaviour in Shropshire

Antisocial Behaviour

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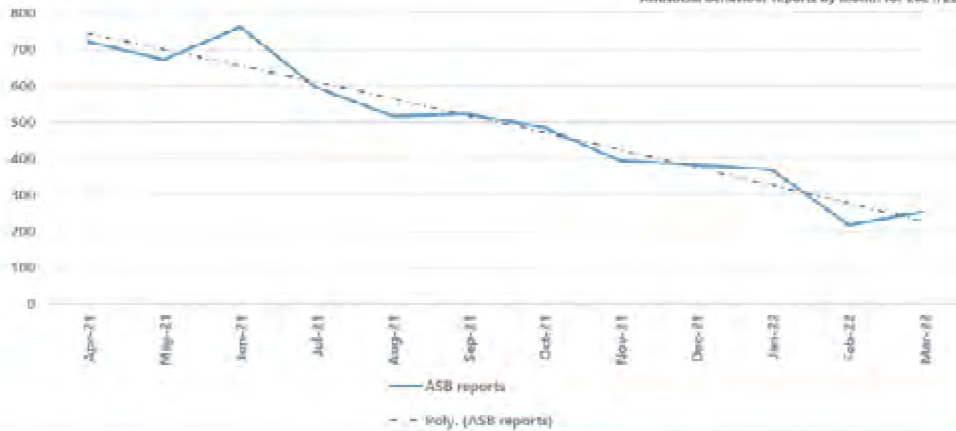
There were 5,889 reports of antisocial behaviour, or ASB across Shropshire during 2021/22, an average of 491 reports per month. There is a decreasing trend, which is believed to be due to a change in recording practices around public order and malicious communications offences following improvements to recording practice. This has led to substantial growth in those offences and a reduction in ASB.



Antisocial Behaviour

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There were 5,539 key words or markers applied to antisocial behaviour reports to help identify the nature of the antisocial behaviour or common themes. Note, more than one key word can be applied to a single report.

Antisocial behaviour keywords for 2021/22 (n=5,539)

11%

Youth (n=583)

8%

Drugs (n=444)

8%

Alcohol (n=428)

8%

Mental health (n=93))

6%

of Shropshire's antisocial behaviour reports went on to become crime records (n=328).

Anti-Social Behaviour Case Reviews[6]

There were 5 requests to conduct Anti-Social Behaviour Case Reviews during this year. Only one did not progress as a review. 4 reviews had action plans developed in response to the concerns raised.

2 of the reviews related to victims who were reporting ongoing issues with one individual, who was their neighbour. The other two reviews related to groups of individuals whose collective behaviour was causing harassment, fear and distress.

Alcohol featured strongly in three of these reviews and the behaviour of those who were consuming it was having a negative impact. There was no geographical connection between the reviews, they were spread across Shropshire.

What was evident in all the reviews undertaken was the detrimental impact that Anti-Social Behaviour can have on the individuals that live with it. Victims reported loss of sleep, high levels of anxiety, feeling nervous to be at home alone and wanting to move from their home.

Prevent and Channel Panel

Prevent plays an important role in protecting the public from the threat of terrorism. Multiagency Channel meetings are an important part of Prevent and the meeting is a vital tool for early intervention to prevent individuals of all ages being drawn into terrorist activity.

30%
increase

Nationally, in the year ending 31 March 2022, there were **6,406 referrals to Prevent.** This is an **increase of 30%** compared to the year ending March 2021 (4,915). There were **804 referrals** adopted as a Channel case in the year ending March 2022. This is **145 more** cases compared with the previous year (645).

In the West Midlands, the percentage of referrals adopted as Channel cases (see table on the next page), is in line with the national figures explained above.

6 – This is a multiagency process set up to respond to concerns about how agencies have responded to reported Anti-Social Behaviour

Region	Prevent Referrals		Discussed at a Channel Panel		Adopted as a Channel Case	
	Total	Per million population	Total	Per million population	Total	Per million population
North East	1,063	130.8	224	27.6	128	15.7
North West	758	102.2	327	44.1	145	19.5
East Midlands	678	138.9	100	20.5	47	9.6
West Midlands	650	109.2	139	23.4	82	13.8
East	410	64.7	116	18.3	67	10.6
London	992	112.7	153	17.4	102	11.6
South East	1115	120.2	265	28.6	134	14.4
South West	468	82.1	98	17.2	58	10.2
Wales	272	87.5	64	20.6	41	13.2
Total England and Wales	**6,406**	**107.5**	**1,486**	**24.9**	**804**	**13.5**

The ACT Early campaign seeks to raise awareness of the signs of radicalisation and where to go if you need support about someone you know. You can visit the Act Early website for more information and support (https://actearly.uk/).

Islamist ideology remains the most serious terrorist risk to the national security of the United Kingdom. The ideology held by Islamist extremists, and the crimes committed by Islamist terrorists, are completely distinct from Islam and are overwhelmingly rejected by Muslims around the world. It is also important to note that having an islamist ideology is not the same as following the faith of Islam.

The majority of people discussed in Channel in Shropshire have an extreme right-wing ideology. Most people are discharged from Channel when there is no identified terrorist threat.

Adult Safeguarding

Total number of safeguarding contacts to First Point of Contact

- 2406

Number of Safeguarding Concerns

- 765

Number of completed Safeguarding Enquiries

- 191

Number of Safeguarding Plans started

- 29

(14 new, 15 refreshed)

Number of Safeguarding Plans ended

- 24

(11 new, 12 refreshed)

There is an increase of over

451 (23%)

additional safeguarding contacts since last year.

Covid-19 led to partner agencies reducing or suspending services and this would have had an impact on vulnerable people.

Despite the increase in contacts, First Point of Contact have still only passed on very similar number of safeguarding concerns to the Adult Safeguarding Team.

What this tells us is that the majority of people in the safeguarding process are helped to stay safe. The evidence for this comes from the very small number of people who end up on Safeguarding Plans. These plans are kept under review and only removed when the risk to that person has reduced.

Types of adult abuse

- **27%** of concluded enquires were about domestic abuse.
- **14%** of concluded enquires were about financial abuse.
- **16%** of concluded enquires were about emotional abuse.
- **18%** of concluded enquires were about neglect caused by people outside the family.
- The remaining **25%** were about other forms of abuse including; physical abuse (10%) and self-neglect (3%).

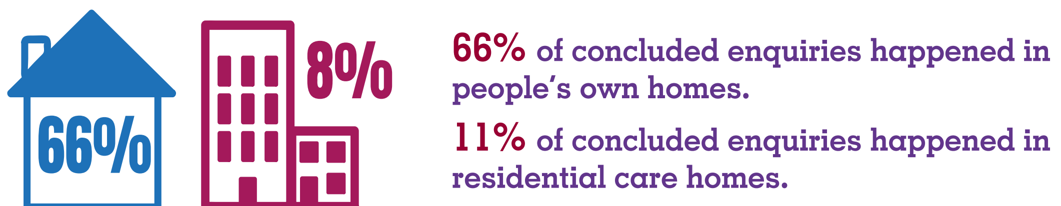
The age of people affected by adult abuse (taken from concluded enquiries)

50% are between the ages of 18-64.

50% are 65+

This shows that those between 18 and 64 are increasingly affected by abuse. In the past, it has always been those over 65 who were the majority affected. This needs to be understood in more detail.

Where does abuse happen?



66% of concluded enquiries happened in people's own homes.

11% of concluded enquiries happened in residential care homes.

What happens as a result of a concluded enquiry?

93% of people (or their representative) were asked what outcomes they wanted to be achieved. This indicates a strong emphasis on Making Safeguarding Personal which includes seeking the person's (or their representative's) views.

65% of people who expressed a desired outcome, were identified as having their outcomes fully met.

69% of concluded enquiries resulted risk being reduced and action taken to safeguard the person.

Where safeguarding risks were identified for individuals:

- **45%** risk was removed
- **49%** risk was reduced
- **6%** risk remained

This demonstrates the effectiveness of the adult safeguarding enquiry process in Shropshire.

Slight increase

Calls about children

There were **12,818 contacts** made to Compass during 2021/22. This is a slight decrease on what was reported in last year's report.

Early Help

No information was provided for this report.

Children in Need

CIN (exc Short Breaks)		
By Category of Need	2020/21	**2021/22**
N0 - Not Stated	32	4
N1 - Abuse or neglect	369	322
N2 - Child's Disability	23	28
N3 - Parental illness or disability	12	2
N4 - Family in acute stress	56	28
N5 - Family dysfunction	41	33
N6 - Socially Unacceptable Behaviour	5	4
N7 - Low income		1
N8 - Absent Parenting	1	5
U9 - Non-Agency Adoption	1	
Total	540	**427**

This is a reduction of 21% on the year before. The main reason for children being on a Child in Need Plan is because they've experienced abuse or neglect.

Child Protection

Types of abuse

CPP		
By Category of Need	2020/21	**2021/22**
N0 - Not Stated	7	3
N1 - Abuse or neglect	345	256
N2 - Child's Disability	7	3
N3 - Parental illness or disability		3
N4 - Family in acute stress	17	4
N5 - Family dysfunction	18	24
N6 - Socially Unacceptable Behaviour		2
N8 - Absent Parenting	1	
Total	395	**295**

For children going on to Child Protection Plans, there has been a decrease of 25% on the previous year. As with Child in Need plans, the main reason for being put on a Child Protection Plan is because they've experienced abuse or neglect.

There were **301 Child Protection conferences** held last year.

Looked after children

245 children came looked after during this year. This is an increase of **23%** on the year before.

Child Exploitation

In total, there were **309 referrals** about child exploitation during the year.

61% was about criminal exploitation

29% was about sexual exploitation

56% of referrals were about young men

44% of referrals were about young women

Impact on Adults and Children and their Families in Practice

One of the ways we understand what impact our work has had on our communities is to carry out one of four different types of statutory review. They are:

- Rapid Reviews/Child Safeguarding Practice Reviews[7]
- Safeguarding Adult Reviews[8]
- Domestic Homicide Reviews[9]
- Anti-Social Behavior Case Reviews

Child Safeguarding Practice Reviews/Rapid Reviews

G Children Serious Case Review

This Serious Case Review examined the agency involvement with six children in a family from the ages of 2½ to 16½ years. The eldest child experienced neglect, abuse and maltreatment. All children experienced neglect, maltreatment and considerable instability in their home and school life.

This is what we learned:

- When you have concerns about a child's welfare never assume that someone else is dealing with it.
- Home visits are important as they allow practitioners to observe children in their home environment, observe family interactions, and assess the standards of the living environment.
- Noise and nuisance complaints may be symptomatic of a chaotic and dysfunctional household and referring information from neighbours should be treated with equal importance as those from other professionals.
- Consistency of worker, especially during pregnancy, can help a more trusting relationship to develop.
- When working with parents who are not living in the same household, or who are separated, each parent should have the opportunity to fully express and voice their views, wishes and feelings.

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7 – A multiagency process undertaken when a child dies or the child has been seriously harmed and there is cause for concern as to the way organisations worked together
8 – A multi-agency process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place
9 – A multi-agency review of the circumstances of the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person who they were related or they were an intimate partner with

- Parental non-engagement, or failure to enter into a dialogue about the welfare of children, should be viewed as a risk factor which may have an impact on a child's welfare and safety.
- Creating a multi-agency chronology, cross checking information and working together as a tight network is imperative when working with complex situations and families.
- When faced with one parent who appears to take control it is important to explore the impact of this behaviour on children.
- When working with families where there are multiple children in the household it will be important to understand the lived experience of all the children.

Further learning is published in the Learning Briefing for this review.

Child I

This review is ongoing and is about the non-accidental injury of a 4-month-old baby. Both parents are care leavers and their children had been the subject of a child protection plan and child in need plans in another local authority area before moving to Shropshire. The outcome of the social work assessment on moving to Shropshire was to step down to Early Help as the risk had reduced.

The learning from this review will be published in next year's annual report.

Child J

The review in respect of Child J is on-going. Child J was 16 years old at the time of his death following a suspected drug overdose. Evidence recovered from Child J's bedroom suggested that he had been criminally exploited for some time.

His situation has been mapped against the findings from the National Child Safeguarding Practice Review Panel's themed report on criminal exploitation: 'It was hard to escape' 2020. A learning event with practitioners is planned to inform the revision of the SSCP Child Exploitation Pathway.

The full findings of this review and learning will be reported in next year's annual report.

Children M & N

This review is ongoing and is about two siblings, one of whom died. Due to the on-going criminal investigation, it would not be appropriate to comment further on the review at the time of writing. Learning will be disseminated upon publication and reported in next year's annual report.

Child O

A Rapid Review took place regarding a 17-year-old who became looked after due to self-harming behaviours, suicidal thoughts and parents feeling unable to keep them safe. Whilst in care, the risk to the young person increased due to repeat missing episodes and so plans were put in place to support her twenty-four hours a day in the family home.

This is one of a number of cases of young people in mental health crisis requiring a Tier 4[10] bed or alternative specialist provision or assessment which is not readily available. These young people are often inappropriately having to remain on a children's ward in hospital, which is presenting a further risk to themselves, staff and other young patients on the ward. The Partnership is currently challenging this issue by arranging an event with partners to find out how they are going to tackle this.

The event is due to take place on 13th June 2022. What happened as a result of the event will be described in next year's report.

Child R

A referral was received for a 3-year-old who had sustained non-accidental injuries. There were differences of medical opinion regarding the outcome of the child protection medical and the view of other paediatricians through the quality assurance process. Partners initially decided that the case did meet the criteria for a Local Child Safeguarding Practice Review but on the advice of the National Panel will not be undertaking a review as it was felt that all learning was identified through the rapid review process.

This is what we learned:

- Improvements are needed in respect of information sharing, use of chronologies and use of the Escalation Policy
- Referrals to Targeted Early Help need to be made in a timely manner
- Practitioners need to be up to date with their safeguarding training
- Practitioners need to exercise professional curiosity and provide challenge when they are not happy with the medical opinion given regarding potential non-accidental injuries to a child

Child T

A referral was received at the end of the financial year for a 16-year-old child who is looked after and at risk of exploitation. The outcome of the rapid review meeting and any subsequent actions will be reported on in next years' report.

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10 – specialised day and inpatient units, where people with more severe mental health problems can be assessed and treated. Currently this is commissioned by NHS England

Safeguarding Adult Reviews

Kim

A Safeguarding Adult Review has been initiated following the death of a homeless woman. She found herself homeless having been asked to leave specialist drug and alcohol provision as she had not confirmed with the requirements of the environment. Her vulnerability increased immediately because of her eviction. There were also concerns about self-neglect and the way in which multi-agency partners worked together to support her.

This referral was considered for a review because of the publication of the Rough Sleeping Strategy, August 2018, which highlighted the precarious position rough sleepers find themselves in.

The learning from this review will be reported in next year's annual report due to length of time it's taken to pull the final report together.

Mr G

A review was initiated following the death of a 74-year-old man from Sepsis after he had laid on his kitchen floor for 48 hours. Mr G had a history of Depression, including features of self-neglect. Mr G had a relapse profile when his mental health was deteriorating which included him neglecting his physical care needs.

Mr G's care giver would also request help at the point of crisis and then both of them would choose not to accept further support when the crisis had eased leading to the assessment of care and support often not being able to be completed fully.

The learning from this review will be reported in next year's annual report.

Mr I

A Safeguarding Adult Review was initiated following the death of Mr I, a 70 year old male who lived alone. There were significant issues of self-neglect and hoarding. Mr I did not have access to heating and hot water and did not have any utilities connected to his home. Mr I's circumstances were impacted upon by the Covid-19 Pandemic which significantly increased his level of isolation.

The learning from this review will be reported in next year's annual report.

Mrs H

A Safeguarding Adult Review was initiated following a referral from the family of an 87-year-old female. This lady had a significant history of mental health issues, including several attempts to take her own life, as well as physical health problems. She was found unconscious at home after refusing her carers access for several days. Medication was found strewn on the floor near to where she was laying. She died in hospital 5 days later. The learning from this review will be reported in next year's annual report.

Lily

A Safeguarding Adult Review was initiated following the death of a 34-year-old female who was found dead in her home. She had a history of mental health problems and services were unable to find ways to positively engage with her.

The learning from this review will be reported in the next year's annual report.

Domestic Homicide Reviews

Ms A

Ms A was a 65-year-old woman who was unlawfully killed by her 38-year-old daughter. The learning from this review will be reported in next years' annual report.

Mr C

Mr C was an 80-year-old man who was killed by his 31-year-old grandson. This was following an argument about money and the grandson pushed his grandfather who fell and banged his head. The learning from this review will be published in next year's annual report.

Hearing the voice of children and families, adults with care and support needs and victims of crime

We currently capture the voice of our communities in number of ways including through:

- our data collection process
- conducting statutory case reviews
- undertaking multi-agency file audits

We have also started work on reviewing our Anti-Social Behaviour Case review process. People who have been affected by Anti-Social Behaviour are supporting this process.

Learning and Development

Shropshire Safeguarding Community Partnership' training programme for this reporting period delivered a mixture of online live, learning webinars and in person classroom delivery to meet the needs of participants.

Training delivered is informed by the findings of local and national reviews; emerging themes and trends, guidance, and workforce needs identified through multiagency case file audits.

Training Pool members continued to be supported by the Learning and Development Co-ordinator each month to enable consistent safeguarding training to be delivered effectively to multi-disciplinary staff.

Learners' engagement has been high using online platforms which operate in real-time and support learning.

Training courses are designed using criteria set out in the Partnership's Learning and Development Strategy tiers, Induction, Awareness and Universal, and Advanced and Specialist:

The following section includes participants voices, taken from evaluation comments.

Sessions : Participants		
Train the Trainer 2 : 11	Child Neglect Online Workshop - Recognising and Responding 11 : 142	Raising Awareness in Safeguarding and Protecting Children 8 : 134
Lived Experience of the Child - Graded Care Profile 2 9 : 98	Domestic Abuse Briefings 9 : 109 (Delivered jointly with Joint Training)	Child Exploitation Briefings 8 : 157
Total 47 sessions to 651 participants Delivered online live learning webinars		

In addition to the information above, 11 Training Pool sessions were delivered to in-between 30 and 50 trainers each month.

What difference has this made? Participants told us:

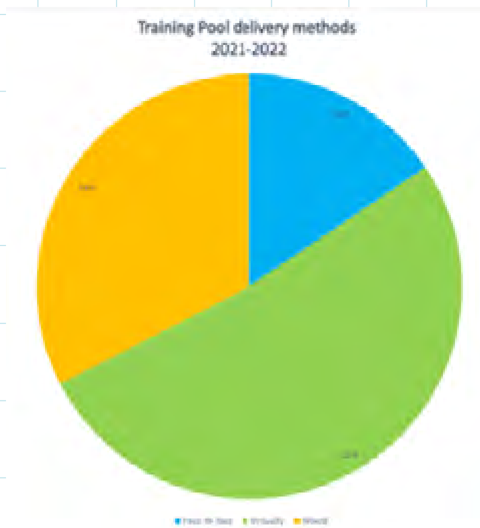
- I sent a Multi-Agency Referral Form after spotting emotional and social neglect of a child (along with other issues)
- I completed 'A Day in the Life' with a parent prior to making a referral to FPoC requesting a social work assessment. I have previously only used this tool with pupils.
- When making a safeguarding referral I was able to specifically evidence different types of neglect
- An awareness of the role of the "invisible" male in the family has made us much more professionally curious about a family we are working with. We are monitoring the situation and remain more vigilant than we would have been prior to the training
- I have recently completed a Child Exploitation screening tool and I've shared information about a young person which has been effective in gathering information and risk concerns
- A student at our school was involved in risky behaviour and we alerted family and started an Early Help intervention. Risk reduced with increased parental engagement.

Shropshire Safeguarding Community Partnership Training Pool

The impact and reach of the Partnership to raise awareness about Safeguarding and Child Protection Training across Shropshire is only possible because of the dedication and enthusiasm of the professionals who make up the Training Pool.

The Training Pool train within their own agencies to multi-disciplinary participants using the Raising Awareness in Safeguarding and Protecting Children package of resources, supplied by the Shropshire Safeguarding Community Partnership Learning and Development Coordinator.

The ambition of the partnership is to expand the number of people in the Training Pool to deliver training in other areas such as Adult Safeguarding and Community Safety.



Total 258 sessions to 4325 attendees

Examples of the agencies that make up Training Pool include: Shropshire Council Fostering Service; Connexus housing; Education Improvement Service; Education settings (Early Years; Primary; Secondary; Academy; Maintained; Independent; Special schools; and Further Education Colleges); Enhance; Family Information Service; Independent Care Providers; Joint Training; Learning and Skills; Public Protection; Shire Services; Shrewsbury and Telford Hospitals NHS Trust; Shrewsbury Town Council; Shropshire Community Health Trust; Shropshire Council (Targeted and Early Help Children's Services); Shropshire Partners in Care (SPIC) Shropshire Youth Association; Strengthening families through Early Help team; Children's Residential Care Homes.

What difference has this made? Participants told us:

- Much greater understanding of relevant legislation and local authority procedure. With focus on local issues as well as national. I had never heard of Adverse Childhood Experiences before.
- A really good refresher course highlighting other areas of safeguarding I was not aware of such as breast ironing
- Actively listen to the young people I am supporting, be aware of signs of safeguarding issues. Know who to contact and what to do and say if disclosure takes place
- Understanding the whole process following a child making a disclosure and the role of COMPASS
- How children with Special Educational Needs and Disabilities are vulnerable and may not be able to make a disclosure
- Legislation history was very powerful and information about new slang words
- Shocked at children viewing sexualised images - I love Zipit App
- Female Genital Mutilation - I didn't know about it or understand why - I do now

Shropshire Partners in Care – Safeguarding Delivery and Events

To fully reflect the work this organisation has undertaken, they also delivery training for the Joint Training Team in Shropshire Council.

Sessions : Participants		
Safeguarding Adults Forum 4 : 83	Safeguarding Adults - Level 3 (Full day) 8 : 99	Safeguarding Adults Awareness (half day) 16:109
Safeguarding adults an introduction 3:26	Safeguarding adults (bespoke session) 2:28	Safeguarding Adults Level 3 (half day) 2:16
Professional Boundaries in Social Care & Health Settings 2 : 22	Professional Boundaries – An Introductory Level Course (Bespoke 2 hours) 2:27	Safeguarding Adults - your role as safeguarding lead in Housing (half day) 2:19
Safeguarding Children and Young People (Bespoke, Housing) 2:19	Developing a positive safeguarding culture webinar 1 : 37	Safeguarding Adults Lead- Embedding Learning into Practice 1:11
Safeguarding Adults - your role as safeguarding lead (half day) 4:40	Safeguarding Adults for Trustees of Charities (half day) 2:12	Safeguarding Children and Young People, An Introduction (Bespoke, 2 hours) 3:24
Total 54 sessions to 572 participants Delivered online live learning webinars and in person classroom delivery		

What difference has this made?
Participants told Shropshire Partners in Care:

- I came away with having consolidated the 6 safeguarding principles, will be reinforcing my knowledge on a daily basis by developing my professional curiosity and maintaining professional monitoring supervising when necessary
- Exercise "Professional curiosity". If something doesn't seem "right" look into it
- The more I can understand needs of the service and legalities around them, the better I can support and safeguard the community I live in
- I have already raised a safeguarding concern as a direct result of the course. I will be more vigilant in future and explore my professional curiosity
- More aware of identifying risk to patients, being 'professionally curious' and involving the patient in the decision to raise a safeguarding concern, and if they refuse, making a professional judgement about whether to proceed anyway (public interest)

Joint Training – Safeguarding Delivery

Sessions : Participants		
Safeguarding Adults Forum 4 : 83	Safeguarding Adults - Level 3 (Full day) 8 : 99	Safeguarding Adults Awareness (half day) 16:109
Safeguarding adults an introduction 3:26	Safeguarding adults (bespoke session) 2:28	Safeguarding Adults Level 3 (half day) 2:16
Professional Boundaries in Social Care & Health Settings 2 : 22	Professional Boundaries – An Introductory Level Course (Bespoke 2 hours) 2:27	Safeguarding Adults - your role as safeguarding lead in Housing (half day) 2:19
Safeguarding Children and Young People (Bespoke, Housing) 2:19	Developing a positive safeguarding culture webinar 1 : 37	Safeguarding Adults Lead- Embedding Learning into Practice 1:11
Safeguarding Adults - your role as safeguarding lead (half day) 4:40	Safeguarding Adults for Trustees of Charities (half day) 2:12	Safeguarding Children and Young People, An Introduction (Bespoke, 2 hours) 3:24
Total 54 sessions to 572 participants Delivered online live learning webinars and in person classroom delivery		

What difference has this made?
Participants told Joint Training:

- If I ever need to make a safeguarding referral or complete a referral form I have learnt not to leave any gaps and to give as much information as possible including using 'own words'
- When I conduct section 42 enquiries it will help me consider relevant information
- Most of it will affect the conversations I have with the Housing Officers I manage, as they have the more hands-on dealings with adults that are in need of safeguarding. It will lead me to constantly provoke their professional curiosity
- Ensure that we have Safeguarding on our team meeting agenda
- Reflection - I will be looking at the Padlet to use the Resources. Noted to look at the My Enquiry & Safety Plan cards - have we got these? If not, then look at purchasing them
- Be mindful of how to approach safeguarding concerns with future clients, save useful tools to use in the future, feel more confident in how to deal with safeguarding concerns

Shropshire Council Early Help through Strengthening Families

Safeguarding Delivery

Sessions : Participants	
Reducing Parental Conflict: Building Confidence and Using Resources 1 : 16	Introduction to Liquidlogic Early Help Module 6 : 29
Introduction to Early Help 8: 61	Introduction to Reducing Parental Conflict 5:77
Total 20 sessions to 183 participants Delivered online live learning webinars and in person classroom delivery	

What difference has this made?
Participants told Strengthening Families:

- An improved appreciation of how parenting conflict affects the development of a child and their individual lived experience
- A family I have recently worked with involved parental conflict and I was able to spot this and address this with them. I was able to use some of the course material to be able to relay to the family and best support them all.
- I use Early Help Module daily within my work, I am still learning and believe it will be an ongoing process however, this training provided me with confidence and ability to use the system to full advantage
- I found that the ability to question the course delivery staff about specific areas that I need to contribute to in my role was invaluable and clarified many queries that I had
- The training went into depth and gave really good examples of the difference between parental conflict and domestic abuse. It is hard to know where it lies at times but I soon understood the difference after the trainers gave a good clear examples

Throughout training across the partnership, participants tell us that they appreciate the knowledge of trainers and the interactive methods used to engage participants with the content.

Changes to published arrangements

There have been no changes to our published arrangements.

The effectiveness of these arrangements in practice

Shropshire
Fire and Rescue Service

Guy Williams, Head of Service Delivery, Shropshire Fire and Rescue Service

The Partnership has been effective in providing the strategic challenge which is necessary to energise and promote community safety and effective safeguarding.

We need to prevent "mission creep" where partners, through best intentions, diverge away from the original objective as the volume of work coming in overloads the capacity within it.

Tanya Miles, Executive Director of People, Shropshire Council

Joint working across the areas of children, adult and community safety continues to develop positively in 21/21 and we are clear what our priorities and focus must be going into next year.

There is of course more to do and more that should be done to continue to improve safeguarding services, continue to create safer communities and become an effective learning system. We have started to build up a partnership dataset but as stated in this report, we need to get better at how we collate and use data insights across the partnership.

It is therefore more important than ever that we collaborate effectively to manage risk and deliver an excellent service, protecting adults and children and our communities from harm.

Shropshire, Telford and Wrekin
Clinical Commissioning Group

Alison Bussey, Executive Director of Nursing & Quality, Shropshire Telford and Wrekin Clinical Commissioning Group

This report provides us with an important opportunity to assess our effectiveness. It highlights the priority areas that the Partnership has identified as our key concerns. I will not reproduce that list here, but to be effective in our work it is right to focus upon the things that matter to the children and adults who most need safeguarding support.

The Partnership has demonstrated some effective work in terms of training our staff and has been seeking to aid trainers to identify what they will do differently because of that learning.

I am pleased to see the emphasis on data to help us understand issues pertaining to the neglect of children as this means our ongoing priority setting is based upon recognising need.

Similarly, the report explains that there has been a 23% increase in adult safeguarding contacts, and this coupled with the work to understand the prevalence of domestic abuse is informing the priorities we have set ourselves the next year.

I was pleased to note that the Partnership has continued to emphasise the importance of "making safeguarding personal" when safeguarding adults which means the work must focus upon the outcomes identified by the adult and we have now achieved this in 93% of cases.

Data is something we must keep returning to as we need to measure what areas are the most impacting and evaluate our effectiveness in dealing with them. This reminds me of the adage if you think you are good then you are comparing yourself with the wrong person. It is therefore necessary to ensure that we focus attention on what else needs to be done and I can see that we have set an important list of achievements for next year. For example thanks to some really helpful Police data on crime including hate crime we have ambitions to improve the Anti-Social Behaviour Case Review process, continue to work on child neglect and exploitation as well as take actions to improve outcomes for adults who self-neglect.

This means that we can never be satisfied with our effectiveness and will and must continue to make the strides outlined in this report.

Stu Bill, Superintendent, West Mercia Police

Only by working together has the Partnership been able to deliver for the communities in Shropshire. The annual report documents several achievements in addressing safeguarding priorities and improving practises. Furthermore, it is evident there has been a commitment to embed learning, both locally and nationally, within each partners organisation. To this end the partnership working is effective.

We should never be complacent, however. While the partnership has made progress in several areas and demonstrated a commitment to improving safeguarding practices, there are areas where further efforts and resources are needed to fully achieve goals | and enhance effectiveness. Data sharing and analysis is an example of this. Continued collaboration, willingness to address challenges, and implementing feedback from practitioners and the community is crucial to safeguard both adults and children in Shropshire.

I remain convinced that the Shropshire Safeguarding Community Partnership is focussed on this. There are passionate and dedicated people in all partner agencies that will ensure we deliver.

George Branch, The Probation Service

Working in partnership is critical to driving the Probation Service's reducing reoffending ambitions. As an agency, we know that working collaboratively with our partners we will achieve better outcomes for victims, communities and for offenders.

Despite the immense challenges, all partnership agencies have worked throughout the COVID-19 pandemic to maintain key services. The Partnership vision has emphasised the need to prioritise key deliverables that we know have the biggest impact on reducing reoffending, safeguarding and public protection.

There has been a welcome renewed emphasis on improving practices of frontline staff with learning briefings but we do need to improve our data and analytical capability. Its only by having such performance data we are able to measure progress and impact.

The Partnership has taken strong steps in creating a more inclusive society through work on making hate crime and diversity training available. However, further work is required in this area.

I have every confidence through partnership working we can accomplish together a safer stronger community for all.

What we want to achieve in 2022/23

Joint Case Review Group

- Improve the quality of information and analysis of practice that agencies provide to reviews.
- Raise awareness of the statutory case review processes and professionals' roles and responsibilities in case reviews.
- Provide information to support families who are involved in case reviews.

Assurance and Improvement Group

- Carry out the Care Act Compliance audit and peer review.
- Roll out the new online regional audit tool.
- Develop the datasets to ensure that all data which is collectable is submitted, and agency analysis and narrative is provided, to enable us to produce meaningful dashboards of improvement information for the Partnership to consider.

Learning and Development Group

- To offer a sustainable multiagency training offer for Children's Safeguarding
- To offer a sustainable multiagency training offer for Community Safety
- GCP2 to be delivered in a classroom environment
- To work with Police Exploitation and Vulnerability Trainers to deliver multiagency Exploitation training

Local Domestic Abuse Partnership Board

- Undertake a strategic needs assessment as per direction of the Domestic Abuse Act 2021 as a matter of urgency
- Embed and review the effectiveness of the perpetrator programme that has commenced
- Develop a child and adolescent to parent violence and abuse policy

Preventing Offending Group

- Review the Anti-Social Behaviour Case Review Process ready for public consultation
- Develop a clear reporting process for Hate Crime/Incidents which will make data collection easier, through a small task and finish group
- Conduct a multi-agency case file audit on continuity of care for prison leavers who use substances and implement the learning from this audit

Self-Neglect Group

- Review and update the Responding to Self-neglect in Shropshire Guidance
- Conduct a Multi-agency case file audit relating to individuals who self-neglect in Shropshire
- Create a profile of self-neglect in Shropshire

Drug and Alcohol Misuse Group

- Revise our local strategy in line with the National Strategy 'From Harm to Hope'
- Carry out a Joint Strategic Needs Assessment
- Re-establish the Drug Related Death Panel

Child Neglect Group

- Complete our co-produced poster campaign
- Enable external partners to use the Early Help Module (Liquidlogic) to record their involvement with Children and Families
- Recruitment of Police Early Help and Intervention and Prevention Officers

Exploitation Group

- Raise awareness of and response to the issue of exploitation in communities/ among businesses, elected members and town councils
- Complete the pilot Adult Exploitation Allocation Meeting
- We will produce a standard template for all business to use to encourage them to publish an annual statement regarding their commitment to tackling Modern Slavery

Closing Scrutiny statement

Ivan Powell

Independent Chair
and Scrutineer
Shropshire Safeguarding
Partnership

Independent Scrutiny

The function and purpose of 'independent scrutiny' is defined within Working Together 2018. It is primarily focussed on how well the statutory safeguarding partners are working together and with any relevant agencies and organisations, to ensure that local children are safeguarded, and their welfare promoted. Within the Shropshire structure the scrutiny function is also applied to the adult safeguarding and community safety duties.

The Independent Scrutiny function is delivered by the Independent Chair of the SSCP. The areas of scrutiny framework activity during this reporting period are identified below.

As the partnership and role of the Independent Chair and Scrutineer have become embedded there are a number of areas of scrutiny activity which have emerged as an annual cycle, they are:

- **Scrutiny and challenge of data provision to the board**

  The partnership has laudable ambition to establish a broad approach to data collection across the three disciplines, however experience has shown that some aspects are not currently able to be provided by partners. The scrutineer has continued to challenge the partnership to provide an interim dataset to enable line of sight to frontline practice and decision making. This remains a work in progress, but I would expect to see urgent progress during the next reporting year.

- **Seeking assurance on the implementation of contextual safeguarding.**

  The work of the exploitation sub-group is largely effective for children. Whilst there is clear evidence of the use of complex strategy discussions leading to partnership problem solving approaches there remains an intention for a contextual safeguarding strategy, which needs to include stronger focus on adults subject of exploitation.

- **Challenge to core partners on insecure funding arrangements for the partnership**

  This remains an annual challenge and one which is not unique to Shropshire. There is no doubt that financial pressure on all partner agencies is presenting significant challenges to the delivery of frontline services. Resourcing the business function of the partnership in the light of this remains a difficulty.

  As with many partnerships stability has been achieved by the allocation of previous years reserves but this position cannot be maintained during the forthcoming year.

  One specific anomaly which makes this a particular challenge for Shropshire is through the inclusion of the community safety function. Whereas Working Together 2018 and the Care Act 2104 provide guidance whereby partners accept their responsibility to fund the arrangements, no such guidance exists for the resourcing of the community safety function. Shropshire have provided feedback to the Home Office on this point in response to the consultation on the revision of community safety.

- **Scrutiny of decision-making by core partners in respect of rapid reviews and CPSRs and learning loop**
- **Engagement with child death overview panel in respect of findings of annual report**
- **Engagement with local authority designated officer annual report**

2022-23 Scrutiny framework activity:

April 2022 the Scrutineer reviewed the work of the childhood neglect working group with particular focus on the guidance documents and tools available to support staff when working with children and families. He also confirmed training modules available for staff and the profile of multi-agency attendance at these. There was some focus on the police service with regard to their own toolkit devised for officers and staff and assurance sought on relevant criminal offences being recorded when they were encountered. This in of itself was important, but it also related to direct learning from the previously commissioned 'G' children serious case review.

During the year the Scrutineer reviewed progress against the open action plans for statutory case reviews across Shropshire and takes as an agenda item to the governing group interim position updates to ensure they are fully sighted on them and for their action where barriers to progress existed.

May 2022 the Scrutineer confirmed that Local Youth Justice Board was operating in line with national guidance and was taking account of;

•quarterly performance data on reducing the number of first-time entrants to the system, reducing reoffending and reducing the use of custody, improving resettlement and transitions outcomes (and comparison with YJS families as well as examining national averages)

•locally agreed performance data and indicators (for example caseload size, the profile and needs of the youth justice and out of court cohorts, demographics, disproportionality, numbers of children held in police custody, remand and custodial episodes, children requiring resettlement support and transitions to probation and other adult services)

The scrutineer provided an 'areas for assurance' report in respect of the learning from the Solihull joint targeted area inspection and Child Protection in England, presented to the partnership board and subject of multi-agency self-assessment and supporting action plan. This includes an ongoing action regarding the experience and wait times for children accessing CAMHS and specialist care provision.

The scrutineer has ensured that the partnership has reflected on local learning from case reviews and engaged directly with the national panel in the regional workshops held during this reporting year.

Other areas subject of scrutiny activity have been the partnership and police response to the learning from Child Q, in particular stop and search data provision and scrutiny.

Under the adults and community safety portfolio the scrutineer has pursued the police response to the national adults missing framework and has engaged with the Home Office with regard to the update and revision of the Statutory Guidance for the conduct of domestic homicide reviews.

The scrutineer has also been directly involved in the revision of the anti-social behaviour case review process, and in one case tested the model by visiting the victim. This particular case remains the subject of ongoing work with West Mercia Police.

Shropshire Safeguarding Community Partnership

Annual Report 2021-22