SOLIHULL SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

EXECUTIVE SUMMARY

RACHEL

Independent Reviewer: **Chris Brabbs**

Date of report: **28th January 2019**

1. THE REVIEW PROCESS

Circumstances leading to the Review

1.1 This Safeguarding Adults Review (SAR) was commissioned in May 2017 following the death of Rachel who was 20 years old. [1] Rachel had previously been a victim of sexual abuse, and had a history of mental health difficulties and self-harming behaviours. She was also a victim of sexual exploitation and trafficking from the age of 17 onwards.

1.2 Rachel was found dead in her bedroom at the supported accommodation where she had been living. The outcome of an inquest was the Coroner reaching a determination that the cause of death was drug related.

Time Period Covered by the Review

1.3 The Review covered the period from Rachel's 13th birthday in October 2010 when agencies became involved because of concerns about her emotional and mental health, and her first allegations of being a victim of sexual offences.

Focus of the Review

1.4 The key lines of enquiry were:

- the response to sexual exploitation – pre and post 18-years of age;
- the response to episodes of young people going missing;
- the response to mental health issues and incidences of self-harm;
- the arrangements for transition from children's to adult services;

1.5 Within these, there was particular focus on how agencies ensured that "Making Safeguarding Personal" was at the centre of the services provided, what policy or governance gaps impacted on actions taken, and the effectiveness of multi-agency joint working, case coordination and leadership.

Agencies Involved

1.6 The following agencies and services contributed to this Review:-

Solihull Metropolitan Borough Council
NHS Birmingham and Solihull Clinical Commissioning Group [2]
Heart of England NHS Foundation Trust / University Hospitals Birmingham [3]
Birmingham and Solihull Mental Health NHS Foundation Trust
West Midlands Police
West Midlands Ambulance Service
Solihull Community Housing
Solihull College

---

[1] *Section 44 of the Care Act 2014 requires a Review to be carried out where "An adult with care and support needs (whether or not those needs are met by the local authority) in the Safeguarding Adult Board's area has died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult"*

[2] *From 01.04.18 Solihull CCG merged with 2 other CCGs to form the NHS Birmingham and Solihull CCG.*

[3] *From 01.04.18 HEFT became part of the University Hospitals Birmingham Trust (UHB)*

1.7 A SAR Panel comprising senior representatives of most of the above agencies was independently chaired by Chris Brabbs, who was also the Independent Overview Report Author. Specialist advice was provided by the SSAB Board Manager, Solihull Local Safeguarding Childrens Board (LSCB) Training Officer, and the West Midlands Regional Strategic CSE Coordinator.

Involvement of Family Members

1.8 Information about the SAR process was sent at the start of the Review to Rachel's mother, father and maternal grandmother, with an invitation to contribute their perspectives, but no response was received at that stage. But Rachel's mother did respond to a further approach in February 2019, when she explained the initial contact was too soon after Rachel's death for her to participate. The SAR process and this Executive Summary were shared with Rachel's mother who expressed appreciation that positive work has taken place and is planned to safeguard young people from exploitation in Solihull in the future.

2. TIMELINE OF KEY EVENTS

2.1 Prior to the Review period, Children's Services were involved briefly between 1999 and February 2000 when Rachel was subject to a child protection plan and an interim care order.

2.2 In her early teenage years, Rachel was the victim of several sexually abusive experiences, which contributed to concerns about her mental health:-

- July 2010 - Rachel alleged that she had been raped by a young person at a local school *(when aged 13 years and 8 months old);*

- January 2011 - Rachel was referred to CAMHS by the school because she was saying she wanted to kill herself

- April 2011 - Rachel alleged that she had been a victim of ongoing sexual abuse for the last 3 years since she was 11 years old. Solihull Children's Services (SCS) completed a core assessment which concluded that Rachel's mother was willing and able to keep her safe, and the case was closed in May after Rachel was referred to the Barnardos Amazon Project for support [4].

2.3 A police investigation into the 2 allegations of rape / abuse could not be progressed because of the alleged perpetrators' denials, and Rachel's unwillingness to provide further information. In June 2011, Rachel disclosed that she had recently had sex with a 17 year old boy although she had not wanted this to happen, and was worried she might be pregnant. *(Then aged 14 years and 8 months old).*

2.4 Rachel was referred to CAMHS again that month because of concerns about her self-harming which she explained was due to the ongoing impact of the alleged peer rape, and alleged sexual abuse. CAMHS ended its involvement when Rachel declined the offer of further support, but became re-involved in October 2011 following Rachel taking an overdose, and she was referred to children's services. In December 2011, Rachel became subject to a child protection plan in the category of emotional abuse due to the concern that Rachel was emotionally fragile as a result of her experiences.

---

[4] *Amazon is a specialist counselling service for women and girls that have experienced sexual abuse provided by Barnardos..*

2.5 In early February 2012 CAMHS informed children's services that Rachel was feeling down because no-one believed her allegations about the sexual abuse she had disclosed. Soon after, Rachel asked to come into care because she was finding aspects of her home situation difficult and following discussion at a review case conference, Rachel moved to live with the family of a school friend when she was 15 years old as a private fostering arrangement. This proved positive and the child protection plan was ended in November 2012 with support continuing through child in need processes.

2.6 This living arrangement provided some stability for Rachel for 18 months until October 2013 when she declared herself homeless 2 days before her 17th birthday after she fell out with the friend. Rachel was initially placed in a hostel run by a specialist voluntary organisation, and then given a tenancy in semi-supported accommodation in Solihull.

2.7 At the start of January 2014, Rachel told her GP that she was feeling low and had fleeting suicidal thoughts because she was finding it hard living on her own, and had little contact with her family. Later that month, Rachel made an allegation of rape against another young person living in the unit but did not provide any details. The alleged perpetrator denied the allegation saying the sex was consensual and the outcome of the police investigation was that there was insufficient evidence to either support or negate the allegation.

2.8 In March 2014, following an overdose requiring hospital admission, Rachel became looked after by the local authority [5] and placed in a 4 bed supported accommodation unit with 24 hour staffing where she developed a positive relationship with the unit manager and her social worker.

2.9 In July 2014, the accommodation unit informed the police that Rachel was possibly a victim of sexual exploitation by Male A, aged 30. He had been contacting Rachel to demand sex in return for helping her out when she and friends had no money to get a taxi home. In addition to the sexual exploitation, Rachel had disclosed that Male A was supplying her with drugs, and that she was scared of him because he had a firearm and was part of an organised gang. Rachel agreed to a video interview and medical examination.

2.10 Following the arrest of Male A, who had a criminal record including firearms offences, a complex abuse meeting involving the police and children's services agreed arrangements to keep Rachel and 2 other young women safe, and shared information about Male A to assist the police's further enquiries. When interviewed Male A denied rape, but admitted to having consensual sex and sometimes giving Rachel money. Male A was released on police bail with conditions that he did not make contact with Rachel. The police drew up a trigger plan [6] which included immediate actions to be taken if officers encountered Rachel. At the follow up Review Complex Abuse meeting in August, it was agreed that future planning would be carried out through the Looked After Children's Review meetings and Multi Agency Sexual Exploitation (MASE) meetings. [7]

---

5 *Accommodated under Section 20, Children Act 1989*

6 *A trigger plan may be developed by the police when a person is a high risk missing person at risk of CSE. It contains information about the person, and known associates, which can help direct enquiries, and fast track actions to be considered if the person is encountered.*

7 *The purpose of the MASE meeting is to co-ordinate support and interventions to reduce the risk of child sexual exploitation (CSE).*

2.11 At the first MASE meeting in September 2014, the CSE risk was graded as level 2/3 – medium to high risk.[8] During that month the police investigation was transferred to another police team because it was established that the alleged offences had taken place in the Birmingham area.

2.12 In early October 2014 a joint child protection investigation was carried out after Rachel received text messages of an explicit sexual nature from her step-father. The outcome was Rachel's half sister being made the subject of a child protection plan.

2.13 Rachel became 18 in October 2014 which marked a significant shift in her legal status, as Rachel was now legally an adult. She received statutory support from the children's services 16+ team because of her status as a care leaver. At this point, the protection work through the MASE meetings ended as Rachel was no longer a child and therefore not covered by Solihull LSCB's multi-agency procedures.

2.14 Between November 2014 and January 2015, there were 3 incidents where there were concerns about possible risks of suicide when Rachel was found on a motorway bridge.

2.15 From March 2015 onwards, the Children's Services CSE team recommended to the 16+ team that MASE meetings should be reconvened, but this was not immediately taken up because of uncertainty about the appropriateness of this process being used to address sexual exploitation issues in relation to adults.

2.16 In April 2015, the investigating police officer was finally successful in meeting Rachel who stated that she wished to retract her allegation against Male A. A written retraction statement was subsequently made in June despite efforts by the police officer to dissuade her from doing this.

2.17 In May 2015, Rachel presented as homeless because of fear of violence in the supported accommodation, and was placed in a guest house. Rachel struggled to come to terms with this move and in June was seen at hospital after an overdose. In August 2015, Rachel had to be moved to a hotel at short notice due to Male A having been seen in the vicinity of the guest house. A month later, she was allocated her own tenancy in a flat by virtue of her priority status as a homeless person.

2.18 In September, the MASE meetings were resumed where the risk was assessed as level 3, but subsequent meetings in November and December resulted in the risk being reduced to level 1, and in February 2016, it was agreed that no further meetings were required because Rachel was considered no longer to be at risk of sexual exploitation.

2.19 However, the following month, the college reported that there were clear indicators of Rachel being trafficked within the UK, and she was said to be desperate for help and in fear of her life. During an attendance at the hospital ED, Rachel confirmed that she was being trafficked and explained that she had withdrawn her allegation against Male A because he had threatened to kill her. During April 2016, Rachel presented at college with physical evidence of her suffering continuing violence.

[8] *The Solihull LSCB safeguarding procedures include 3 levels for categorising the degree of risk of CSE. Level 1 - low risk (a child who is at risk of being groomed for sexual exploitation): Level 2 - medium risk (a child who is targeted for abuse): Level 3 significant risk (a child who is entrenched in sexual exploitation, coercion/control is implicit).*

2.20 In May 2016, Rachel agreed to being placed under a Guardianship Order [9] using the provisions within the Mental Health Act, and moved to supported accommodation in Birmingham to provide her with greater safety. However, at a safeguarding adults meeting in June, Rachel stated her wish to revoke the Guardianship because it had not reduced risks and she returned to her own flat. The meeting heard the view of a police officer from the CSE team that there were possibly grounds for Rachel to be placed in “witness protection”.

2.21 At that meeting, Rachel agreed to a referral being made under the National Referral Mechanism, which resulted in the National Crime Agency making a decision in June that there were “Positive Reasonable Grounds” that Rachel was a victim of modern slavery. This development resulted in independent support being commissioned from Black Country Women’s Aid during the 45 day period of reflection pending a final decision on the NRM referral. The NCA arrived at a “conclusive grounds decision” in August that Rachel was a victim of modern slavery. Rachel moved back to the temporary “safe” accommodation, and the following month funding was agreed for an out of area placement.

2.22 During September, when police officers encountered Rachel and her half sister in a distressed state, Rachel reported that that she had been raped by her step-father and provided full details which led to his subsequent conviction.

2.23 Rachel was initially ambivalent about the prospect of moving out of the area because of her worries about the welfare of her younger half sister. However, towards the end of October 2016 Rachel shared her excitement with college about the prospect of a move to the East Midlands but also shared that she was back in her “old routines” and was fearful of the repercussions if she did not agree to engage in sex work. 12 days later, Rachel was found dead at the temporary accommodation in Birmingham. A brief note found in Rachel’s diary led to professionals attending the scene wondering if she had taken her own life.

3. AGENCY INVOLVEMENT 2014 - 2016

3.1 From July 2014 when it was first known that Rachel was the victim of sexual exploitation, the following statistics show the high level of agency involvement:-

- 23 attendances at the hospital emergency department;
- 20 contacts with the hospital mental health Rapid Assessment Interface Discharge Team (RAID); [10]
- 4 periods of involvement from the Adult Community Mental Health Team;
- ongoing support from the Children’s Services 16+ team;
- ongoing involvement of the local authority Adult Social Care and Mental Health Team from March 2016;

---

[9] *Section 7 of the Mental Health Act provides for the making of a Guardianship Order (usually to the local authority), and confers powers to require the person to reside at a certain place, or attend for medical treatment, or require access to the person by any doctor or other mental health professional.*

[10] *The RAID service offers a 24 hour integrated liaison psychiatry service single for all inpatients and people who attend emergency departments in acute hospitals in Birmingham & Solihull who are aged 16 and over.*

- support from the Solihull Integrated Addiction Service (SIAS)[11] between April and July 2016;

- West Midlands Police responded to 13 missing episodes or other crisis situations.

Issues around Engagement

3.2 Despite persistent efforts to support Rachel, most agencies experienced difficulty in achieving effective engagement with Rachel due to a number of contributory factors:-

- missed opportunities to undertake direct work in 2011 to help her share experiences when she made the allegations of rape and sexual abuse;

- Rachel not experiencing the early CAMHS involvement as helpful which possibly led to her questioning the value of the support offered later by adult mental health services;

- a loss of trust in agencies ability to protect her. Several times, Rachel shared her perspective that she felt that her allegations had not been believed, and these had not resulted in any convictions (*This did not reflect the difficulty faced by agencies in progressing investigations because she had not provided information to support these)*

- her experiences of feeling overwhelmed by the number of professionals involved;

- the coercion and threats from her perpetrators. Rachel often indicated that the more professionals tried to contact her, the more she was placed at risk of violence.

- Rachel's chaotic lifestyle which stemmed from her being trafficked at all hours of the day, and the impact of alcohol and drugs - either that she was plied with by her perpetrators or she used to blank out the memories of events.

- the loss of valued relationships established with some professionals because of unavoidable changes in worker or the several moves to different accommodation.

Response to the Sexual Exploitation of Rachel

3.3 Following the disclosure of possible sexual exploitation, prompt and effective action was taken to protect Rachel and other young people at risk through an immediate strategy meeting, 2 complex abuse meetings held in July and August 2014, and the actions taken by the police. This included Male's A's arrest and all appropriate information being placed on the national and local police records systems.

3.4 Subsequent protection planning proved less effective. No detailed CSE plan was drawn up when Rachel's case was moved into the MASE meeting process in September 2014, and the MASE meetings ended soon after when Rachel was 18 years old and no longer came within the ambit of Solihull LSCB's procedures. It was

---

11 *SIAS is a partnership between BSMHFT, Welcome, Changes UK & Aquarius and includes a Young Persons service jointly responsible for the delivery of the drug, alcohol and gambling services, in the Borough of Solihull.*

to be a year before MASE meetings were re-commenced in September 2015. Although referrals were made for direct work to be provided by the Children's Services Specialist CSE Team, this was never achieved because of its limited staffing capacity.

3.5 In addition, the transfer of responsibility for the police investigation contributed to a 9 month gap before the investigating officer was successful in making contact with Rachel in May 2015. During that intervening period, there was no evidence of liaison between the police and children's services to discuss the progress of the investigation, or Rachel's needs for support. It does not appear that any information was provided to Rachel by either agency about the progress of investigation, and as a consequence, Rachel would have felt isolated and exposed to possible coercion from the perpetrator which she later confirmed had led to her retracting her allegation.

3.6 When Rachel became 18, multi-agency protective action was hampered by lack of agreed arrangements for multi-agency working for adult victims. This is a gap which was not unique to Solihull and stems from the lack of national guidance or framework for the type of collaboration which exists for children's cases. It was positive that ad hoc decisions were made to fill this vacuum through the continued use of MASE meetings, and for the CSE and Missing Operation Group (CMOG) [12] to include adult victims on its agenda. However, although Rachel's case was discussed at 18 CMOG meetings between May 2015 and October 2016, this had little impact on the response to the increasing risk or management of her case.

4. KEY ISSUES AND LEARNING

4.1 The learning and priorities for action centre around a combination of strategic, partnership working and practice issues in responding to victims of sexual exploitation both pre and post 18 years of age, the processes and eligibility criteria for identifying support when children transition into adulthood, and issues around joint working in response to adults who go missing.

4.2 The Review has confirmed that there have been a number of important developments during and since Rachel's case, which are enhancing the response to children and adults who are at risk of exploitation, and / or are experiencing mental health issues. However, it also identified that the development agenda remains considerable both in terms of strengthening partnership working, and addressing gaps in service provision.

4.3 A number of the issues are not new and have been identified previously through the work of the CSE Steering Group and / or the findings of the Local Government Association (LGA) Peer Diagnostic Review [13] carried out in November 2017 which led to an action plan to address these and respond to new national initiatives. It has been agreed that this action plan will be updated to reflect the additional insights gained from this SAR.

4.4 The key findings and learning from this SAR will be covered in the following order and groupings:-

- processes for co-ordinating action to protect victims of child sexual exploitation and pursue perpetrators, including the role of, and interface between, MASE meetings and the Children Missing Operations Group (CMOG).;

---

12 *CMOG is the group tasked with co-ordinating action to implement the 4 strands of the Solihull Safeguarding Children's Board CSE Strategy – "Prepare, Prevent, Protect and Pursue".*

13 *LGA safeguarding peer reviews and diagnostics are offered to local authorities to assist the latter's work to continuously improve services.*

- the arrangements for responding to adult victims of sexual offences and exploitation;

- risk assessment; use of the National Referral Mechanism (NRM); [14]

- the differences in legal options which can be considered to protect child and adult victims; issues around consent to sexual activity which is abusive; the impact of coercion on mental capacity;

- the pathways and eligibility criteria for identifying support when child victims transition into adulthood;

- challenges and joint working in identifying "safe" accommodation options;

- return interviews and information sharing in respect of adults at risk who go missing;

- the governance arrangements for directing strategic and operational priorities to protect victims of exploitation;

- the arrangements for commissioning services to address gaps in support.

5. JOINT WORKING PROCESSES FOR CO-ORDINATING ACTION TO PROTECT VICTIMS OF CHILD SEXUAL EXPLOITATION

5.1 Although the Solihull LSCB arrangements for addressing CSE are well established, the SAR findings raises questions around the extent to which the remit of MASE Meetings and the CMOG and the interface between these processes, were being applied effectively.

MASE Meetings

5.2 MASE meetings have a dual function of developing a protection plan for the child based on the risk assessment, but also agreeing action to disrupt perpetrator's activities and gather evidence to support prosecution. However, a focus on the "pursue" function was lacking in the MASE meetings in respect of Rachel which was part of a general pattern picked up in the 2016 Ofsted inspection who observed that this was resulting in significant risks still remaining.

Role of CMOG

5.3 CMOG is designed to be the tactical oversight panel to deliver the CSE Action Plan co-ordinating activity under the 4 strands of the CSE strategy - Prepare, Prevent, Protect and Pursue. As such, it is the key mechanism for providing assurance and challenge that collective work in tackling CSE is having a real impact on the ground.

5.4 CMOG relies on information identified through MASE meetings to build an overall problem profile of victims, perpetrators and places and use this to drive its tactical planning of disruption and pursue activities. However, the gaps in MASE meetings in not addressing the "pursue" agenda hampered this work, and also resulted in CMOG

---

[14] *The NRM which was introduced in 2009 is a victim identification and support process which is designed to make it easier for agencies to co-operate, to share information about potential victims and facilitate their access to advice, accommodation and support. From 31 July 2015 the NRM was extended to all victims of modern slavery in England and Wales following the implementation of the Modern Slavery Act 2015.*

filling the gap and becoming over-focused on discussion of individual cases at the expense of focusing on the bigger picture. This is something which national and local frameworks state should be avoided.

5.5 This created a domino effect through to the CSE Steering Group which strayed into becoming too operational in its focus, and found itself dealing with matters which should be the remit of the CMOG. A contributory factor was that the CSE Steering Group had not been receiving regular formal reports from CMOG as had been intended in order to provide the overall picture, emerging trends, and the impact of action taken. Therefore it was recognised that the group needed to be re-focused onto the strategic agenda.

Action to Pursue Perpetrators

5.6 In September 2015, the CSE Steering Group raised concerns about the extent to which action was being taken to disrupt the activity of perpetrators given the low number of prosecution of offenders in Solihull compared to Coventry. Given that both areas are covered by the same police CSE team, this suggested that the difference was not related to the police response but to other local factors. One factor was the lack of prompt sharing of information hampering CMOG's work.

5.7 The outcome of the discussions was to make the "pursue" agenda the group's top strategic priority. The Review was assured that this is now resulting in more effective mapping, more effective sharing of information, and the partnership network operating in a healthy way. In addition, investigations are benefiting from the use of a Strategic Management Group to oversee complex CSE investigations and co-ordinate action. However, although recent cases have generated considerable learning for partners, there is still some way to go before these processes are firmly embedded across both the adult and children's safeguarding partnerships.

5.8 The findings from this SAR therefore reinforce the recommendation of the 2017 LGA Peer Diagnostic Review that a review is carried out of the links between MASE meetings, CMOG and the CSE Steering Group, in order to ensure that these dovetail.

6. PARTNERSHIP WORKING ARRANGEMENTS FOR VICTIMS OF SEXUAL EXPLOITATION / MODERN SLAVERY POST 18 YEARS OF AGE

6.1 This report has previously referred to how the effectiveness of multi-agency working in respect of adult victims is affected by the lack of formal arrangements in SSAB's multi-agency procedures. As highlighted earlier, this reflected the lack of statutory and national policy on this area due to this issue previously having a lower national profile. Although it is positive that pragmatic solutions were found to fill that void through the continued use of MASE meetings for over 18s and for them to remain on the CMOG agenda, the ad hoc nature of the CMOG arrangements have some crucial downsides because of the under-developed feedback loops with adult agencies.

6.2 This gap contributed to some weaknesses in the co-ordination of support in Rachel's case particularly after the adult mental health team became involved and was working alongside the continuing statutory involvement of the 16+ team. This appears to have led to some differences in understanding as to which professional from these 2 teams held the lead role for co-ordinating support. This points to the need to ensure there is agreement about which agency is taking the lead role, and greater clarity for other agencies involved to understand the communication channels.

Information Sharing

6.3 Although there was generally prompt and appropriate information sharing in Rachel's case, there were 2 types of situation where this did not happen. The first was where professionals relied on others to share information or make referrals following crisis interventions. The downside of first hand information not being passed on is that the full extent of the safeguarding concern can be masked. This was an issue highlighted in an Ofsted thematic review of serious case reviews in 2011[15], and also featured in the case reviews of sexual exploitation in Rochdale [16] and Newcastle.[17]

6.4 The second was professionals feeling constrained from sharing information without Rachel's consent, and that her right to withhold consent needed to be respected even when there were clear indications that there was not only a risk to herself but also potentially to other young people. An example was the 16+ team initially not feeling they could share information with the CSE team when Rachel disclosed that she was being trafficked. On occasions this led to some tensions and disagreements.

6.5 This latter finding indicates a need to remind professionals of the guidance such as that published by SCIE, [18] the College of Policing, and the recent national guidance covering information sharing in children's cases. [19] These explain that a professional can reasonably override a person's decision not to give consent where other people may be at risk, a serious crime has been committed, or might be prevented, or where coercion appears to be influencing the decision not to give consent. In these circumstances, sharing information would be considered legally proportionate, and avoids the risk of data protection concerns being used as an excuse to withhold information.

6.6 In considering whether to share information without consent, it is important of course to weigh in the balance not just the above factors, but also the consequences of going against their wishes. This might result in a loss of trust and reduced engagement with professionals which could lead to an increase in the risks rather than diminishing them. Where professionals are uncertain on whether they are justified in sharing information, advice should be sought from their safeguarding leads and / legal advisors.

6.7 Given the uncertainty around this issue in Rachel's case, there would be value in the Safeguarding Adults Board seeking assurance that local information sharing agreements provide the necessary clarity on this issue, and provides a framework for swift information sharing without the need to negotiate access to information on an individual case-by-case basis.

---

15 *Ages of concern: learning lessons from serious case reviews: A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011. Ofsted. 2011*

16 *The Review of Multi-Agency Responses to the Sexual Exploitation of Children in Rochdale; Rochdale Borough Council. 2012*

17 *Joint Serious Case Review Concerning Sexual Exploitation of Children and Adults with Needs for Care and Support in Newcastle-upon-Tyne - Newcastle Safeguarding Children Board and Newcastle Safeguarding Adults Board – published February 2018*

18 *"Adult safeguarding: sharing information" - Social Care Institute for Excellence (SCIE) January 2015*

19 *"Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers" – HM Government - July 2018*

Partnership Working with the Police

6.8 The Review identified that work needs to be done to strengthen the partnership working with the police given the finding that other agencies appear to lack sufficient understanding about the police's approach and organisational arrangements for investigating allegations of sexual offences and human trafficking in respect of adult victims, and the factors influencing these. One issue where there appeared to be uncertainty is the criteria and arrangements for the transfer of cases from the police CSE team to the adult sexual offences team. It was clarified that the police CSE team will continue to retain responsibility when young people reach 18 years of age until the completion of any ongoing investigation.

6.9 Another area of uncertainty is the arrangements for sharing information and how this will be followed up by the police. The Review identified that there appears to be a gap around collaboration to draw together the "bigger picture" in terms of adult victims, suspected perpetrators, and locations, which might support a co-ordinated approach to pursuing perpetrators. A significant contributory factor for this is that the national framework covering the response to adult victims does not lay down mandatory requirements for the kind of joint working which exists for children's cases as set out in Working Together, associated national guidance and the West Midlands CSE framework. These set out the wider responsibilities of the police to work with partners on gathering and sharing intelligence and protection planning for victims of sexual exploitation.

6.10 An important factor governing the police's approach is that sexual exploitation of adults is not an offence in itself, unless it involves trafficking. Therefore for the sexual offences team to commence an investigation, there needs to be a complainant and a reported offence. Where no criminal offences are apparent there is no requirement for continuing police involvement although WM Police do signpost victims to local statutory partners where they might seek assistance with their specific needs.

6.11 A key priority therefore will be to explore the opportunities for joint working with the police to share information, and support the victim through the investigation process to secure their engagement with the investigation. This is especially important in cases like Rachel who either could not disclose because of coercion, or would not disclose because she lacked confidence as to whether she would be believed or would be protected.

6.12 Looking at emerging best practice in other parts of the country, possibilities for closer collaboration might include the development of an adult multi-agency safeguarding hub (MASH) or a "family" MASH which delivers an integrated approach covering both adults and children's cases. In addition, there may be transferable learning from the arrangements for holding a Multi-Agency Risk Assessment Conference (MARAC) in high risk cases of domestic violence which has proved an effective model for sharing on information and managing risk. The Review Panel also noted that the developing initiatives around Modern Day Slavery could make a significant difference as this provides a legitimate basis for collaboration.

7. RISK ASSESSMENT

7.1 In reaching a view through the MASE meetings in late 2015, that the risk of ongoing exploitation was low, professionals did not contextualize the information shared sufficiently which would have indicated the possibility of continuing risk. This downgrading of risk stemmed from insufficient weight being given to several pieces of concerning information and an over optimistic view of some recent positive factors. The decision reached did not reflect the advice in national and local sexual

exploitation frameworks which advocate the need for caution before ruling out the possibility of exploitation taking place. The decisions in Rachel's case appear not to have been an isolated example as the 2017 LGA peer diagnostic report also picking up on the inconsistencies around risk assessment with examples of young people moved up or down the risk levels without the reasons being immediately apparent.

7.2 It is important therefore that when professionals are using the Solihull CSE multi-agency risk assessment tool account is taken of the observation provided by "Research in Practice" [20] that whilst the use of suggested 'risk indicators' is helpful, these should not be used as a prescriptive and definitive list. More important is a critical analysis of the complex presenting evidence which takes account of the history, the behavior of a young person and the context in which they are functioning.

7.3 This approach becomes particularly important in cases when there is insufficient evidence to support a prosecution, in order to avoid assessments being unduly influenced by the lack of disclosure. The 2016 SCIE guide highlighted the risk of other agencies 'stepping down' their response when victims do not want, or are unable to support a criminal investigation.

8. CONSENT TO SEXUAL ACTIVITY WHICH IS ABUSIVE

8.1 During the Review, questions were raised as to the extent both professionals and young people understand the concept of consent in respect of sexual activity which is abusive, and it was agreed that there would be value in exploring the benefits of promoting in local practice the "social model of consent" being led by Professor Jenny Pearce and the University of Bedfordshire. This model provides a framework for understanding why children and young people might appear to be consenting to sexual exploitation and abuse. Underpinning the model is the observation that all too often the focus and attention has been on the behaviour of victims who are often inappropriately blamed for apparently consenting to sexual exploitation, rather than assessing the impact of the environment surrounding them. While their research is focused on children the thrust of their approach is equally applicable to adult victims.

8.2 The proposed model presents 4 areas to assist professionals in identifying the context of the abuse to help establish if the child or young person is being groomed, or engaging in survival sex because of financial pressures, or is being affected by the normalisation of sexual violence as projected through violent pornography or through peer group patterns that accept violence as part of everyday life. The model also acknowledges that there can be an issue that the abuse is being overlooked or ignored through what it terms a culture of 'wilful ignorance', where professionals or others in contact with the child turn away from the truth of what is happening.

9. NATIONAL REFERRAL MECHANISM

9.1 The Review identified the need to increase professionals' awareness of the importance of the NRM, its potential benefits, how the referral process works, and the importance of effective joint working with agencies commissioned to provide independent support during the 45 day reflection period following a "positive reasonable grounds" decision. This finding stemmed from:-

- the lack of coverage, or accurate information in local agency records, about the NRM process;

[20] *https://www.rip.org.uk/resources/publications/evidence-scopes/working-effectively-to-address-child-sexual-exploitation-evidence-scope-2017*

- insufficient, or delayed information sharing between local agencies about NRM developments and notifications received from the Salvation Army / NCA regarding Rachel's NRM status;

- the problems which arose initially around liaison with the Salvation Army and BCWA, the agency commissioned to provide independent support;

- local professionals appearing uncertain as to what support might be sought from the independent provider.

9.2 It was confirmed that a training programme has been developed through the West Midlands Region Preventing Violence against Vulnerable People Programme (PVVP) [21] which will be delivered in Solihull once local pathways have been agreed.

10. ARRANGEMENTS FOR WITNESS PROTECTION

10.1 The Review exploration of the reference in June 2016 to the possibility of Rachel being eligible for "witness protection" identified that there is the potential for misunderstandings through the generic use of this term. Professionals need to be aware of the significant differences between local arrangements which can be made by the police and / or safeguarding partners, which may include relocation, and the national arrangements provided through the United Kingdom Public Protection Service (UKPPS).

10.2 The UKPPS [22] is a bespoke covert service, co-ordinated by the National Crime Agency, which provides protection to people judged to be at risk of serious harm, including witnesses, but potentially also people assisting in serious criminal investigations and others including those in danger of honour based violence. Although the eligibility criteria was widened in 2014, [23] UKPPS operates at the high end of risk where there is a real and immediate risk to the life, and the protection arrangements required are beyond those which can be provided through the local arrangements. WM Police clarified that Rachel's circumstances would not have met the criteria for the UKPPS.

10.3 Being clear which arrangements are being considered, and using the correct terminology, ensures that victims, and other professionals involved, have accurate information about the practicalities and implications of the options being offered. For some young people, the thought of going into "witness protection" could be off putting given the often negative coverage in the media about the life changing impact which can result in being cut off from their family, friends and community. In addition, it is important to avoid the possibility of professionals acting on the belief that "witness protection" has, or is going to be offered, and not giving sufficient consideration as to what safety plans they can put in place.

---

[21] *The West Midlands PVVP, established in 2013 and jointly local authority and police funded, has a number of work streams which include CSE, modern slavery and human trafficking.*

[22] *The UKPPS was formed in 2013, bringing together what were previously called Witness Protection Units into new teams of police and National Crime Agency officers which are arranged regionally.*

[23] *The eligibility for public protection was originally set out in the Serious Organised Crime and Police Act 2005 (SOCPA). Eligibility was widened through amendments made to SOCPA 2005 by the Anti-Social Behaviour, Crime and Policing Act 2014 enabling protection arrangements to be made for anyone whose safety may be at risk by virtue of another person's possible or actual criminal conduct. The making of such arrangements are not dependent on their being an actual or potential witness in legal proceedings.*

11. LEGAL OPTIONS TO PROTECT VICTIMS

11.1 This case has again highlighted the challenges faced by professionals in identifying if there are legal options which can be considered to protect victims. This was an issue picked up in the 2018 Newcastle Joint Safeguarding Review and led to 2 recommendations being directed to the national government to review the arrangements for obtaining authority to control or restrict the liberty of children and vulnerable adults at risk of sexual exploitation, and carry out a review of the criminal law to ensure that it provides a range of criminal offences that reflect the body of knowledge about sexual exploitation.

11.2 For children, there may be circumstances where an application can be made to the High Court under Section 100 of the Children Act 1989 requesting that it exercises its powers of Inherent Jurisdiction. However, this will only be accepted by the court if it can be shown that there are no other orders under the Children Act 1989 available to safeguard a child.

11.3 Case law has provided some clarification on the criteria for such applications, and the scope of injunctions which can be made. [24] However, questions have been raised within the legal arena as to how wide ranging injunctions should be, and whether there are more appropriate powers that could be used since the advent of Sexual Risk Orders [25] and Sexual Harm Prevention Orders. Legal commentators have made the observation that further case-law would be beneficial to provide further clarification given that Sexual Risk Orders and Sexual Harm Prevention Orders are narrow in their scope.

Legal Options for Adult Victims

11.4 In Rachel's case, an added complication is the question of mental capacity. For an application to be accepted by the Court of Protection, or the High Court, robust evidence would need to be submitted that coercion is impacting on a person's mental capacity when making decisions that potentially could place them at serious risk.

11.5 Although Rachel's mental capacity may have been temporarily impaired at times because of either coercion, poor mental health, or the effects of alcohol and drugs, this was said not to have been apparent during contacts with professionals, including the occasions when formal and robust MCA assessments were carried out. However, the Review concluded that there was possibly insufficient deeper evaluation of the impact of the coercion on Rachel's capacity to "use and weigh" the information not just in making a decision, but also the ability to act on her choices to keep herself safe.

11.6 Although coercion was a feature in Rachel's case, pursuing the Court of Protection or Inherent Jurisdiction option were not viewed as a viable route to pursue. Instead the use of the Guardianship provisions within the Mental Health Act was seen as an alternative and creative response to try and achieve greater protection. However, it was quickly found it did not deliver this because the effectiveness of Guardianship

---

[24] *The case of Birmingham County Council v Riaz_ in 2014 established that injunctions can be made in respect of perpetrators and these can be wide-ranging.[24] However, the subsequent case of Redbridge London Borough Council v A in 2015[24] established that the power to make injunctions against identified perpetrators is only exercisable in relation to a known child who is the subject of the proceedings.*

[25] *The Sexual Risk Order replaced the Risk of Sexual Harm Order (ss.122A-122K Sexual Offences Act). If granted the Sexual Risk Order will last for a fixed period, not less than 2 years, or until further order. The only prohibitions that may be included within the order are those that are necessary to protect a specific child or adult, or to protect children or adults generally (section 122A(9)).*

was entirely dependent on Rachel's continuing co-operation as the powers are not enforceable such as the stipulation as to where she should reside.

11.7 Against this complex background, it is essential that professionals have access to up to date information about the legal framework and current case-law. This will help them identify possible options at an early stage and seek the necessary legal advice. This is particularly important in relation to cases involving adults because most of the national and local guidance such as that published by the College of Policing, the Crown Prosecution Service (CPS) and the West Midlands CSE Disruption Toolkit is in the main directed at the options in dealing with cases involving children. As yet there is no corresponding guidance in relation to the legal options in respect of adults.

12. RESPONSE TO CHILDREN AND ADULTS WHO GO MISSING

12.1 Most of the missing episodes occurred when Rachel was an adult and these were reported, and responded to quickly by the police. However, The Review has highlighted a number of issues in relation to the use of trigger plans, the arrangements for return interviews and the thresholds for sharing information after someone is located.

12.2 A significant contextual issue here is that there is no comparable multi agency statutory framework or national guidance, as exists for children's cases. This was cited as a major gap in the report published in July 2018 by the All Party Parliamentary Group (APPG) for Runaway and Missing Children, [26] with a recommendation that the Home Office and the Department of Health and Social Care should develop joint guidance on multi-agency working as part of the implementation of the Missing Children and Adults Cross Government Strategy. [27]

12.3 A concern raised in the APPG report which is relevant to the findings from this Review, are the arrangements for return interviews which provide the opportunity to explore the reasons for a person going missing in order to minimise further incidences. In respect of possible victims of sexual exploitation and trafficking, these are vital to try and draw out their experience, obtain descriptions of perpetrators, places they were taken to, or routes taken, so that a detailed intelligence picture can be built up to assist in the pursuit of perpetrators.

12.4 However, while return interviews are a statutory requirement for children's cases [28] for adult cases, the only guidance is that issued by the College of Policing. [29] In addition to the immediate "prevention" interview, which WM Police always carry out and is good practice, individuals should be offered the opportunity to engage in a more in-depth interview. However, the APPG report's finding was that these are not currently being provided in any police area in the country.

---

[26] *"Inquiry into safeguarding missing adults who have mental health issues" - All Party Parliamentary Group (APPG) for Runaway and Missing Children – July 2018*

[27] *"Missing Children and Adults - A Cross Government Strategy" - Home Office 2011*

[28] *Paragraphs 31-32 in the "Statutory guidance on children who run away or go missing from home or care" –in the Department of Education - January 2014 - This requirement is included in the West Midlands CSE Strategy. There are two stages to the process - the immediate "safe and well check" carried out by police officers, [28] and the more in depth Return Home Interview (RHI) to be completed within 72 hours, normally by an independent person with appropriate training.*

[29] *Section 12.1 - College of Policing Approved Professional Practice – Major Investigation and Public Protection – Specific Investigations - Missing Persons Investigations*

Referrals and information sharing when missing persons are located

12.5 The Review identified that there still appears to be some uncertainty locally around when, and whether, referrals should be made by the police once a person is located, and the legal basis for doing this. The College of Policing APP advises an individual should be referred to social care when there is concern that the person requires extra help beyond those services routinely available to the general public.

12.6 On many occasions in Rachel's case, the police did not share information with Children's Services which was said to be because the view taken was that Rachel's consent would be required, and second a referral to children's services was not required as she was an adult. This approach did not take account of the "fast track" action in Rachel's trigger plan that Children's Services should be informed immediately. It appears that officers were unaware that children's services were still involved on a statutory basis because of her care leaver status, and raises questions as to the extent that officers referred to the trigger plan.

12.7 Since Rachel's case, there have been a number of developments which have strengthened the response to both children and adults going absent or missing. Within schools, revised local guidance has seen a much stronger focus on children missing from education and the recognition of this being a potential safeguarding issue.[30] Children's Services also changed their processes around missing children in March 2017, with clearer expectations around follow up action and recording, including return interviews to improve intelligence sharing with the police.

12.8 The initiatives from July 2015 by WM Police, overseen by its Missing Person Operations Group, has seen the implementation of a revised missing and absent person policy, which together with operational changes, [31] have resulted in greater emphasis on the initial assessment of notifications to direct its response. Since 2016, a force-wide 'Locate' team has been set up who take over missing persons enquiries, both for adults and children, making greater use of trigger plans, and developing early intervention and prevention plans with partners. However, while noting the improvements these changes have brought, the most recent 2017 PEEL inspection of West Midlands Police found that there were still inconsistencies in the response during the early stages, and trigger plans are not always updated, or lack specific actions.

12.9 Notwithstanding the positive developments, the Review findings suggest that there are still issues which need to be addressed, and lends support to the advice in the College of Policing APP that local multi-agency protocols should agree a threshold for when referrals should be made, particularly when the individual is a repeat missing person, or the individual has experienced, or is likely to experience, significant harm.

12.10 Such multi-agency protocols would reflect the importance of a multi-agency approach as advocated in the APPG report and the 2011 Cross Government Strategy which identified the collective responsibility of agencies to deliver strategies covering prevention, protection and provision – rather than this being seen as solely the responsibility of the police. The APPG cited evidence that local protocols have resulted in improved exchange of information and better joint working, thus enabling partners to make better informed assessments of adults at risk of harm and be better prepared to support those who are vulnerable.

---

[30] *Solihull MBC Designated Safeguarding Leads in Education Handbook, March 2017*

[31] *Responsibility was transferred to the control room to improve management of risk at the initial point of contact and speed up the force's response*

13. HOUSING OPTIONS / RESPONSE TO HOMELESSNESS

13.1 This Review has again brought to the fore the challenges in identifying safe accommodation for victims. Rachel had many accommodation placements of different types – private fostering, supported and semi-supported, 24 hour support, respite accommodation but none of them proved to be safe and / or sustainable. The potential for continuing risks of sexual exploitation highlight the importance of full information sharing between agencies about known risks and areas to be avoided so that housing agencies can take this into account when identifying possible housing options. This did not happen initially in Rachel's case.

13.2 There have been some significant changes since the period covered by this review. A purpose built 21 unit supported accommodation facility for single people and childless couples opened in 2017 which may have been an option for Rachel if it had been available then. In addition, there is evidence that Solihull Youth Hub is having a positive impact. This was commissioned in April 2017 on a two-year pilot basis delivered by an agency that specialises in working with young people aged 16 to 25 who are homeless or threatened with homelessness. The Hub provides an individual assessment of housing and support needs, access to a range of housing options, and access to a range of specialist support services including housing related support, benefits advice, and employment / education advice.

13.3 The Review also noted that the implementation of the Homelessness Reduction Act (HRA) from April 2018 and the revised code of guidance [32] may provide an opportunity to influence future developments as it strengthens the duties to prevent and relieve homelessness for all eligible people, regardless of priority need and intentionality. The Review Panel agreed that it will be important for the Safeguarding Adults Board to receive a report outlining how the findings from this SAR and the additional statutory requirements introduced by the HRA, are being used to further develop the response and service provision to meet the accommodation needs of adult victims of sexual exploitation. This should also cover any related homelessness initiatives, pathways or enhanced partnership arrangements.

14. TRANSITION AND SUPPORT WHEN VICTIMS REACH 18 YEARS OF AGE

14.1 One of the key findings from the Review is the need to firm up the multi-agency pathways and eligibility criteria for considering what support might be provided when child victims transition into adulthood. Currently there is a lack of robustness in the transition pathways unless they are "looked after" children where there are statutory responsibilities entitling them to continued support up to the age of 25 from the local authority. For other young people, their circumstances and needs do not readily fall into the existing transition arrangements and referral routes into adult services – those provided by all agencies not just the local authority. This can result in professionals being unsure about what different services can offer, the referral criteria, and the care pathways for accessing these.

14.2 Where transition to adult services has been achieved, this has largely been due to the good will and creative solutions of some teams in finding ways of providing support because of an ongoing concern to safeguard young adults at risk. However, the processes followed, and arrangements made, are not currently set down in a formal pathway or covered by any governance framework.

---

32 *Homelessness Code of Guidance for Local Authorities – Ministry of Housing, Communities and Local Government – February 2018*

14.3 Again an important contextual issue here is the gap in national policy and guidance covering transition and service responses to adult victims of exploitation, and there being no specific references to a duty on particular agencies to provide services to this group.

14.4 The current position therefore is that while both the adult and children's safeguarding arrangements set out responsibilities for preventing abuse and neglect, the differences in the national frameworks can result in a very different system response more governed by the age of the service user rather than the risk. The children's system has a clear focus on welfare and emphasises protection of children from harm and promotes risk management approaches. Whereas for adults, current legislative frameworks places an emphasis on promoting wellbeing and that adults have the right to make informed decisions about their own lives, even if those decisions appear unwise. The difficulty which can arise around this key principle is when coercion or other factors become so significant that they have a serious adverse impact on how this 'right / ability' is exercised. This was evident in Rachel's case where her ability to make decisions to stay safe was impaired by the abuse and exploitation she was experiencing.

14.5 A key issue therefore is the approach adopted in applying the provisions of the Care Act 2014. There is considerable concern nationally among professionals that a strict interpretation of the eligibility criteria can result in victims of sexual exploitation not qualifying for services and / or a safeguarding response because they are not assessed as having care and support needs. The consequence is victims remaining at risk of further exploitation.

14.6 In considering how to address this, the prevention duty in the Care Act provides a possible platform for more flexible approaches in considering how young adults at risk of exploitation can access appropriate support. It is also important to bear in mind the potential cost benefit to early intervention and support because without it, victims are likely to appear elsewhere in the health and social care system as they grow older which may result in more costly service responses.

Access to Mental Health Support

14.7 The Review findings reinforce the importance of access to ongoing mental health and therapeutic support for victims moving into adulthood. This group is one of those identified in the 2013 report of the Joint Commissioning Panel for Mental Health (JCPMH)[33] as being at high risk of experiencing negative longer term outcomes in terms of developing mental health or conduct problems where difficulties are encountered around transition. However, a previous national study tracking transition outcomes revealed that up to a third of teenagers, mostly with "emotional disorders", whom CAMHS considered were suitable for transfer to adult mental health services, lost mental health support because referrals were not made. This was either due to the young person not wanting to be referred, or CAMHS practitioners pre-judging that the referral was unlikely to be accepted. The study also revealed that a further third experienced an interruption in their care. [34]

---

[33] *Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services - February 2013*

[34] *Process, outcome and experience of transition from child to adult mental healthcare: multi-perspective study. Singh, S.P., Moli, P., Ford, T., Kramer, T., McLaren, S., Hovish, K. et al (2010). British Journal of Psychiatry, 197(4), pp. 305–312.*

14.8 A contributory factor to the problems around transition picked up in the JCPMH report is the marked difference in the services offered by CAMHS and adult mental health (AMH) services which stem from their systems, structures, and ethos. While CAMHS provide support around a wide range of mental health issues, AMH services tend to focus on services for people with severe and enduring illnesses such as psychosis or severe depression.

14.9 A further difficulty is that commissioning of CAMHS and AMH services often takes place within different frameworks which can result in care pathways being developed separately. This was an issue during Rachel's case with CAMHS and AMH services being delivered by different mental health trusts. This has changed with the development of SOLAR which sits in the same trust as AMH services. This has led to reported improvements in service access, joint working and handover at transition.

15. COMMISIONING ISSUES AND ARRANGEMENTS

15.1 The Review has confirmed that there are limited support options available following initial involvement with the Sexual Assault Referral Centre (SARC), and limited outreach support which is seen as a key element of engaging with victims whose often chaotic lives make it difficult for them to access clinical based services. Anecdotal evidence would indicate that there are lengthy waiting lists for support from the Rape and Sexual Violence project (RSVP). A further gap, both in relation to adult and child victims, is the limited service options for those experiencing some form of post traumatic stress disorder (PTSD).

15.2 During 2017, an important joint initiative was made through the work of what was referred to informally as the "4 Boards Group" comprising the managers of the 2 Safeguarding Boards, the Community Safety Partnership and the Public Health officer supporting the Health and Well-Being Board. Their work led to several discussions at the Solihull LSCB's CSE Steering Group flagging up the difficulties around transition and support post 18 years of age.

15.3 One product of this collaboration was the development of a draft business case setting out the rationale to create a new team to support 16 -25 year old people experiencing, or at risk of, sexual exploitation. A key element of the proposal is that this would provide support to young adults who do not have care and support needs as defined within the Care Act 2014. The draft business case has recently been updated to reflect the findings from this Review, and notwithstanding the current challenging financial climate in identifying the necessary funding, sets out a good foundation on which to build a final, multi-agency business plan. Given the potential positive impact in addressing the current gaps, this is seen as one of the most important recommendations from this Review.

Commissioning Arrangements

15.4 In considering how the proposed new service can be considered, and other gaps in provision might be addressed, the Review identified the need for greater clarity around the commissioning arrangements. These are perceived as being very complex because there are a variety of possible services that could be construed as relevant to the exploitation agenda, and responsibility for considering these sits with different partnership groups.

15.5 The complexity of the arrangements became apparent from the number of different groups / boards identified where commissioning activity is taking place:-

- Solihull Partnership
- Health and Well Being Board
- Solihull Together Partnership
- Corporate Parenting Group
- Birmingham and Solihull Sustainability and Transformation Partnership
- Safer Solihull Partnership (Community Safety Partnership)

15.6 The perception of some panel members is that too often these are operating in isolation with insufficient cross dialogue between them. Consequently, there is uncertainty and no shared understanding of where commissioning for this group is, or should be, taking place. Nor is there a shared understanding of whether there is a hierarchy around the various partnership groups / boards, and whether there is one particular board where issues can be taken for direction.

15.7 As referred to earlier, a contributory factor to this uncertainty is the lack of a national framework setting out the statutory responsibilities that require, or give a power to, agencies such as the local authority, CCG or the police to provide support to victims of sexual exploitation. This can create a difficulty locally when there is a need to identify a lead agency prepared to 'co-ordinate and lead' multi agency developments. An added layer of complexity and uncertainty stems from how local development work fits with regional initiatives which the Review Team was informed was taking place, for example the work being undertaken through the Preventing Violence Against Vulnerable People Programme (PVVP).

15.8 A high priority therefore is the need for agreement on the commissioning framework the processes to be followed, and the governance arrangements in order to provide the necessary clarity for commissioners and providers on where and how decisions will be made. Second is the development of a comprehensive commissioning strategy with respect to reducing the risk of exploitation of vulnerable people and provision of key support, which maps existing services, both in the public and voluntary sector, in order to identify the gaps and develop affordable options to address these. .

15.9 While responsibility for leading and delivering this strategy rests with the commissioners from the statutory partners - the local authority, CCG and WM Police – it is essential that there is close collaboration between the 2 Safeguarding Boards, the Health and Well Being Board, and the Community Safety Partnership (Safer Solihull) in seeking assurance that the strategy is being delivered. The involvement of the latter is vital given its theme of addressing "hidden harm" in the Community Safety Plan 2018-21 which includes a priority on focusing on child sexual exploitation and modern slavery / human trafficking.

16. GOVERNANCE ISSUES

16.1 The Review findings led to the Panel agreeing that there should be a review of future governance arrangements for driving the work to implement the findings from this Review, and the existing action plan which was drawn up following the LGA Peer Diagnostic Review. This is because the issues around transition are a shared agenda for the Safeguarding Adults Board and Solihull LSCB, and the Community Safety Partnership's role in leading the "Prevention and Pursue" elements of Solihull's strategy for tackling exploitation.

16.2 The key issue identified in respect of the existing governance arrangements is that although the officers supporting the 4 boards came together as equal partners, all development work around transition and post transition support for young adults is routed through Solihull LSCB's CSE Steering Group. The Review heard the perspective of adult service representatives that it was proving difficult for them to influence how that work plan is being delivered and learn what progress is being made. A further observation is that the action plan is largely children focused, and the necessary updating of the action plan will need to address the transition issues and work to strengthen the partnership working in respect of adults.

16.3 In thinking through how a greater joined up approach might be achieved, the Panel took account of the fact that following the Wood Report, [35] the Government passed legislation which will result in LSCBs being replaced by new "safeguarding partner arrangements". [36] Given these imminent changes, the panel agreed that an opportunity exists to consider replacing the CSE Steering Group with a cross age joint strategic group which can direct activity in respect of both adults and children. This wider role would reflect the decision previously made by the CSE Steering Group to widen its remit to encompass all forms of exploitation, and offer the best option for co-ordinating multi-agency initiatives and action.

16.4 To ensure the effectiveness of this group, it will be essential that there is a shared vision of its purpose, clear terms of reference, the appropriate multi-agency membership, and the responsibilities defined. In terms of membership, it will be important to broaden the membership to include services that have regulatory powers which can contribute to the "pursue" element of the exploitation strategy for example those in relation to licensing, trading standards, and parks management.

17. MULTI AGENCY RECOMMENDATIONS

17.1 In addition to the following multi-agency recommendations which flow from the SAR findings, most agencies had previously identified the early learning for their own organisation when carrying out their individual management reviews, which they translated into an action plan to implement their single agency recommendations.

Multi Agency Recommendations

1. SSAB, Solihull LSCB and Solihull Community Safety Partnership should agree to establish a single joint strategy group, reporting to all three boards, with responsibilities to develop strategic priorities, co-ordinate actions and oversee delivery of these, in respect of both children and adults who are victims, or at risk of exploitation. This group would replace the existing CSE Steering Group.

2. Solihull SAB, Solihull LSCB, and Solihull Community Safety Partnership should work in collaboration to seek assurance that their statutory partners, with the support of other member organisations, develop an action plan, with target dates and milestones, to strengthen multi-agency partnership working and service development in response to sexual exploitation of children and adults, which ensures:-

---

35 *Wood Report - Review of the role and functions of Local Safeguarding Children Boards – March 2016. Commissioned by the government, it set out recommendations for a new framework for improving the organisation and delivery of multi-agency arrangements to protect and safeguard children.*

36 *The details on these new arrangements are set out in Working Together 2018, and the related Transitional Guidance issued in July 2018 [36] with a requirement that from 29th June 2018, local authority areas must begin their transition to the new arrangements and publish these by 29th June 2019. Following a 3 month transition period the new arrangements must be operating by 29th September 2019.*

- there is a multi-agency commissioning strategy which maps the current gaps in support for adults who are victims of sexual offences, or at risk of sexual exploitation, and establishes priorities to address these;

- a clear framework for multi-agency commissioning which sets out the roles, responsibilities, decision-making arrangements and processes to be followed;

- delivery of the findings from this Safeguarding Adults Review, the 2017 LGA Peer Diagnostic Review, national guidance, and draws on best practice and emerging models of partnership working across the UK.

- early consideration of the draft business case, when this is finalised from its current draft status, to establish a multi-agency specialist service for people aged 16 to 25 years.

3. SSAB, in consultation with the Solihull LSCB, should seek assurance from their statutory partners that there are agreed joint processes and clear pathways to ensure appropriate support for children who are victims, or at risk of all types of exploitation, including sexual exploitation, as they transition into adulthood.

4. SSAB should seek assurance from its statutory partners that joint protocols and multi-agency procedures ensure a shared understanding across the wider partnership of:-

   - agency roles, responsibilities and arrangements for responding to possible sexual offences and / or sexual exploitation of adults;

   - multi-agency processes for sharing information to co-ordinate support for victims, and action to prosecute, and / or disrupt the activities of alleged perpetrators;

   - the criteria for developing trigger plans and how they are used.

5. SSAB and Solihull LSCB should each receive assurance from their statutory partners that there are quality assurance processes in place to support effective and consistent practice in the use of the multi-agency risk assessment tool for cases involving sexual exploitation.

6. SSAB and Solihull LSCB should seek assurance from their statutory partners that professionals across the wider partnership have the necessary understanding of the processes and possible benefits of the National Referral Mechanism for victims of human trafficking, including the importance of partnership working with the agency commissioned to provide independent support when a “positive reasonable grounds” decision has been made.

7. SSAB should seek assurance that relevant professionals have access to updated legal guidance, including reference to current case-law, on the different legal options which are available to protect adult victims of sexual exploitation, including situations where mental capacity may be impaired because of coercion.

8. SSAB should seek assurance from member agencies that their quality assurance arrangements and training programmes ensure that their staff are aware of the circumstances in which information can be shared without consent.

9. SSAB should seek assurance from its statutory partners that there are multi-agency protocols and guidance which ensure there is a shared understanding across the wider partnership of the arrangements for responding to incidences of adults reported

as missing, including the arrangements for return interviews, information sharing, and joint working to minimise the risk of further episodes.

10. SSAB should request a report from Solihull MBC and Solihull Community Housing outlining how the findings from this SAR and the additional statutory requirements introduced by the Homelessness Reduction Act, including any related homelessness initiatives, pathways or enhanced partnership arrangements, are being used to further develop the response and service provision to meet the accommodation needs of adult victims of sexual exploitation.