Shropshire Safeguarding Community Partnership

Safeguarding Annual Report and Community Safety Needs Assessment

2022 - 23

Contents page

Foreword by Key Partners	3-6
Information about Shropshire	7
Introduction	7-8
What we achieved this year	8-24
What we know about crime, adult safeguarding, children at risk in Shropshire	25-40
Impact on adults and children and their families in practice	40-54
Hearing the voice of children and families, adults with care and support needs and victims of crime	54
Our approach to learning and development	55-62
Changes to published arrangements	63
The effectiveness of these arrangements in practice	63-65
What we want to achieve next year	65-66
Closing scrutiny statement	66-67

Foreword by Key Partners

Tanya Miles, Executive Director of People, Shropshire Council

Shropshire Safeguarding Community Partnership publishes an annual report each year that highlights the work as partners we do, to ensure Shropshire is a safer place for our children and adults. The annual report provides an opportunity to recognise our collective achievements, delivery against our priorities and also reflect on where we need to focus our work to ensure we continue to prevent, reduce, and remove harm.

During 2022/23, the partnership remained focussed on our safeguarding and community safety priorities, continuing to maintain a high standard of work as the country moved from the COVID pandemic into a Cost of Living Crisis; the impact of both on our rural county has been significant. In this year, to that end, we and partners raised our concerns to national government about the impacts of the cost of living (16th September 2022) and on the lack of funding being provided for much needed Childrens' Hubs (May 2022). We also raised concerns to local health services, about mental health provision for our children and young people particularly post pandemic.

In this reporting year, Shropshire Council saw a continued overall increase in contacts to adult and children services however, only a small number became safeguarding concerns. There, was also an increase in the number of safeguarding referrals received during the year in both adult safeguarding referrals and Safeguarding Adult Reviews. The number of Rapid Reviews that have been conducted and then converted into Local Child Safeguarding Practice Reviews also rose during the period.

Themes that were prevalent in Safeguarding Adult Reviews include self-neglect, agencies not calling multi-disciplinary meetings to share concerns and discuss risk, lack of professional curiosity and practitioners not working in a trauma informed way. Local Child Safeguarding Practice Reviews show themes include non-accidental Injuries in children under 2 years, practitioners not using the "think family" approach and referring into Adult Services, lack of information sharing and lack of recording and flagging on Health systems.

Although we have a reduction of 16% in child exploitation in Shropshire, as a partnership, we continue to understand the very real risks of exploitation. We need to prevent and reduce the risk of this form of abuse, building on the good work started 2020. For example our exploitation referral figures are analysed each month by our Together Reducing & Ending Exploitation in Shropshire team, to gain a picture of Exploitation in Shropshire. This information is then being used to identify what is going well, and what needs improvement.

As a partnership we continue to work on the principle of involving individuals and families as much as possible. Listening to the voice of the person remains a key focus area and it's great to report this work continues.

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

As a Fire Service we are at our most successful when we work in partnership, this is true of fighting fires but equally so in our prevention activities.

Our service recognises the value of the Partnership and that by investing time and resources to support the wider agenda of community safety and wellbeing helps reduces community risk.

The Partnership requires all partners to contribute and pool their expertise, to share skills and knowledge, best practice, innovation. Where we work closely together often in the same room or community hub, we can achieve the positive outcomes the community expect.

Shropshire Safeguarding Community Partnership's Strategic Governing Group offers a safe place where partners can contribute and challenge to ensure the communities we serve are central to everything we do.

Our service recognises the financial challenges that all partners face and is committed to working together to build for the future and learn from the past.

Stu Bill, Superintendent, West Mercia Police

West Mercia Police are proud to be members of Shropshire Safeguarding Community Partnership. As a partner agency, it is essential that policing plays its part and that we work collaboratively to deliver for children and adults in the community. No one agency has the solutions here, the commitment to work together, and hold each other accountable in doing so, is what drives the partnership forwards.

Continuous improvement is essential. This report, along with previous ones, will highlight areas that need to develop. We should not try to hide this, but rather focus our efforts on these to ensure we deliver the best possible outcomes.

Policing 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.

Vanessa Whatley, Interim Chief Nursing Officer, NHS Shropshire Telford and Wrekin Integrated Care Board

The Shropshire Telford and Wrekin integrated Care Board is pleased to be a partner in the Shropshire Safeguarding Partnership and contribute to the ongoing development and response to the challenges faced by Shropshire's services and communities.

I am particularly pleased to see the reported strengthening of education aimed at primary care partners' knowledge of safeguarding processes, as well as enabling organisations to benchmark their arrangements to help them to progress. Through the Partnership's governance structures there has been good progress in meeting set objectives including contributions such as information to support families who are involved in case reviews and the development of policies and guidance for our partners. Educating our workforce is essential to safe practice and the training of 10858 people is pleasing to see, and as we move into 2023/24, we will understand the effectiveness of this investment in practice.

NHS Shropshire Telford and Wrekin remains a committed partner in Shropshire Safeguarding Partnership arrangements, and I look forward to further progress of the developmental work and learning from this report in to coming year.

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

West Midlands Probation has built on the progress of previous years by continuing to work in partnership with statutory and voluntary organisations so that the issues that impact upon offending can be effectively addressed.

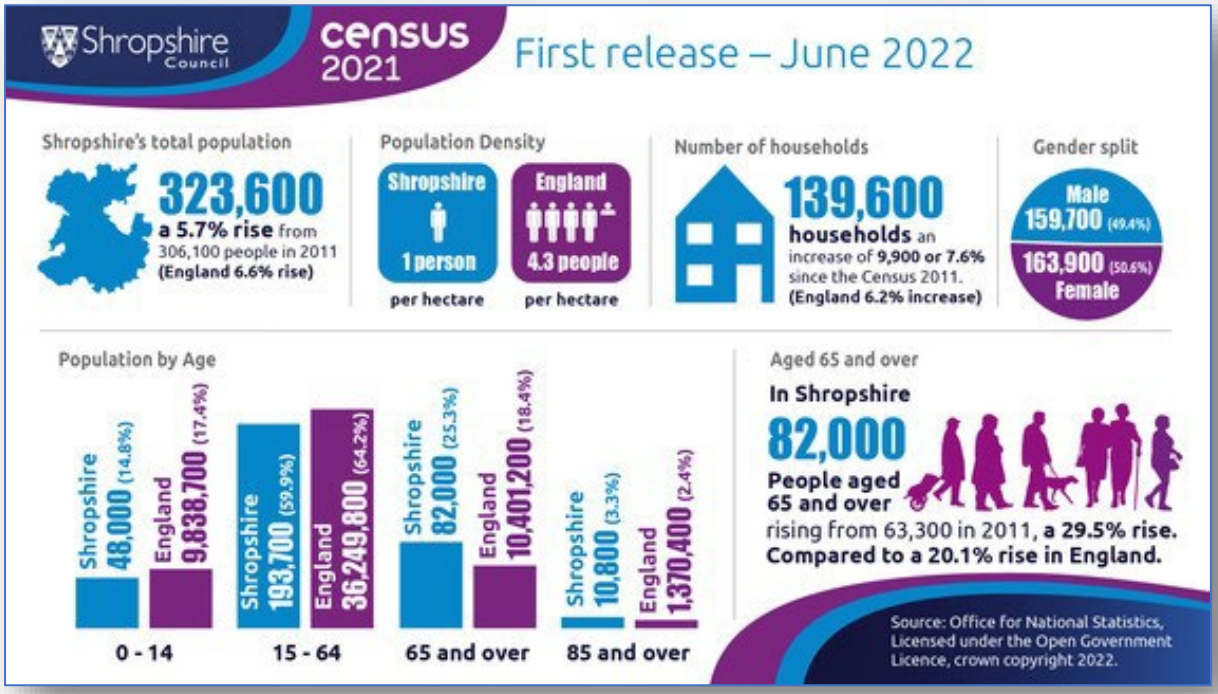
We have commissioned rehabilitative services across employment, and accommodation which has improved the rate of employment for prison leavers, as well as the number of individuals in suitable accommodation.

We have also ramped up our support to those on probation who are in need of drugs and alcohol recovery.

However, it is in the area of mental health where we have with the help of Midland Partnership University Foundation NHS Trust, made significant progress. The employment of Integrated Offender Management Mental Health Nurses has greatly assisted offenders in this group to meet their mental health needs. We have mental health clinical psychologists in court which has improved the appropriate sentencing of those whose offending behaviour is linked to their poor mental health. This has seen a marked increase in Mental Health Treatment Requirements.

There is still more work to be done to tackle the drivers for reoffending, to protect communities and help people live decent law-abiding lives. This cannot be done without our partners across the area, and we look forward to making more improvements together.

Information about Shropshire



Introduction

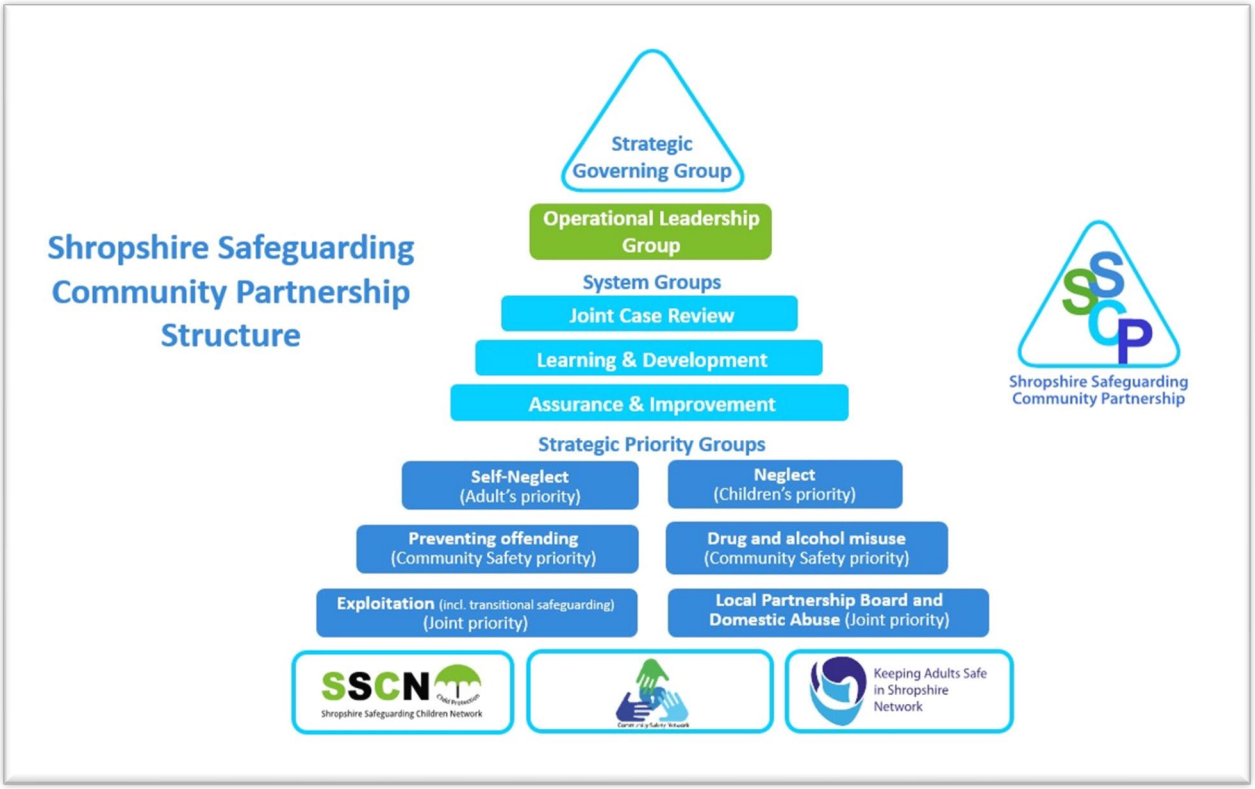
This report fulfils the statutory duty to produce an annual report for both Adult and Children's safeguarding arrangements and the needs assessment for our Community Safety Partnership. Whilst there is no requirement on the Community Safety Partnership to publish an annual report about its activity, 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 priorities to safeguard our communities.

It explains what has been achieved in this financial year and what we plan to do in 2023-24.

In our report for 2021-22 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 structured:



What we achieved this year

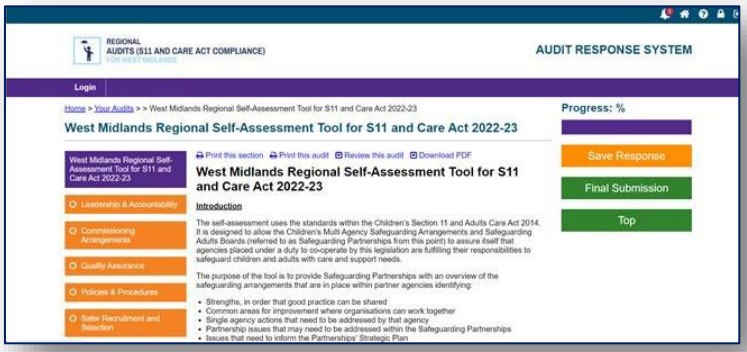
Joint Case Review Group

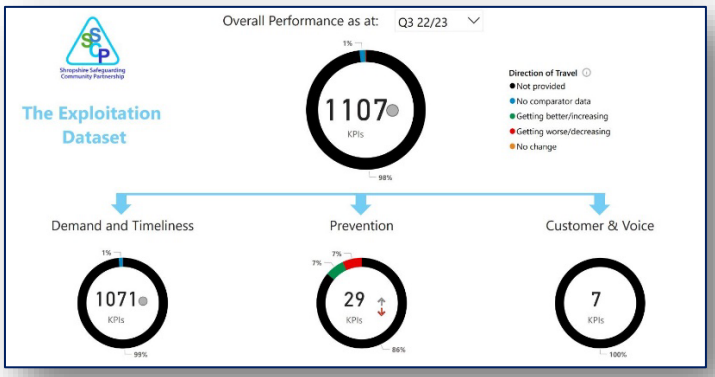
We said we would…….	We did…….
Improve the quality of information and analysis of practice that agencies provide to reviews.	Business Unit developed a webinar to raise awareness of case reviews and to improve the quality of scoping forms and chronologies. Any forms that don't meet the expected standards are sent back to agencies with feedback for improvement.

	Offer support to anyone that requires it, and this offer was added to the letter that is sent with the paperwork.
Raise awareness of the statutory case review processes and professionals' roles and responsibilities in case reviews.	In addition to the above, briefings about Rapid Reviews for General Practitioners were delivered by the Integrated Care Board.
Provide information to support families who are involved in case reviews.	Working with the group and regional colleagues, the Business Unit created two user friendly leaflets about Safeguarding Adult Reviews. Information for Individuals Friends and Family Leaflet

Assurance and Improvement Group

We said we would…….	**We did…….**
Carry out the Care Act Compliance audit and peer review.	This was completed and the information provided by partners discussed in the meeting on December 2022.
Roll out the new online regional audit tool.	Alongside regional colleagues, the Business Unit were involved in the production of this joint self-assessment tool. The tool enables agencies to assess themselves against their statutory duties to protect children and adults with care and support needs.

	The tool went live on 27th February 2023. 
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.	This was completed and work started on collecting data from partners. The following area were prioritised: • Children's safeguarding data  • Child neglect data 

	• Exploitation data  However, it has proved very challenging to implement the data collection successfully as some of the data that partners had identified they wanted, was not reportable from their electronic systems as can been seen in the exploitation data image.

Learning and Development Group

We said we would…….	We did…….
Offer a sustainable multiagency training offer for Children's Safeguarding	The group scoped what was needed and delivered what was possible within the resources available. Please look at the Learning and Development section of this report for the numbers of those that were trained. Training Pool continued to support the delivery of this training.
Provide a sustainable multiagency training offer for Community Safety	The group scoped what was needed and were successful in delivering Prevent and Domestic Abuse sessions. Please look at the Learning and Development section of this report for the numbers of those that were trained. Some of the Training Pool members continued to support the delivery of this training.

Delivered the Graded Care Profile 2 (an assessment tool to help identify and measure risk of neglect in children) training in a classroom environment	This was partially achieved. 3 sessions had to be cancelled mainly due to the lack of capacity to deliver them and in other sessions practitioners were unable to come along at the rate hoped. Please look at the Learning and Development section of this report for the numbers of those that were trained.
To work with Police Exploitation and Vulnerability Trainers to deliver multiagency Exploitation training	This was achieved with support from colleagues from West Mercia Police and Counter Terrorism Policing West Midlands. Please look at the Learning and Development section of this report for the numbers of those that were trained.

Local Domestic Abuse Partnership Board

We said we would…….	We did…….
Undertake a strategic needs assessment as per direction of the Domestic Abuse Act 2021 as a matter of urgency	This was achieved and was approved at the group in September 2022. It was disappointing that not all teams/agencies responded to the request for data. The findings included: • A significant barrier for people accessing support, including for domestic abuse, is the rural nature of Shropshire. • Due to a lack of public transport, many are reliant on car travel or accessing something local to them, which in itself can be problematic if the area is small enough for 'everyone to know everyone'. This exacerbates isolation for domestic abuse victims and makes it harder to know about, or reach out for, help, and support.

	• For some survivors who contributed to the needs assessment, rurality was relevant with regards to the 'standing' of their abusive partner in the community in which they lived, making calling the police, or seeking support, feel impossible. • The short-term, often hand-to-mouth funding model has created competing and fragmented service provision. • Retreating rural resources make help and escape harder.
Embed and review the effectiveness of the perpetrator programme that has commenced	The All Risk Perpetrator Programme has been rolled out across West Mercia, with Shropshire starting both Drive (for high risk perpetrators) and Men & Masculinity (for standard/medium risk perpetrators) in September 2023. Both programmes have started well with good agency attendance at the Drive Panel and referrals coming through for the Men & Masculinity programme. As partners locally and regionally, we regularly meet at a steering group to ensure the programme is effective and running well. Also, quarterly contract monitoring meetings have oversight of the programmes. They are in their very early days with Shropshire's Men & Masculinity virtual group building well. There were some recruitment issues for the provider of both the perpetrator and victim support elements but these are all established and in place now.
Develop a child and adolescent to parent violence and abuse policy	This was done and is in place on the partnership's website. Child to Parent Abuse Policy

Preventing Offending Group

We said we would…….	We did…….
Review the Anti-Social Behaviour Case Review process ready for public consultation	A series of task and finish groups were held with a range of partners to review the existing process. Although there was a lot of challenge between partners, the meetings were productive and many changes were made in attempt to make the process easier to understand. The public consultation went live on 6th February 2023. The final process can be found here.
Develop a clear reporting process for hate crime and hate incidents which will make data collection easier, through a small task and finish group	This was achieved. Schools decided to maintain a standalone reporting system and can provide information when requested. The task and finish group agreed that the following process would be promoted: • Reporting directly to West Mercia Police • Reporting on-line via True Vision The partnership website includes a page about hate and mate crime including links to where to report and what support is available.
Conduct a multi-agency case file audit on continuity of care for prison leavers who use substances and implement the learning from this audit	This took place in March 2023. Learning included: • When you have a patient, who has just been released from prison in your GP surgery take some time to understand them. You don't know when you will see them again. Make every contact count.

	• If you have a prison leaver making a claim for Universal Credit be specific in your questioning. Who else is working with them? What are their health conditions? This will help direct the support you offer. • Celebrate even the smallest of successes as these may be the biggest of achievements for this individual. You can read the full learning briefing on the partnership's website.

Self-Neglect Group

We said we would…….	We did…….
Review and update the Responding to Self-neglect in Shropshire Guidance	This work started but is not yet complete. It will be overseen by the Adult Safeguarding and Protection Practice Oversight Group from April 2023.
Conduct a multi-agency case file audit relating to individuals who self-neglect in Shropshire	This took place in September 2022. Learning included: • Care Act Assessments play a crucial part in identifying an individual's support needs and plan to reduce risks and promote wellbeing. These need to be completed in a timely way. • The Clutter Image Rating Index should be used when there are concerns about home conditions or hoarding, which is a form of self-neglect. • Where there are concerns of self-neglect, a multi-agency meeting should be arranged in a timely way to ensure that information is shared, risks are identified and support plans are implemented as early as possible.

	You can read the full learning briefing on the partnership's website.
Create a profile of self-neglect in Shropshire	We were not able to complete this task due to the difficulty in getting information from a range of agencies who cannot report on this from their systems. Further work is happening to improve system approaches to self-neglect, including holding multi-agency case meetings.

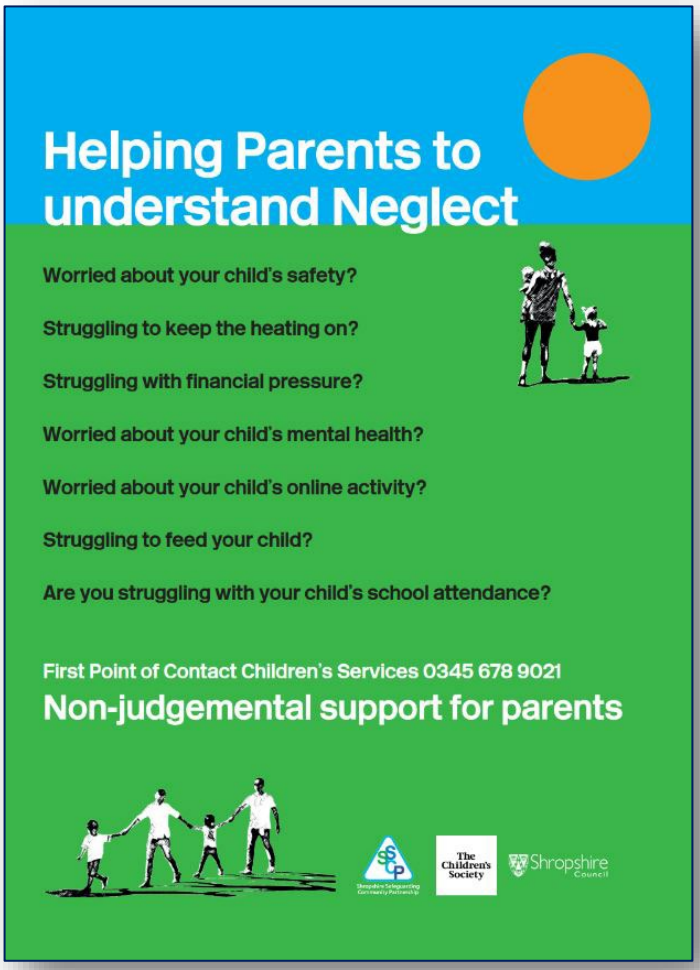
Drug and Alcohol Misuse Group

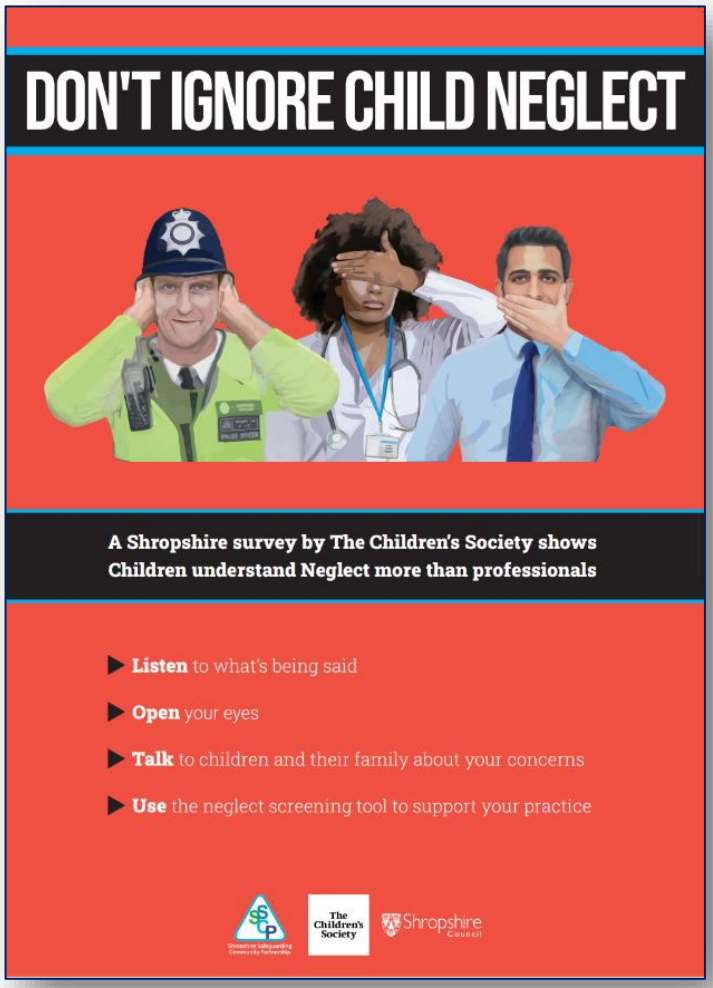
We said we would…….	We did…….
Revise our local strategy in line with the National Strategy 'From Harm to Hope'	This is currently in draft and we are continuing to work on this document.
Carry out a Joint Strategic Needs Assessment	This work is still being developed.
Re-establish the Drug Related Death Panel	This is still being developed however, some learning from drug related deaths has happen though our statutory case review process.

Child Neglect Group

We said we would…….	We did…….
Complete our co-produced poster campaign	The posters were launched on 22nd March 2023. The key headlines from this work with the Children's Society are: • Children understand what neglect is • Parents also understand neglect but are concerned about the cost of living and whether their children could be removed as a consequence of financial struggles • Professionals did not understand neglect as well as children

	Printed copies have been available and can be found in many places including schools and doctor's surgeries. 

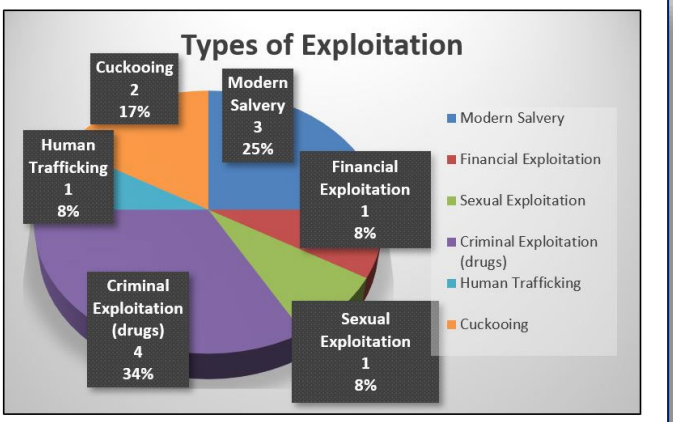

Helping Parents to understand Neglect
Worried about your child's safety?
Struggling to keep the heating on?
Struggling with financial pressure?
Worried about your child's mental health?
Worried about your child's online activity?
Struggling to feed your child?
Are you struggling with your child's school attendance?
First Point of Contact Children's Services 0345 678 9021
Non-judgemental support for parents
The Children's Society
Shropshire Council

	 The posters can be found on our partnership website.
Enable external partners to use the Early Help Module (Liquidlogic) to record their involvement with Children and Families	Over 800 partners have been registered to use this electronic system. The aim of this is to improve the timeliness of communication between professions when they are working with the same family.
Recruitment of Police Early Help and Intervention and Prevention Officers	The recruitment of 1 Police Early Help and Intervention Officer and 2 Prevention officers happened in June 2021.

Exploitation Group

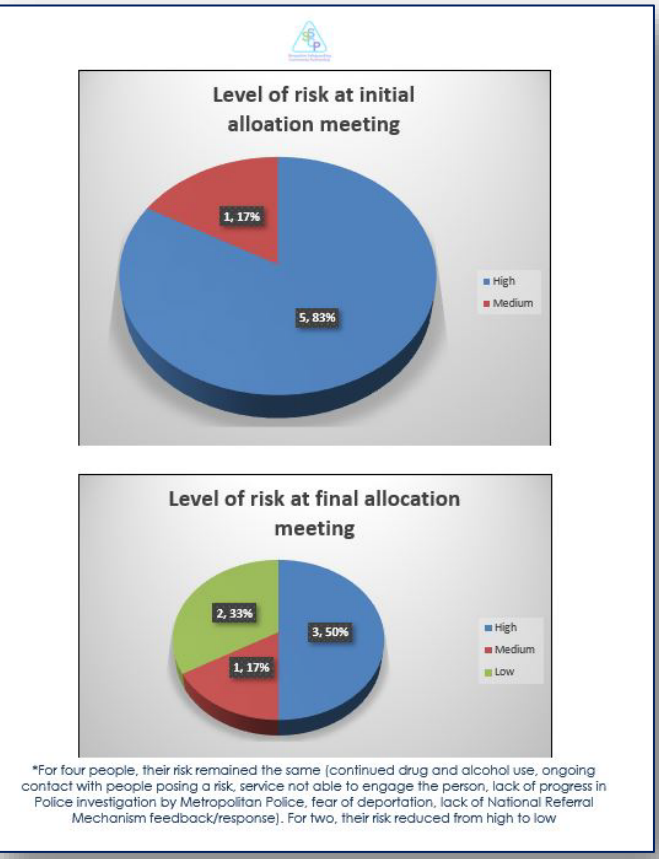
We said we would…….	We did…….
Raise awareness of and response to the issue of exploitation in communities/among businesses, elected members and town councils	We Are With You to continue to make links with our communities by linking with Town Councils.

Complete the pilot Adult Exploitation Allocation Meeting	The evaluation report about the pilot went to the group in June 2022.
	
	The following agencies took part:
	• Midlands Partnership Foundation NHS Trust
	• Shrewsbury Ark (a charity organisation supporting homeless and vulnerable people)
	• Shropshire Council
	  ○ Adult Social Care (Safeguarding Team)
	  ○ Childrens Services (Compass and Leaving Care)
	  ○ Customer Services (First Point of Contact)
	  ○ Housing Services (Housing Options)
	• Shropshire Recovery Partnership (We Are With You)
	• West Mercia Police
	  ○ Local Policing Vulnerability representative
	  ○ Force Tactical Lead for Adult Safeguarding
	
	During the pilot, 12 people experiencing exploitation were supported.



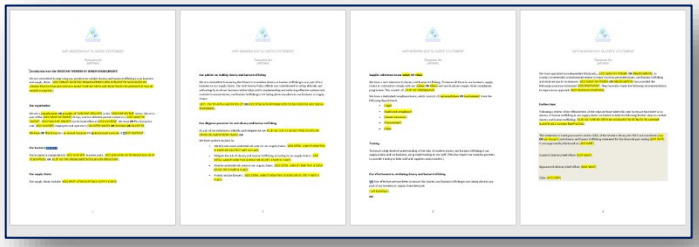
*Multiple types of exploitation were experienced by two people

It was clear that by working together, with the people affected, we were able to reduce the risks from exploitation for some people.



*For four people, their risk remained the same (continued drug and alcohol use, ongoing contact with people posing a risk, service not able to engage the person, lack of progress in Police investigation by Metropolitan Police, fear of deportation, lack of National Referral Mechanism feedback/response). For two, their risk reduced from high to low

The agencies involved considered the pilot to be a success and group accepted to recommendation that the multi-agency

	allocation process should continue and by led by Adult Social Care.
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	 The template can be found on our partnership website.

Strategic Governing Group

Our senior Key Partners met 8 times during this year. Two of those were additional meetings; to sign off a number of statutory case reviews that were due to be completed at the same time and to discuss the budget.

The achievements of this group include:

- Scrutinising and developing the business plans of the strategic priority groups for example, the domestic abuse group.
- Agreeing a risk management framework and risk register for the partnership.
- As a result of Solihull's experience, setting up a multi-agency task and finish group to prepare for a possible Joint Targeted Area Inspection.
- Considering the findings of Child Protection in England and started work to assess ourselves against that.
- Beginning preparations for implementing the Serious Violence Duty.
- Holding a strategic planning and priority setting day to discuss what we achieved over the last three years and what our priorities should be for the next three years. Our priorities were agreed as follows:
    - Adult Safeguarding and Protection Practice Oversight
    - Child Safeguarding and Protection Practice Oversight
    - Community Safety Practice Oversight (hate crime, anti-social behaviour, re-offending and serious violence.

- Undertaking Statutory Case Reviews
- Tackling Exploitation
- Tackling drug and alcohol misuse
- Local Domestic Abuse Partnership Board


YES
MAYBE


NO


SSCP - Strategic Planning & Priority Setting Day
We can be greater than the sum of our parts
Great Working Relationship
How do we make the WHOLE SYSTEM BETTER?
We have lost sight of adult & child PROTECTION & SAFEGUARDING
Re-focus on PROTECTION practice
It's very FLEXIBLE
There's a wider remit of ABUSE
EQUAL REPRESENTATION
What should our future priorities/structures be?
Lets not lose sight of PEOPLE ON THE CUFF EDGE.....
SHROPSHIRE is doing REALLY WELL....
It needs to be SUSTAINABLE with a reduced team....
TRANSITIONAL SAFEGUARDING
Move into PREVENTION
EXPLOITATION
DOMESTIC ABUSE
Multi-monitoring
SCREENING
SELF NEGLECT
TRAUMA
HATE CRIME
DRUGS & ALCOHOL
YES
MAYBE
NO
ARE WE COMMITTED TO THE NEW STRUCTURE OF SINGLE GOVERNANCE?
Artwork by Rowan @ Creative Connection

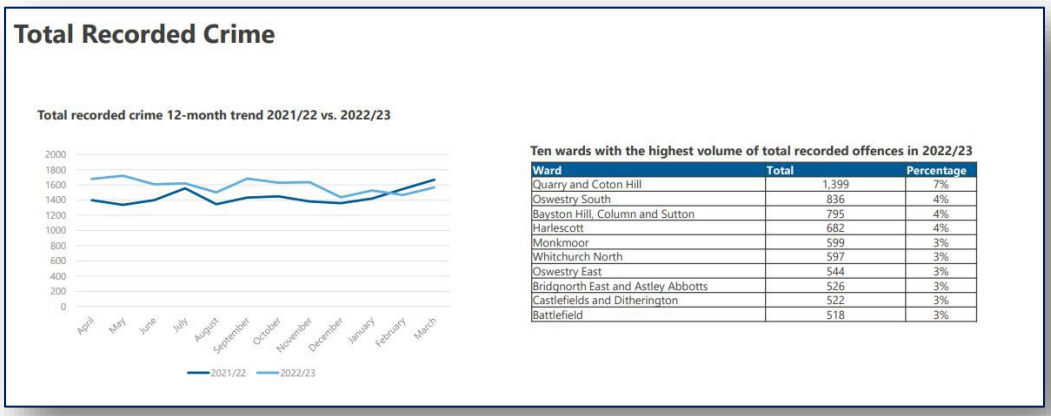
What we know about crime in Shropshire, children at risk and adult safeguarding

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

The information about crime comes from a report produced by partnership analysts working with the Police and safeguarding information is proved by Shropshire Council. We thank them for allowing us to share their work.

Total Recorded Crime

There were 19,080 offences, which is a 10% increase compared to the same period the previous year. The greatest volume of offences were in stalking and harassment which accounted for 2,750 (14%) reports followed by violence without injury accounting for 2,732 (14%) reports.

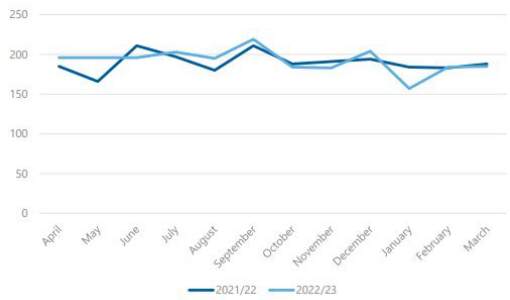


Ward	Total	Percentage
Quarry and Coton Hill	1,399	7%
Oswestry South	836	4%
Bayston Hill, Column and Sutton	795	4%
Harlescott	682	4%
Monkmoor	599	3%
Whitchurch North	597	3%
Oswestry East	544	3%
Bridgnorth East and Astley Abbotts	526	3%
Castlefields and Ditherington	522	3%
Battlefield	518	3%

Violence with Injury

Violence With Injury

Violence with injury offences 12-month trend, 2022/23 vs 2021/22



2,302 violence with injury offences were recorded in 2022/23. This was a 1% (n=24) increase compared to the same period the previous year.

The greatest volume of offences were recorded as assault with injury (92%, n=2,124), an increase of 2% (n=32) compared to the same period in the previous year.

11% (n=241) of all assault with injury offences in Shropshire were recorded in Quarry and Coton Hill Ward.

Ten wards with the highest volume of violence with injury offences in 2022/23

Ward	Total	Percentage
Quarry and Coton Hill	264	11%
Oswestry South	98	4%
Market Drayton West	77	3%
Whitchurch North	77	3%
Harlescott	70	3%
Bridgnorth East and Astley Abbotts	66	3%
Oswestry East	65	3%
Church Stretton and Craven Arms	63	3%
Wem	63	3%
Bayston Hill, Column and Sutton	62	3%

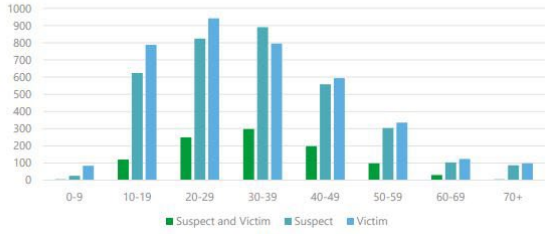
Violence with injury offence type breakdown with % change, 2022/23 vs 2021/22

Offences	2022/23	2021/22	Numerical Change	% Change
Assault with injury	2,124	2,092	32	2%
Assault with intent to cause serious harm	118	129	-11	-9%
Assault with injury on a constable	24	21	3	14%
Race or religiously aggravated assault with injury	13	11	2	18%
Death or serious injury by dangerous driving	9	5	4	80%
Endangering life	6	5	1	20%
Attempted murder	5	6	-1	-17%
Assault with injury on an emergency worker	1	6	-5	-83%
Causing death by aggravated vehicle taking	1	0	1	N/A
Death by careless or inconsiderate driving	1	2	-1	-50%
Cause or allow death etc to child or vulnerable adult	0	1	-1	-100%
Death by careless driving drink and drugs	0		0	N/A
Grand total	**2,302**	**2,278**	**24**	**1%**

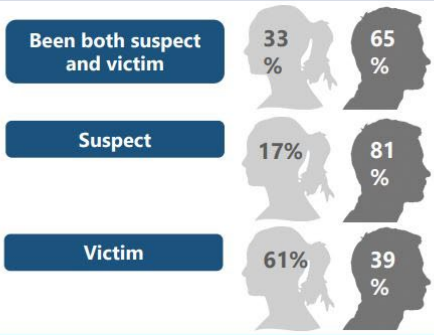
Serious Violence

Who is at Risk of Serious Violence?

Nominal Role and Age



	Suspect and Victim		Suspect		Victim	
Age	Female	Male	Female	Male	Female	Male
0-9	42%	58%	50%	50%	40%	60%
10-19	41%	59%	14%	86%	62%	38%
20-29	34%	66%	18%	82%	45%	55%
30-39	24%	76%	12%	88%	36%	64%
40-49	22%	78%	11%	89%	30%	70%
50-59	30%	70%	16%	84%	44%	56%
60-69	46%	54%	40%	60%	50%	50%
70+	43%	57%	16%	84%	63%	37%
Total	34%	66%	15%	85%	48%	52%



- Men are nearly twice as likely as women to be a victim of violent crime and among children, boys are more likely than girls to be victims of violence. *Source: Men and Boys Coalition*
- However, Shropshire crime data shows that suspects and those who have been a suspect and a victim are most likely to be male, and victims are most likely to be female. This is highly likely due to the presence of domestic abuse. When domestic abuse offences were removed from the data, females still accounted for the majority of victims (53%, n = 1,012).
- Male victims of serious violence including domestic abuse and sexual violence may be less likely to come forward due to the stigma within society and this under reporting leads to an under representation of the issue.
- Suspects, victims and those who have been both a both suspect and a victim are most likely to be aged between 10 and 19 years old (35%).

Source: Shropshire Serious Violence Needs Assessment 2023. Data date range 01 September 2020 - 31 August 2023.

Who is at Risk of Serious Violence?

Nominal Role and Self Defined Ethnicity

17% of offences (n = 1,520) had no ethnicity stated and have been removed from the table

Ethnicity - Self Defined	Suspect and Victim	Suspect	Victim	Total
White British	782	2,516	2,448	5,746
Any Other White Background	13	50	49	112
Any Other Black, Black British or Caribbean Background	4	13	4	21
Any Other Asian Background	5	15	15	35
Indian	4	19	12	35
Gypsy or Irish Traveller	3	12	9	24
White Irish	3	8	7	18
White And Black Caribbean	5	9	6	20
Any Other Mixed or Multiple Background	0	13	0	13
Black Caribbean	1	3	6	10
Any Other Ethnic Group	5	7	7	19
Black African	5	3	5	13
Bangladeshi	0	5	3	8
Pakistani	1	5	4	10
Chinese	1	4	4	9
White And Asian	1	3	5	9
White And Black African	5	2	2	9
Arab	1	1	0	2
Total	**833**	**2,688**	**2,586**	**6,107**

Ethnicity is under recorded within police data and may not reflect the true picture of the victim and suspect demographics in relation to serious violence. In this instance 17% of offences (n = 1,520) had no ethnicity stated and have been removed from analysis.

Overall, 3% (n = 200) of victims, suspects and those who had been a suspect and a victim were of a BAME (black, Asian, and minority ethnic) background. 4% (n = 102) of all suspects were from a BAME background and 3% of victims (n = 73). This compares to 3.2% of Shropshire overall population being from a BAME background as of the 2021 census.

Source: Shropshire Serious Violence Needs Assessment 2023. Data date range 01 September 2020 - 31 August 2023.

Who is at Risk of Serious Violence? – Accident & Emergency Data

According to Shrewsbury Royal A&E data between 01 September 2022 and 31 September 2023, there were 352 attendances at Accident & Emergency where individuals have been the victim of an assault.

Gender breakdown

A gender breakdown shows that mostly males attended Accident & Emergency (69%, n = 244) vs 31% identifying as female (n = 108).

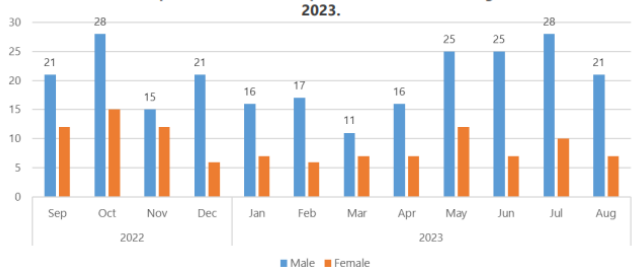
This shows a different picture to police data where victims are most likely female.

Age breakdown

Age band	Female %	Male %
0-9	0%	1%
10-19	7%	13%
20-29	8%	19%
30-39	6%	16%
40-49	7%	11%
50-59	2%	7%
60-69	0.5%	3%
70+	1%	0.2%
Total	**31%**	**69%**

An age breakdown shows that mostly individuals who attended Accident & Emergency were between 20 and 29 years old (27%, n = 95). This is also reflected within the police victim data.

Accident & Emergency attendances for alleged assaults in Shropshire between 01 September 2022 and 31 August 2023.



Offences fluctuated throughout the year with no key identifiable trend.

October 2022 recorded most attendances (n = 43), followed by July 2023 (n = 38) and May 2023 (n = 37).

The most frequent method of violence was punch with a fist 39%, (n = 136). 7% (n = 24) of cases involved stabbing with a sharp object.

Just under half of admissions stated that alcohol or drugs were involved (48%, n = 168).

113 incidents took place on a road or pavement (32%). This was followed by living room (21%, n = 75).

Source: Shropshire Serious Violence Needs Assessment 2023.

Serious violence and Domestic Abuse (DA)

01 September 2020 – 31 August 2023

DA related serious violence offences between 1 September 2020 and 31 August 2023

Offence Group	2020/2021	2021/2022	2022/2023	Change 2022/2023 vs. 2020/2021
Violence with injury	609	723	704	16%
Rape	47	71	48	2%
Other sexual offences	28	18	25	-11%
Robbery – personal	2	6	6	200%
Homicide	2	2	2	0%
Possession of weapons offences	0	2	10	300%
Violence without injury	0	0	0	0%
Burglary – residential	0	0	2	200%
Robbery – business	0	1	0	N/A
Total	**688**	**823**	**797**	**16%**

Source: Shropshire Serious Violence Needs Assessment 2023.

Ten wards with the highest volume of DA offences in 2022/23

Ward	Total	Percentage
Oswestry East	260	5%
Market Drayton West	194	4%
Bayston Hill, Column and Sutton	190	3%
Quarry and Coton Hill	184	3%
Wem	179	3%
Whitchurch North	167	3%
Castlefields and Ditherington	162	3%
Monkmoor	146	3%
Shifnal North	145	3%
Harlescott	139	3%

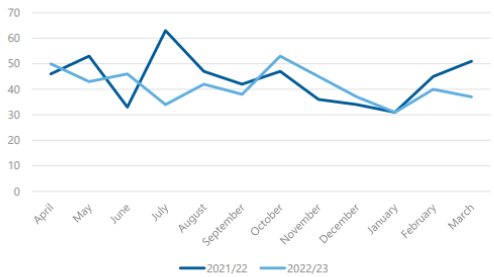
Source: West Mercia Police crime dashboard, March 2023

- 5,432 domestic related offences were recorded in 2022/23. This was a 1% (n=51) reduction compared to the same period the previous year so trend is currently relatively static.
- The greatest volume of offences were recorded as domestic abuse investigation (32%, n=1,717). Outside of this offence category, the greatest volume of domestic related offences were recorded as assault without injury (17%, n=912).
- Oswestry East Ward recorded the greatest volume of domestic related offences overall (5%, n=260) in 2022/23. The Serious Violence Needs Assessment 2023 recorded Oswestry as having the second highest volume of serious violence offences involving DA (13%, n=294).
- Shrewsbury town recording the highest overall volume of domestic-related serious violence with 45% (n=1,031) of all offences recorded in Shropshire between 01 September 2020 – 31 August 2023.

Hate Crime

Hate Crime

Hate Crime offences 12-month trend, 2022/23 vs 2021/22



Between 01 September 2020 – 31 August 2023, **9%** of serious violence was hate related.

Source: Shropshire Serious Violence Needs Assessment 2023.

Ten wards with the highest volume of hate crime offences in 2022/23

Ward	Total	Percentage
Quarry and Coton Hill	41	8%
Monkmoor	27	5%
Bridgnorth East and Astley Abbotts	24	5%
Sundorne	22	4%
Bayston Hill, Column and Sutton	21	4%
Oswestry South	21	4%
Ellesmere Urban	20	4%
Castlefields and Ditherington	15	3%
Bowbrook	14	3%
Whittington	14	3%

496 hate crime offences were recorded in 2022/23. This was a 6% (n=32) reduction compared to the same period the previous year.

All motivations for hate other than transgender recorded a reduction in volume compared to the same period the previous year. Transgender hate had a 76% (n=13) increase in offences when compared to the previous year.

Race recorded the greatest volume of hate crime offences (58%, n=289). 10% (n=29) of these offences were committed in Quarry and Coton Hill Ward which was the highest amongst all wards.

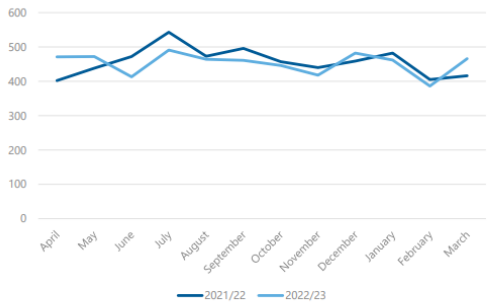
Hate strand breakdown and change, 2022/23 vs 2021/22

Offences	2022/23	2021/22	Numerical Change	% Change
Race	289	297	-8	-3%
Sexual Orientation	105	108	-3	-3%
Disability	55	74	-19	-26%
Transgender	30	17	13	76%
Faith	13	24	-11	-46%
Alternative Sub-culture	3	6	-3	-50%
Age	1	2	-1	-50%
Grand Total	**496**	**528**	**-32**	**-6%**

Domestic Abuse in Shropshire

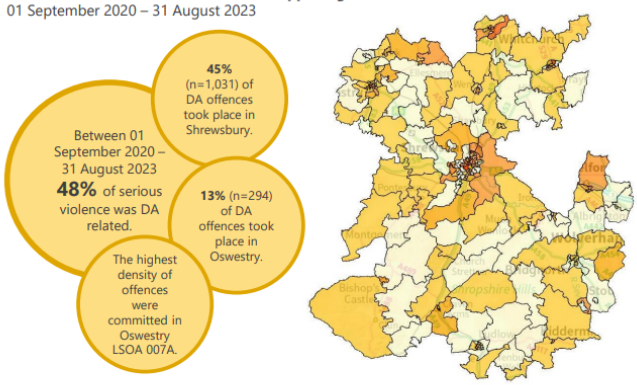
Domestic Abuse (DA)

DA 12-month trend, 2022/23 vs. 2021/22



DA change, 2022/23 vs. 2021/22

Serious violence and DA – where is it happening?
01 September 2020 – 31 August 2023



Serious violence and DA – where is it happening?
01 September 2020 – 31 August 2023

Town	2020/2021	2021/2022	2022/2023	Change 2022/2023 vs. 2020/2021
Shrewsbury	326	356	349	7%
Oswestry	89	113	92	1%
Market Drayton	52	34	45	-13%
Whitchurch	48	42	57	19%
Bridgnorth	23	60	58	152%
Ludlow	40	31	33	-17.5%

Source: Shropshire Serious Violence Needs Assessment 2023.

Domestic Abuse (DA)

Domestic Violence Protection Notices (DVPNs) escalated to Domestic Violence Protection Orders (DVPOs)
1 February 2022 to 31 January 2024

	DVPNs	DVPOs	% Escalated to DVPO
South Worcestershire	**20**	**19**	**95%**
North Worcestershire	**40**	**34**	**85%**
Herefordshire	**32**	**27**	**84%**
Shropshire	**23**	**18**	**78%**
Telford & Wrekin	**62**	**46**	**74%**
West Mercia	**177**	**144**	**81%**

Source: DA Deployment Performance Report Monthly Report-SPI/2024/037.

West Mercia Police Domestic Homicide Reviews January 2018 to August 2023 by calendar year

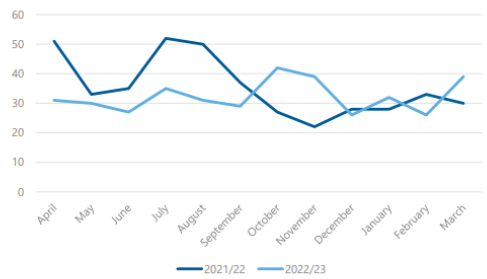
Domestic Homicides	2018	2019	2020	2021	2022	2023 (Jan - August)	Total
Shropshire and Telford	2		1	1	4	7	15
Herefordshire	2		1	1	2		6
North Worcestershire		1	1	4	1	1	8
South Worcestershire		2		3	3	1	9
Total	**4**	**3**	**3**	**9**	**10**	**9**	**38**

Source: Shropshire Serious Violence Needs Assessment 2023.

Drug Offences in Shropshire

Drugs Offences

Drugs offences 12-month trend, 2022/23 vs 2021/22



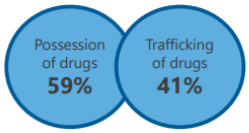
387 drugs offences were recorded in 2022/23. This was a 9% (n=39) reduction compared to the same period the previous year.

The greatest volume of offences were recorded as possession of controlled drugs (cannabis) (39%, n=151). This offence category recorded no change compared to the same period in the previous year. Trafficking of drugs also recorded 39% (n=151) of offences. This offence category recorded a decrease of 8% (n=14) when compared to the same period the previous year.

11% (n=42) of drugs offences were recorded in Quarry and Coton Hill Ward where 7% (n=11) of possession of controlled drugs (cannabis) offences occurred in this ward. Castlefields and Ditherington Ward recorded the greatest volume of this offence type (9%, n=13).

Ten wards with the highest volume of drugs offences in 2022/23

Ward	Total	Percentage
Quarry and Coton Hill	42	11%
Bayston Hill, Column and Sutton	18	5%
Harlescott	18	5%
Sundorne	16	4%
Bridgnorth East and Astley Abbotts	15	4%
Monkmoor	15	4%
Abbey	14	4%
Porthill	14	4%
Oswestry South	13	3%
Ludlow East	12	3%



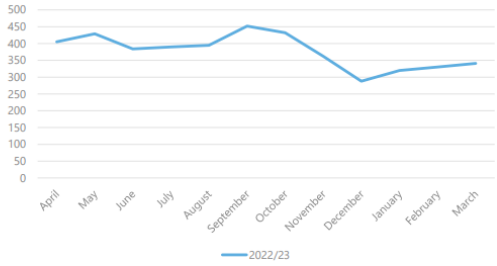
Drugs offence type breakdown and change, 2022/23 vs 2021/22

Offences	2022/23	2021/22	Numerical Change	% Change
Possession of controlled drugs (cannabis)	151	151	0	0%
Trafficking of drugs	151	165	-14	-8%
Possession of controlled drugs (ex cannabis)	78	106	-28	-26%
Trafficking in controlled drugs	6	3	3	100%
Other drug offences	1	1	0	0%
Grand Total	**387**	**426**	**-39**	**-9%**

Anti-Social Behaviour in Shropshire

Anti-Social Behaviour (ASB)

Anti-Social Behaviour incidents 12-month trend*



*Note: The data acquired for this analysis has only been recorded since 2022 due to implementation of a new control and command system recording ASB, therefore comparative analysis of the year 2021/22 was not possible to view against the 2022/23 trend.

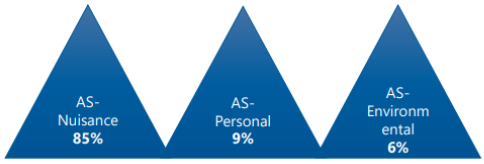
Anti-Social Behaviour type breakdown

Offences	2022/23
AS-Nuisance	3,850
AS-Personal	390
AS-Environmental	288
Grand Total	**4,528**

Ten wards with the highest volume of ASB incidents in 2022/23

Ward	Total	Percentage
Quarry and Coton Hill	516	11%
Oswestry South	252	6%
Bayston Hill, Column and Sutton	235	5%
Harlescott	195	4%
Market Drayton West	161	4%
Monkmoor	158	3%
Sundorne	144	3%
Whitchurch North	136	3%
Castlefields and Ditherington	125	3%
Bridgnorth East and Astley Abbotts	119	3%

Quarry and Coton Hill Ward recorded the highest volume of ASB (11%, n=516) and also the greatest volume of AS-Nuisance (12%, n=480).
Bayston Hill Ward and Quarry and Coton Hill Ward each recorded 7% (n=20) of AS-Environmental incidents.
Bayston Hill, Column and Sutton Ward recorded the highest volume of AS-Personal incidents (6%, n=25).



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.

Nationally, in the year ending 31 March 2022, there were 6,817 referrals to Prevent. This is an increase of 6.4% compared to the year ending March 2021 (6,406). There were 645 referrals adopted as a Channel case in the year ending March 2022. This is 159 fewer cases compared with the previous year (804).

The table below compares the activity between regions in England in Wales.

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
East	510	80.5	122	19.3	81	12.8
East Midlands	614	125.8	66	13.5	33	6.8
London	1103	125.3	136	15.5	83	9.4
North East	1042	128.2	173	21.3	121	14.9
North West	970	130.8	285	38.4	138	18.6
South East	1106	119.2	173	18.6	83	8.9
South West	489	85.8	57	10.0	42	7.4
Wales	271	87.2	31	10.0	16	5.1
West Midlands	712	119.6	70	11.8	48	8.1
Total England and Wales	**6,817**	**114.4**	**1,113**	**18.7**	**645**	**10.8**

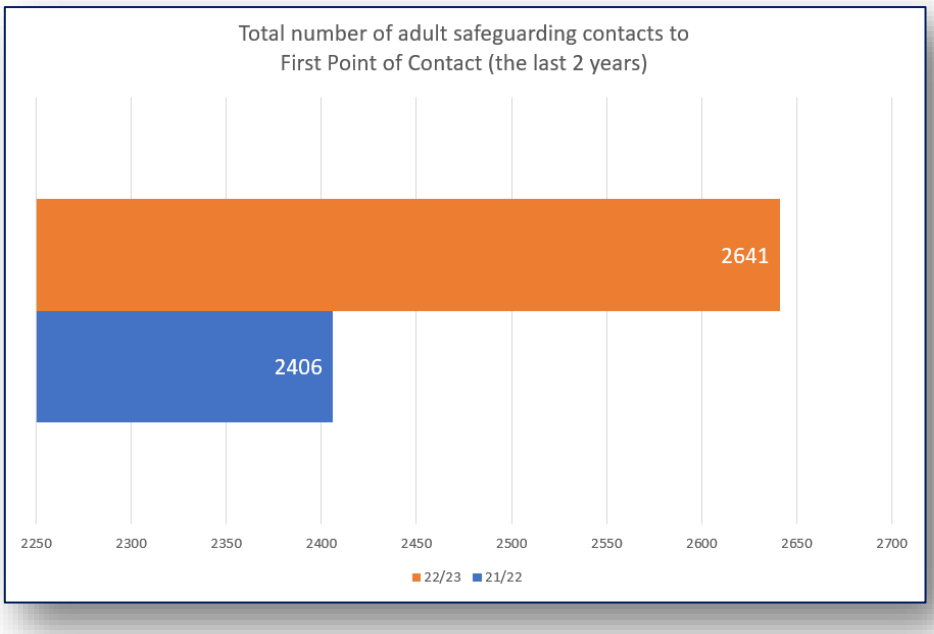
The ACT Early campaign seeks to raise awareness of the signs of radicalisation and where to go if you need support about someone you know. You can visit the Act Early website for more information and support (https://actearly.uk/).

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.

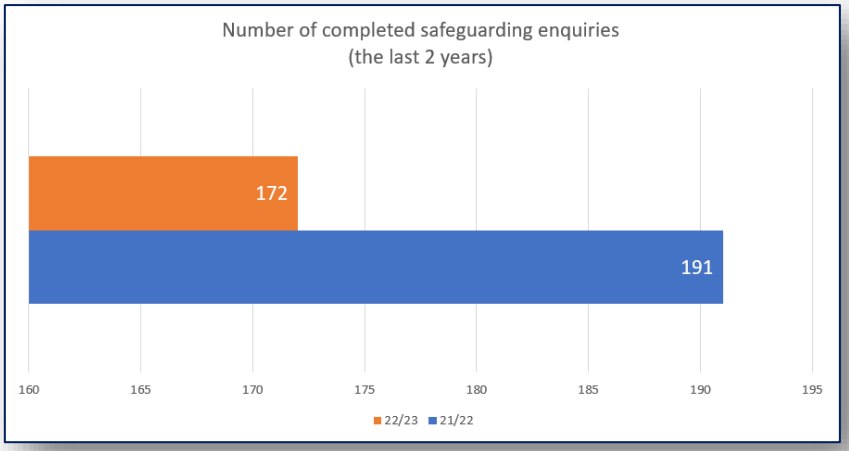
The majority of people discussed in Channel in Shropshire have an extreme right-wing ideology. Most people are discharged from Channel when there is no identified terrorist threat.

Adult Safeguarding

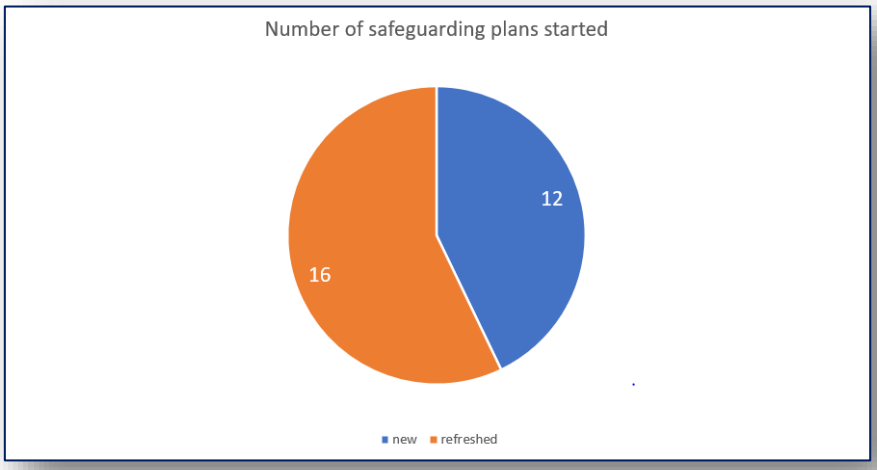
There has been a **10% increase** in the number of safeguarding contacts to Shropshire Council's First Point of Contact Team. This continues a trend of increased contacts to the council.



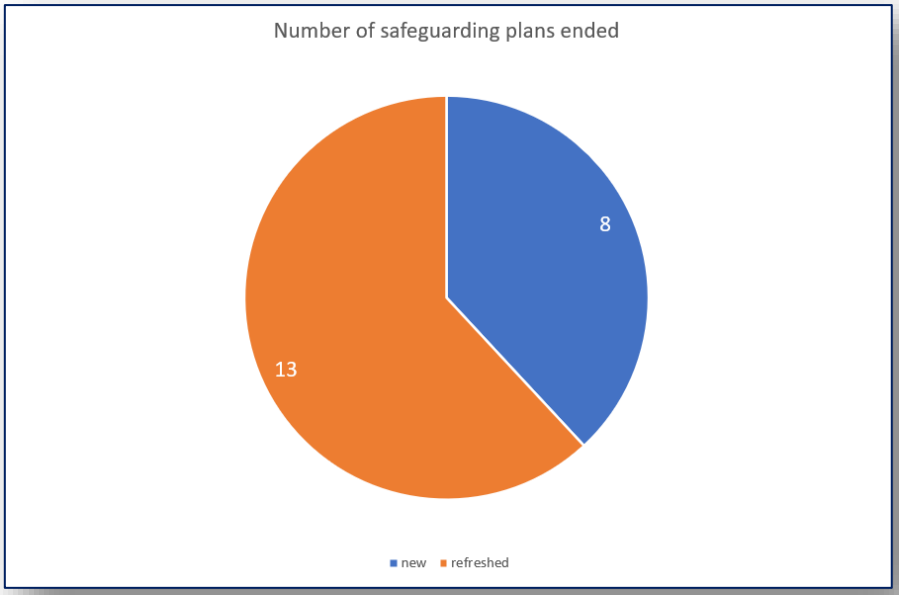
The above contacts turned into 758 safeguarding concerns. Safeguarding Concerns are then assessed by the Adult Safeguarding Team to see if an enquiry needs to be undertaken. The number of enquiries completed in the year can be seen in the table below. This is a **reduction of 9%** on the previous year.



Safeguarding plans are set up if it has not been possible to make the adult safe during the safeguarding enquiry process.

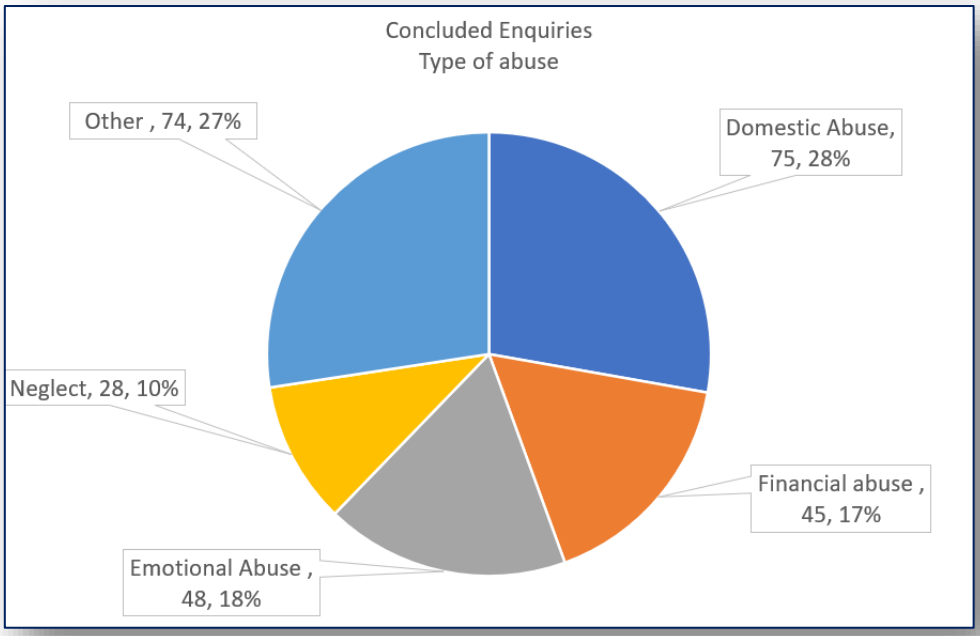


Safeguarding plans are ended when the abuse or risk of abuse has ended or been reduced because of the enquiry process. Some of these plans will have started in the previous financial year.



What this tells us, is 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.

The following chart shows the types of adult abuse where the enquiries have been completed.



The 27% marked as other, were about different forms of abuse including physical abuse (10%) and self-neglect (1%).

72% of concluded enquiries happened in people's own homes. 8% of concluded enquiries happened in residential care homes which is a reduction on what we reported last year.

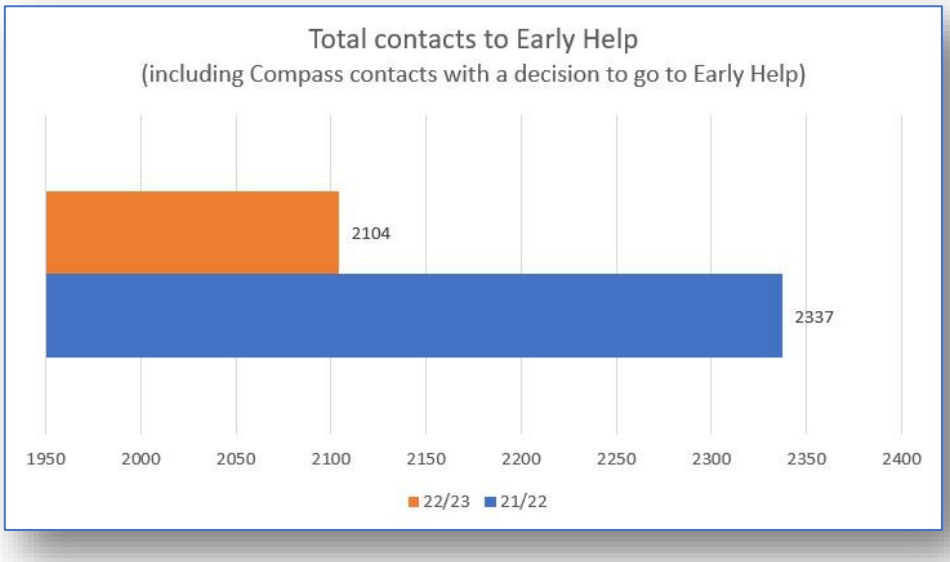
97% of people (or their representative) were asked what outcomes they wanted to be achieved by the enquiry. This indicates a strong emphasis on Making Safeguarding Personal which includes seeking the person's (or their representative's) views. This has improved from what we reported last year (93%).

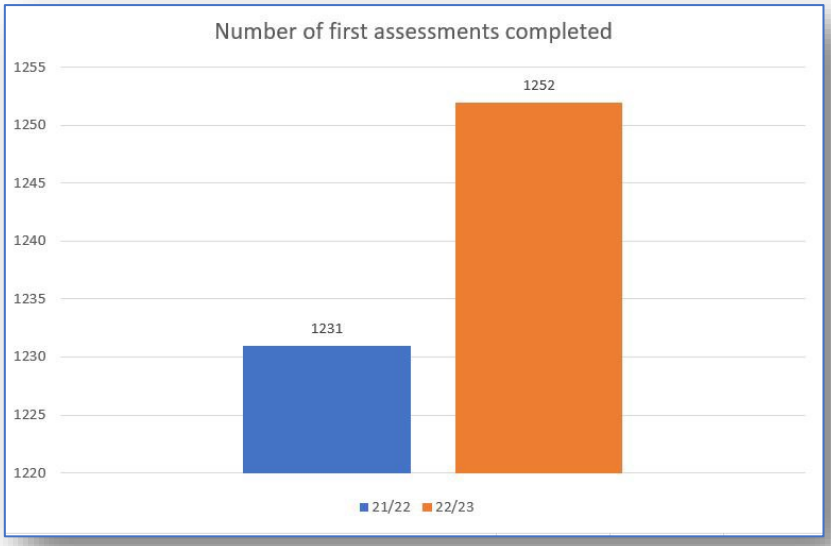
Calls about children.

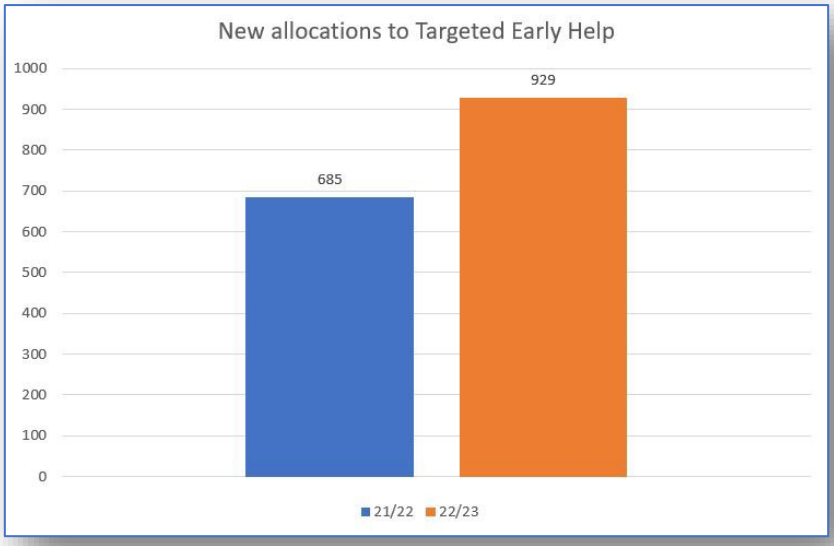
There were 12,897 contacts made to Compass this year. This is a **slight decrease** on what was reported in last year's report.

Early Help

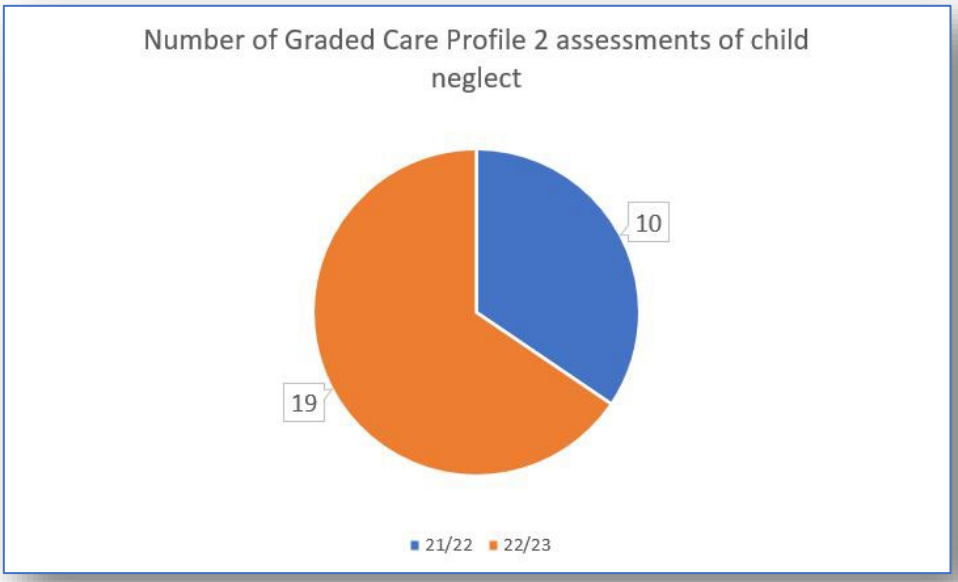
There was a **reduction of 10%** in the contacts to Early Help at Shropshire Council from the year before. We would prefer to see an increase in contacts to Early Help and a decrease to Children's Social Care which would demonstrate involvement with children and families before a crisis point is reached.

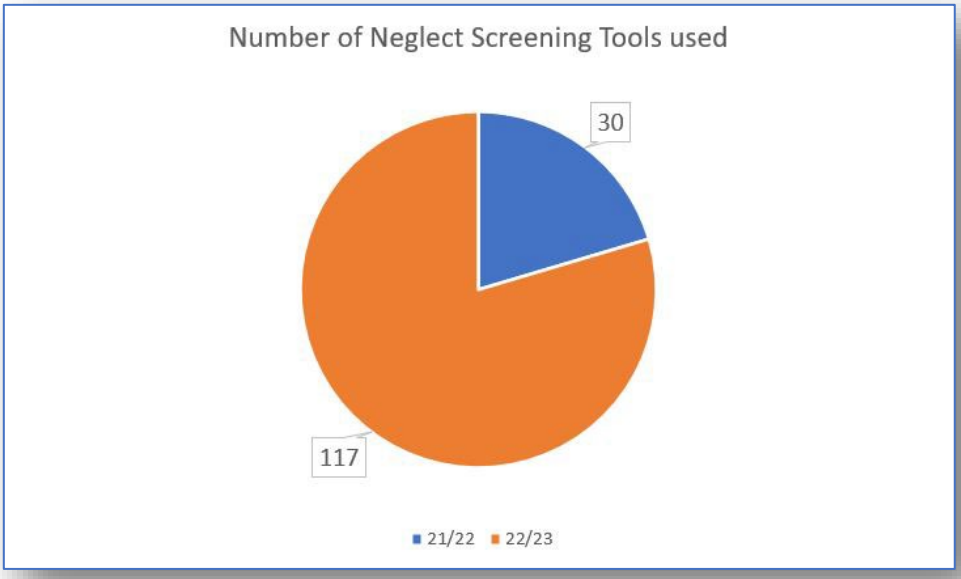



Number of first assessments completed
1255
1250
1245
1240
1235
1230
1225
1220
1231
1252
21/22
22/23


New allocations to Targeted Early Help
1000
900
800
700
600
500
400
300
200
100
0
685
929
21/22
22/23

Early Help has seen a **240% increase** in the use of screening tools to assess the neglect a child is experiencing. This indicates we are able to support children at an earlier stage and prevent neglect from getting worse.

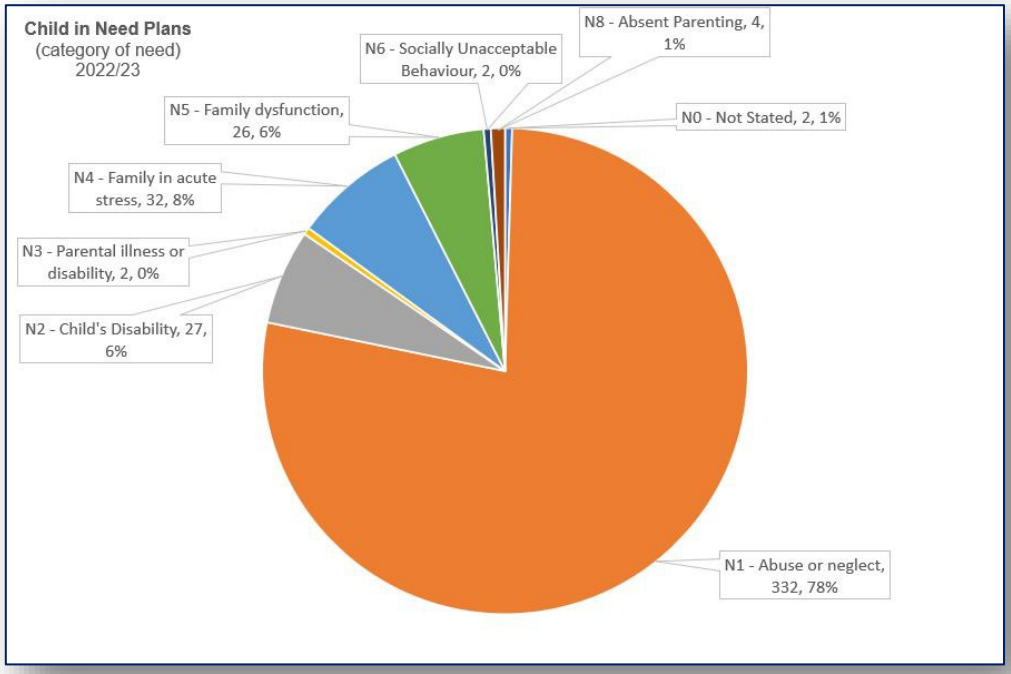




30 families provided feedback about the service they had received from Early Help with 83% of that number saying they felt listened to and understood.

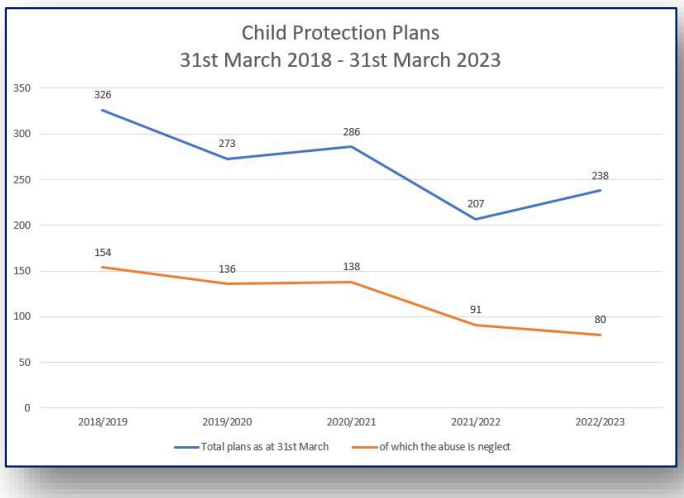
Children in Need

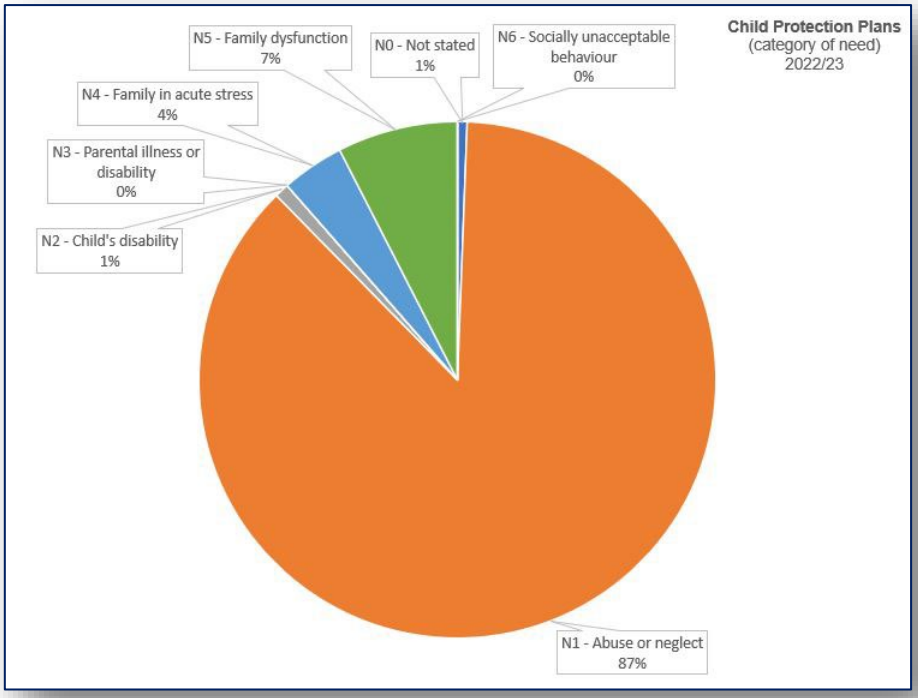
The number of children on a Child in Need Plan has **reduced by 3%** on the year before. The main reason for children being on this type of plan is because a child has experienced abuse or neglect.



Child Protection

The numbers of children needing a Child Protection Plan has **increased by of 13%** on the previous year. As with Child in Need Plans, the main reason for being put on a Child Protection Plan is because a child has experienced abuse or neglect.

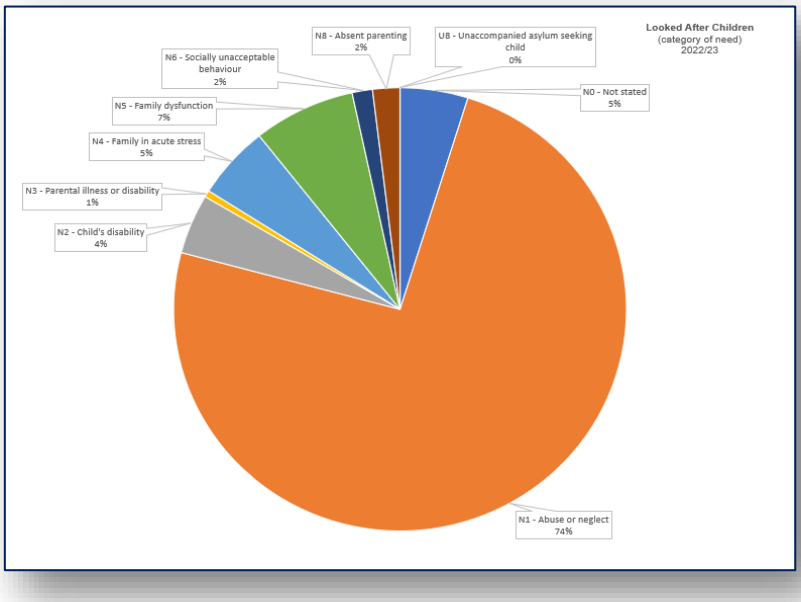




There were 354 Child Protection conferences held last year.

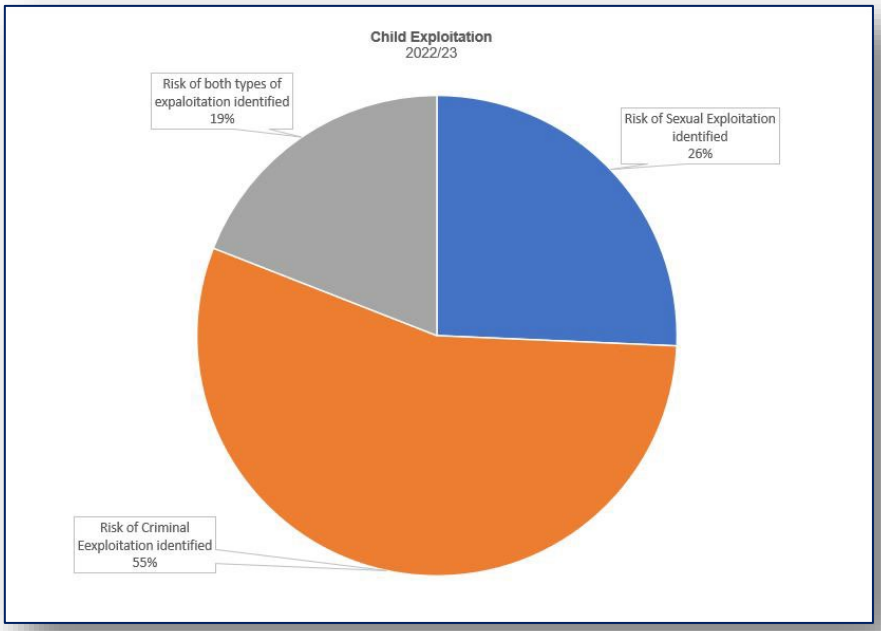
Looked after children

206 children became looked after during 2022/23. This is a **decrease of 16%** on the year before. The reasons children become looked after is explained in the chart below.



Child Exploitation

In total, there were 257 referrals about child exploitation during the year. This is reduction of 17% since our last report.



In terms of a gender split, it is very similar to what we reported last year.

- 55% of referrals were about young males
- 45% of referrals were about young females

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[1]
- Safeguarding Adult Reviews[2]
- Domestic Homicide Reviews[3]

[1] 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

[2] 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

[3] 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

- Anti-Social Behavior Case Reviews

Child Safeguarding Practice Reviews/Rapid Reviews

Child I

This review was 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 review identified the following learning which has been published in a learning briefing:

- The case review highlighted the invisibility of fathers/partners, which is a recurring theme in our case reviews and audits. A practitioner event on Unseen Men was held in June 2022 and is available to view on the Partnership website.

- Agencies must build relationships and share a narrative and picture of the family with other agencies involved so that everyone has a shared understanding of family circumstances.

- Each organisation has their own policy with regards to whether photographs are allowed to be taken of children's injuries. It is crucial that organisational policies and procedures are followed.

- Practitioners should ensure that robust assessment of risk takes place, that information is shared to safeguard the child/ren, be professionally curious and trauma informed.

Child J

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 took place in May 2022 to inform the revision of the SSCP Child Exploitation Pathway.

The learning from the review identified the following:

- Agencies need to find ways of being flexible and responsive enough to be ready to engage with children in those critical moments in real time. Days after the event might be too late to gather intelligence or get a disclosure. Organisations must be flexible enough to respond immediately to the **critical moment** when the child is more likely to be open to change.

- Practitioners cited fear of getting it wrong or making a situation worse when needing to have a difficult conversation. Knowledge, training, access to tools and effective management supervision were all cited as support that is required. Being open and honest is important in building trust and enabling quality relationships to facilitate difficult conversations. Consistency of a key worker enables relationship-based practice.

- All records should be kept up to date with all information that is held and has been shared on the child, family and those exploiting them.

- Where children go missing across borders trigger plans should be shared with neighboring police force areas.

- The partnership's Child Exploitation Pathway has been revised and re-published.

- In a recent case review, there was strong evidence of good multi-agency working to safeguard a young person. Agencies were also able to evidence the implementation of actions arising from the recent Exploitation multi-agency audit which demonstrates that learning is taking place to improve outcomes for children who are exploited.

Children M & N

This review is about two siblings, one of whom died. Due to the on-going criminal investigation at the time, it was not appropriate to comment further on the review. The review was completed in this year and a learning briefing will be published following discussions regarding an appropriate press release.

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[4] 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 took place on 13th June 2022 with a range of partners attending. Agencies were asked to come prepared to answer the following questions:

- what are you doing to respond to children and young people in mental health crisis and improve their experiences of your service?
- how are you implementing a "no wrong door" approach?
- how is your service delivering a trauma informed approach?
- what more can you do?

A significant number of actions and decisions were identified. Schools were recognised as having an important role to play in this area as was the need for investment in low level mental health support.

[4] 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

Everyone agreed that more needs to be done at an early stage to reduce the number of children and young people who eventually need complex interventions.

At their meeting on 5th October 2022, Strategic Governing Group agreed this work should be overseen by Shropshire Telford & Wrekin Integrated Care Board.

Jasmine

A referral was received at the end of the financial year 2022 for a 16-year-old child who is looked after and at risk of exploitation.

The review remains ongoing and the learning will be published in next year's report.

Child U

A referral was received in August 2022. This is a four-week-old baby with a head injury which was suspected to be non-accidental. The statutory partners felt that all learning had been identified during the rapid review, however after discussion with the Child Safeguarding Review Panel, it was agreed that a Local Child Safeguarding Review should be undertaken.

The learning will be published in next year's report.

Safeguarding Adult Reviews

Kim

Kim experienced substance misuse and homelessness and had other problems that made her life difficult. Kim had a daughter who was previously removed from her care, but with whom she had supervised contact.

Kim experienced a series of moves throughout the period under review. The move to an abstinence based residential recovery service provided an opportunity to directly address Kim's substance misuse problems. However, when Kim relapsed and could no longer stay at this placement, this created a period of uncertainty for her.

Since leaving an abstinence based residential recovery service that supports adults recovering from alcohol and drug addiction, Kim slept rough with her boyfriend. She reported he helped her to feel safe whilst sleeping rough.

Kim died suddenly in October 2020 in a friend's home. It is reported she had taken some illicitly acquired Diazepam.

The learning from the review identified the following:

- All staff should be aware of the concept of multiple exclusion homelessness and that when working with individuals who have such complex presentations, a discussion should take place with Adult Social Care about a Care Act (2014) Assessment.

- In line with the management of self-neglect, practitioners should convene multi-agency meetings in cases such as this to help identify plans to manage any heightened vulnerabilities via multi-agency risk assessments and support planning.

- When Housing Officers or other agencies are aware that someone is at risk of being asked to leave temporary (or otherwise) accommodation, they should explore the situation with the person as soon as they have been made aware and contact other agencies with the view of arranging a multi-agency meeting to help the person plan for the future.

- When a service that offers residential based rehabilitation support is considering asking a person to leave, they should convene a multi-agency meeting.

- All front-line services should explore the reasons why a person may be considered to jeopardise their placement or accommodation and use the lens of being trauma informed and why people use unwise coping mechanisms, to review the need for support.

- There was an occasion when following an enforced move, Kim could not travel to collect her medication and went without her medication for over 3 days. This gap in prescribing continued as Kim was having difficulties keeping appointments with her new prescriber. Kim was therefore off script, and she was concerned about the impact this would have on the risk of her taking illicit drugs.

- All substance misuse services should review their policies and procedures to make sure they adequately include guidance about transferring care to another provider to ensure that there is a continuation of prescribing and medication dispensing.

- There is limited evidence that agencies routinely liaised with Children's Social Care and following a review meeting the social worker had an action to contact other services to find out further information about Kim's current health, wellbeing, and illicit drug use as this was vital information needed for planning contact with her daughter.

- It is therefore important that all agencies remind their staff of the need to 'think family' and ensure Children's Social Care are kept up to date about information that may impact upon a child.

- Children's Social Care should consider when they need to share information with agencies working with an adult with care and support needs in line with any consent and/or safeguarding considerations.

- Each organisation should make sure that supervision is available to promote reflection and analysis of case management especially when there are concerns that a service user is at risk of homelessness.

- Staff supervision should help to build professional development by including:
    - Case supervision
    - Practice observation
    - Reflective practice

Mr M

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 M had a history of Depression, including features of self-neglect. Mr M had a relapse profile when his mental health was deteriorating which included him neglecting his physical care needs.

Mr M'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 the review identified the following:

- There were times when practitioners were working in isolation and Mr M and his wife did not receive a coordinated and timely response. Having a multi-disciplinary team meeting at the earliest opportunity will help practitioners to work together to support adults who self-neglect.

- Sometimes called "relapse signatures" are the individual signs a person might show when they are becoming unwell again. Knowing what these are and how to respond is important. Mr M had been known to lie on the floor for long periods of time when he was suffering with poor mental health. Agencies should record when a person has a behaviour that indicates a decline in their mental health and what has helped previously. This will promote earlier positive change.

- Staff supervision should help build professional development by including:

    - Case supervision
    - Practice observation
    - Reflective practice

  There should also be opportunity for shadowing, mentoring and coaching.

- Mr M's wife like many people, cared for her husband on an informal basis, but she did not receive a carers assessment and was not offered one. Had a carers assessment been completed other services could have been offered which if accepted may have been positive in this situation. Practitioners should identify informal carers and offer carers assessments.

- Practitioners working with Mr M and his wife did not appear able to find a way which supported them to engage with services. This led to them often only asking for help when situations reached crisis point. Practitioners should be respectfully persistent when working with individuals who self-neglect.

- There were times when professionals could have exercised more professional curiosity in relation to why Mr. M and his wife were reluctant to engage in support that was being offered.

- Practitioners did not always appear to recognise the need to fully explore Mr M's capacity to make decisions for himself.

- Self-neglect can be difficult to navigate as a professional. An unwise decision does not necessarily indicate that someone lacks capacity but it may indicate a need for a capacity assessment.

- There were other family members who may have been able to provide some insight into the care and support needs of Mr M and his wife. Confidentiality is not breached by receiving background information which may support risk assessments and decision making relating to people who self-neglect. Information gathering is different to information sharing.

- Some local and community services may have been able to provide services that Mr M and his wife were more comfortable in accepting (as opposed to statutory services). Advocates should also be considered for individuals whose capacity may fluctuate or those who have limited understanding of services.

- Mr M's wife was told by one service to call another during a period of crisis. It would have been of benefit in this situation if the service had made the call with her knowledge on her behalf.

Mr I

Mr I was a popular 70-year-old man who lived alone. He died at home in May 2021, the cause of death was considered to be of a natural cause.

Mr I had lived without utilities since at least 2011. His home was insecure and there was evidence of hoarding and living in insanitary conditions.

The COVID Pandemic had a significant impact upon Mr I. Lockdowns prevented him from being able to use the facilities at pubs which had been part of his daily routine, providing companionship, food, drinks, washing and toilet facilities.

The learning from the review identified the following:

- Concerns in relation to self-neglect should be recorded. Use the Clutter Rating Tool when this relates to hoarding link. All staff involved in self-neglect work need access to supervision, specialist advice and an escalation process to escalate circumstances when complex and/or there is significant risk.

- SSCP's Self-Neglect Guidance and Procedure link should be followed as soon as any concerns relating to self-neglect are raised. This ensures that the response is based on best practice. All agencies should ensure that staff are familiar with our Self-Neglect Guidance and Procedure.

- Agencies must work together and share information to ensure they are able to draw on all the available information held within each agency to build a full picture of the risk and extent of self-neglect. The approach should follow SSCP's Multi-Agency Guidance: Working with Risk

- Assessment (including assessing risk) and providing assistance at the earliest opportunity is important. The longer a person has been self-neglecting the more difficult it will be to intervene.

An action plan was developed by the agencies involved. All actions identified have been completed.

Mrs H

Mrs H lived with her husband for almost 60 years until he was admitted to a care home. She had multiple physical and mental health difficulties, including paranoia and had attempted suicide several times and had an extensive history of contact with mental health services including hospital admissions.

Mrs H had been admitted to a mental health service, discharged to a care home, but returned home since she was considered to have the mental capacity to decide where she should live. She was provided with care at home to support her and to ensure that she took medication.

Mrs H said that she had experienced a seizure since she could not access her medication and a decision was made to allow her unregulated access to it. Mrs H's care package was reduced, and Mrs H refused to allow carers in. Mrs. H was found collapsed on the floor and died in hospital.

The learning from the review identified the following:

- Certain brain conditions can affect mental capacity, including the ability to turn decisions into actions. Mrs H appears to have been able to talk persuasively but was unable keep herself safe. Mental Capacity Assessments need to consider executive functioning. Executive function and self-regulation skills are the mental processes that enable people to plan, focus attention, remember instructions, and juggle multiple tasks successfully.

- Always conduct mental health risk assessments and create Suicide Safety Plans with people where there is a risk of self-harm or suicide.

- Mrs. H refused to let her carers into her home. Always agree a plan for how to respond to refusals of care with the care provider and other professionals. This should include what to do when care is refused, who should be notified and what situations would require a more assertive response.

- Mrs. H at times said that she did not want her family to be involved or notified about her. Even in these situations you can still listen to the concerns raised by family members, even if you do not have consent to share information with them. Always verify different accounts of events

- Not all best interests' decisions have to be recorded, but when you are making significant ones about where someone should live or what support they should receive then it is good practice to record how these decisions were arrived at.

An action plan was developed by the agencies involved. All actions identified have been completed.

Lily

Lily was 34 years old when she was found deceased at her home following a call to Police by concerned neighbours. Her body was in a state of decomposition and her living conditions were described as poor. Lily was known to several services in the local area as she had complex mental health needs. There was an inquest into Lily's death. The Coroner recorded that she died of an "unascertained cause, in unknown circumstance".

The learning from the review identified the following:

- Services did not find a way of engaging with Lily leading to them closing her to services.

- There was more than one occasion when there were three or more agencies all struggling to find a way to engage with Lily. Calling a multi-disciplinary meeting may have supported them to find a way forward. Services did not find a way of engaging with Lily leading to them closing her to services.

- Lily had an impairment of the brain or mind (which agencies were aware of). This impairment could have affected her ability to make decisions during periods of crisis and should have led assessments of capacity being carried out.

- When carrying out assessments of someone's mental capacity, it must be properly recorded. The decision that the adult is being asked to make should be included in this record.

- Practitioners often found it hard to engage with Lily. A Housing Compliance Officer visited Lily's home weekly for eight months, speaking to her through the window or door before Lily started to respond.

- Lily did not always communicate how she was feeling verbally. Instead, she preferred to write to professionals. These letters included disclosures about past abuse, concerns about current harm and her feelings. If professionals receive letters from individuals, they are working with they should be responded to and considered as a possible indicator of how the person is feeling or what they might want to tell services.

An action plan was developed by the agencies involved. All actions identified have been completed.

Arthur

Arthur's referral was received in August 2022. He was Deaf and found deceased at home. There were significant concerns about self-neglect, alcohol misuse and his mental capacity to manage his own needs.

The learning will be published in next year's report.

Sophie

A referral for Sophie came in January 2023. She was 35 and had a history of mental health and alcohol misuse issues. She was found deceased at home.

The learning will be published in next year's report.

Joint Safeguarding Adult and Child Safeguarding Practice Reviews

Family Pugh

This referral was received in December 2022. Concerns were raised about significant self-neglect of the mother and the impact of this on her two children.

The learning will be published in next year's report.

Domestic Homicide Reviews

Ms A

Ms A was a 65-year-old woman who was unlawfully killed by her 38-year-old daughter. This review has been completed as the report is currently with the Home Office for quality assurance.

The learning will be published in next year's 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.

This is currently with the Home Office for quality assurance.

The learning will be published in next year's report.

Laura

This referral was received in September 2022. She was 40 years old who took her own life. There was a history of domestic abuse in multiple relationships and concerns about substance misuse.

The learning will be published in next year's report.

Ms E

A referral was received in July 2022 regarding a deceased 48-year-old female who took her own life following a domestic incident with her ex-partner. It was subsequently deemed that there was no evidence of domestic abuse in her most recent relationship and so a Safeguarding Adult Review was recommended. However, the Home Office requested that a Domestic Homicide Review be undertaken.

The learning from this joint Safeguarding Adult Review and Domestic Homicide Review will be published in next year's report.

Anti-Social Behaviour Case Reviews[5]

There were 8 requests to conduct Anti-Social Behaviour Case Reviews during this year. This is a **60% increase** on the year before. Only 2 did not progress as a review. 6 reviews had action plans developed in response to the concerns raised.

All of the reviews related to victims who were reporting ongoing issues with their neighbours.

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.

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
- policy development
- co-production of resources

We'd like to thank the children, parents and professionals who worked with the Children's Society on the production of our child neglect poster campaign. Your insights helped us create powerful messages.

We'd also like to acknowledge the feedback we received from some of our victims of Anti-Social Behaviour who took the time to read and comment on our revised Anti-Social Behaviour Case Review process.

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

Our approach to learning and development

Shropshire Safeguarding Community Partnership's 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 to enable consistent safeguarding training to be delivered effectively to multi-disciplinary staff.

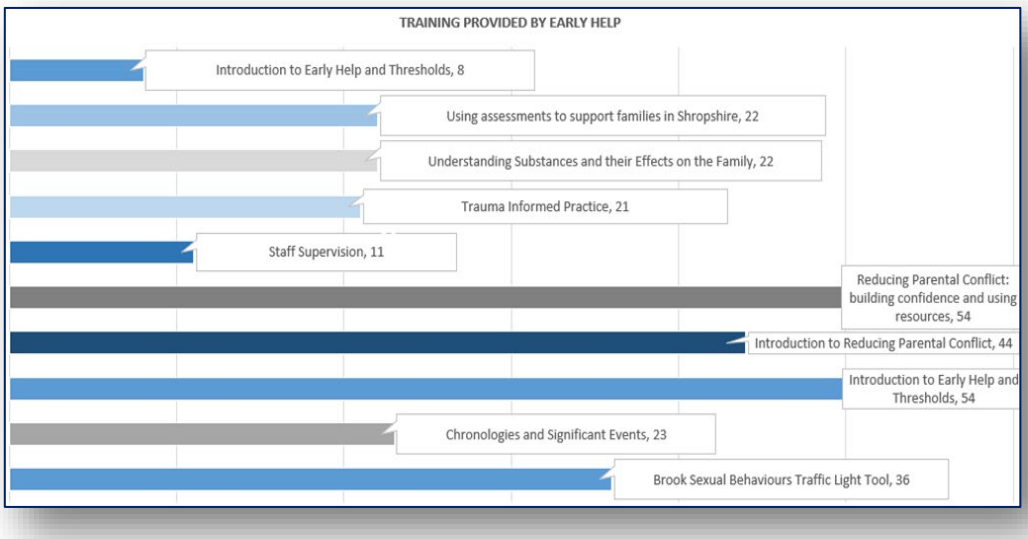
Learners' engagement has been high using online platforms which operate in real-time and support learning.

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.

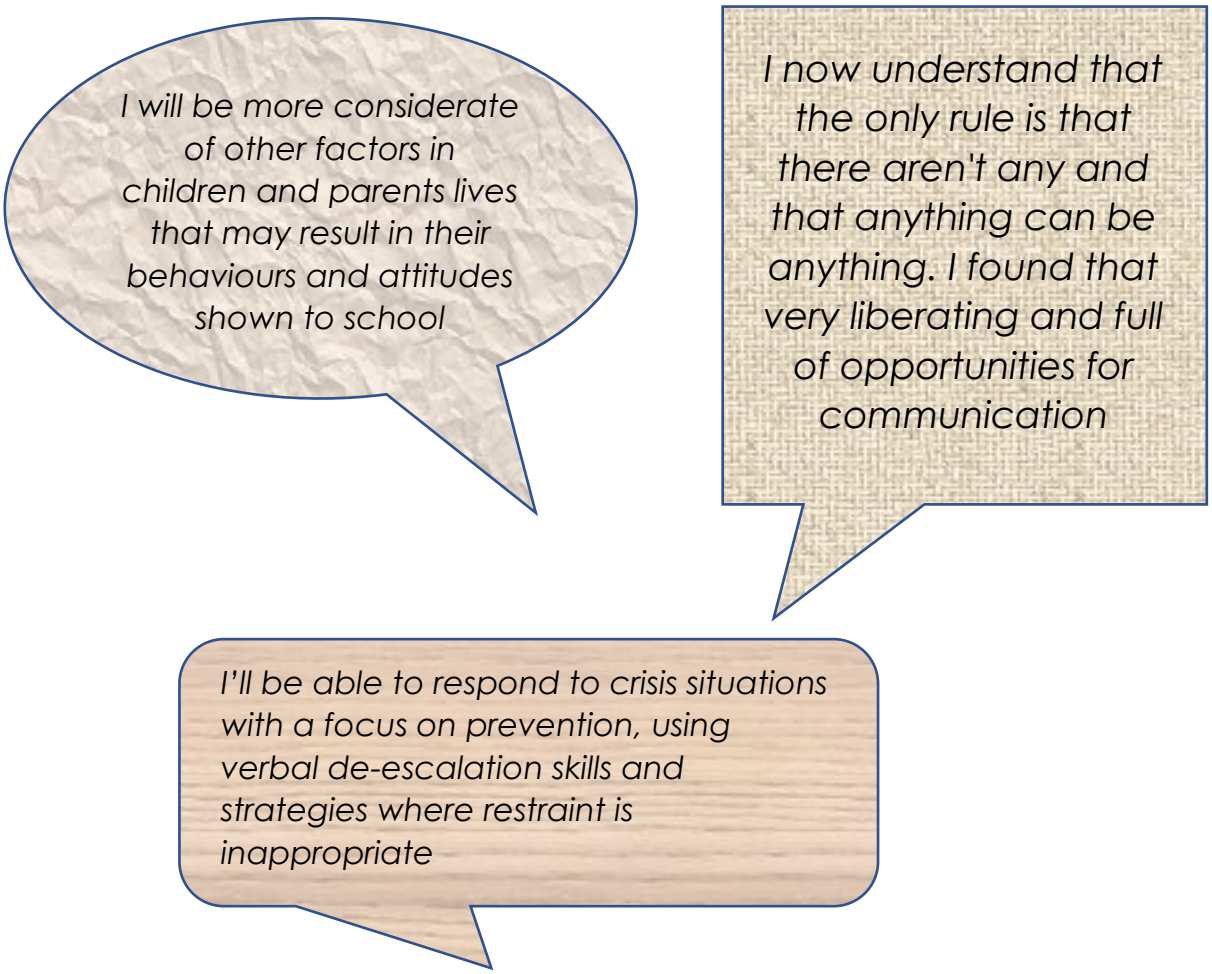
The majority of training sessions described in the report are provided on a multi-agency basis which is the preferred approach of Shropshire Safeguarding Community Partnership.

Early Help through Strengthening Families (Shropshire Council)

295 people received training provided by this team.

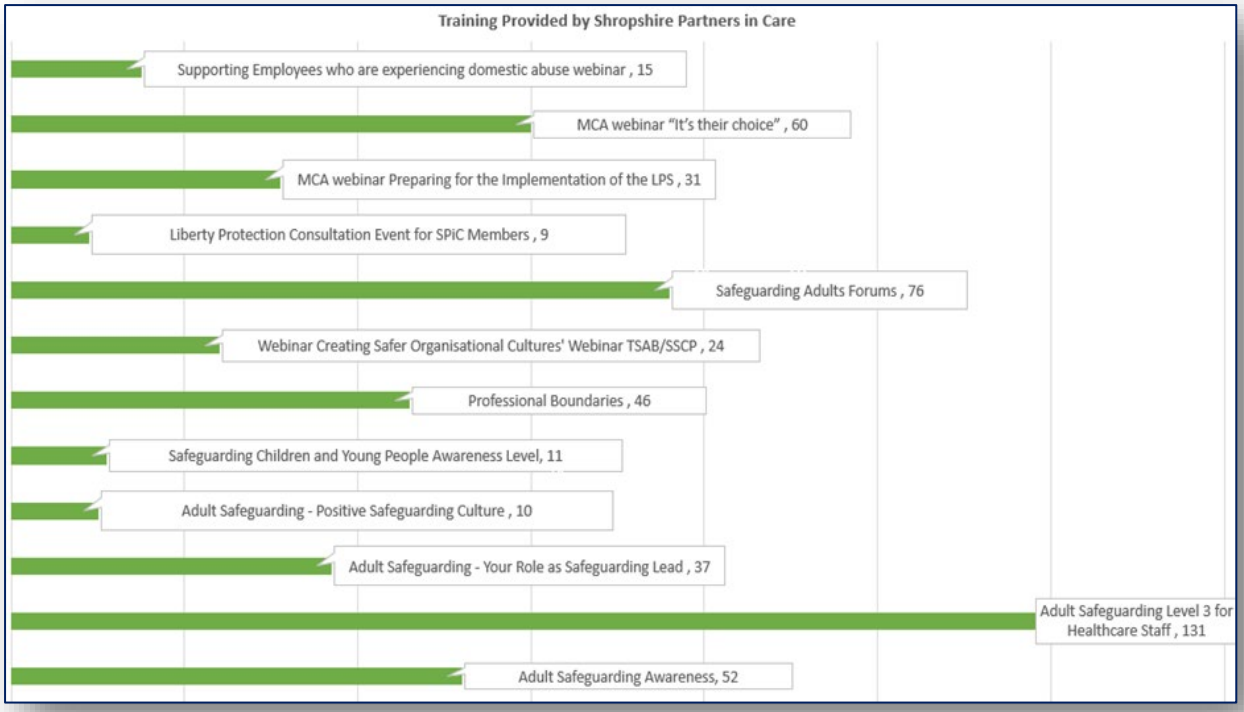


What difference has this made? Participants told Strengthening Families:



Shropshire Partners in Care

To fully reflect the work this organisation has undertaken, they also deliver training for the Joint Training Team in Shropshire Council. In total this organisation has trained 502 staff.



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

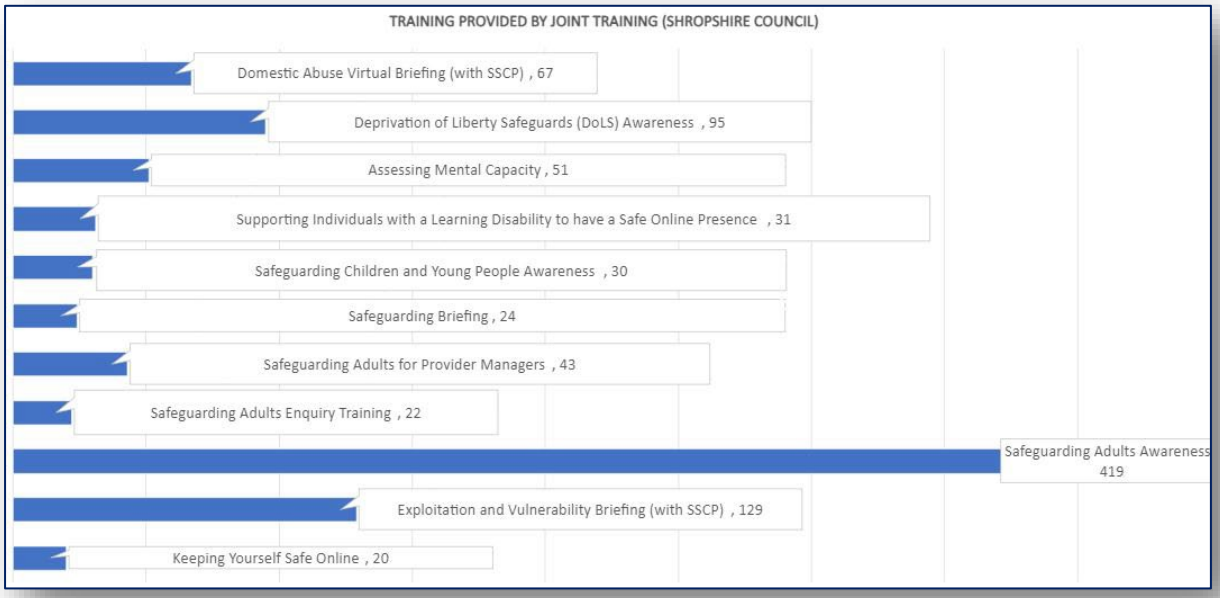
It will allow me to support my service users in deciding if a safeguarding concern needs to be raised

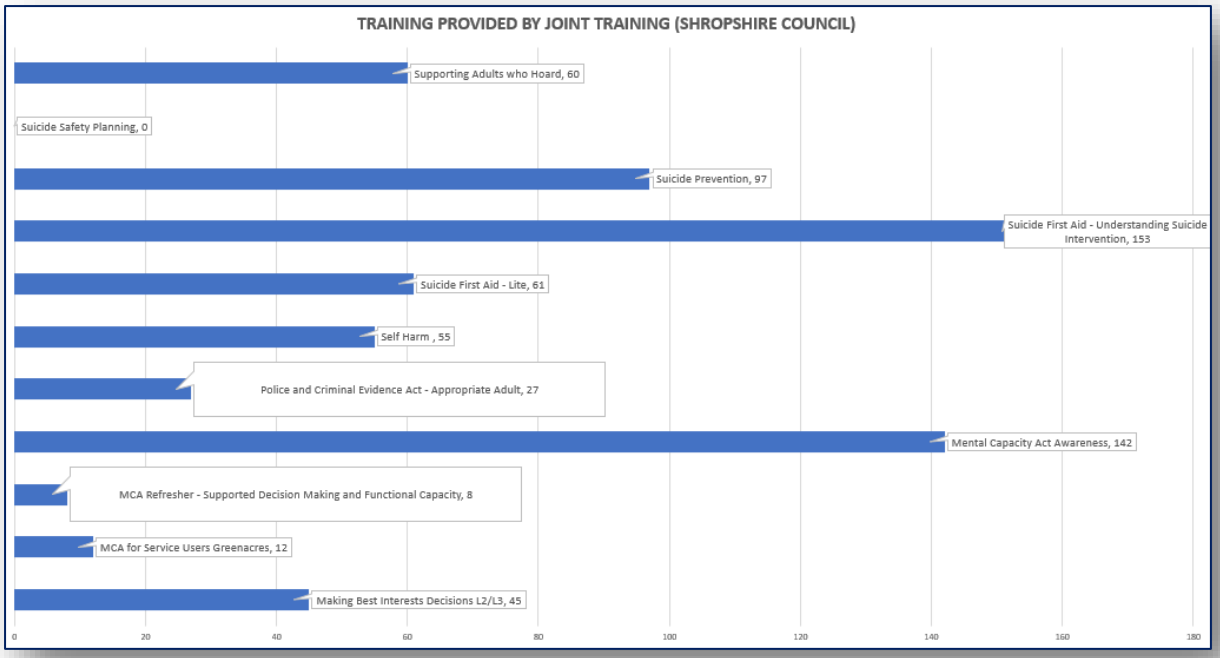
It's given me greater awareness and I feel more empowered to be an upstander!!

I will always be mindful of my own actions and also my colleagues

Joint Training (Shropshire Council)

A total of 1591 people have completed training provided by this team.





What difference has this made? Participants told Joint Training:

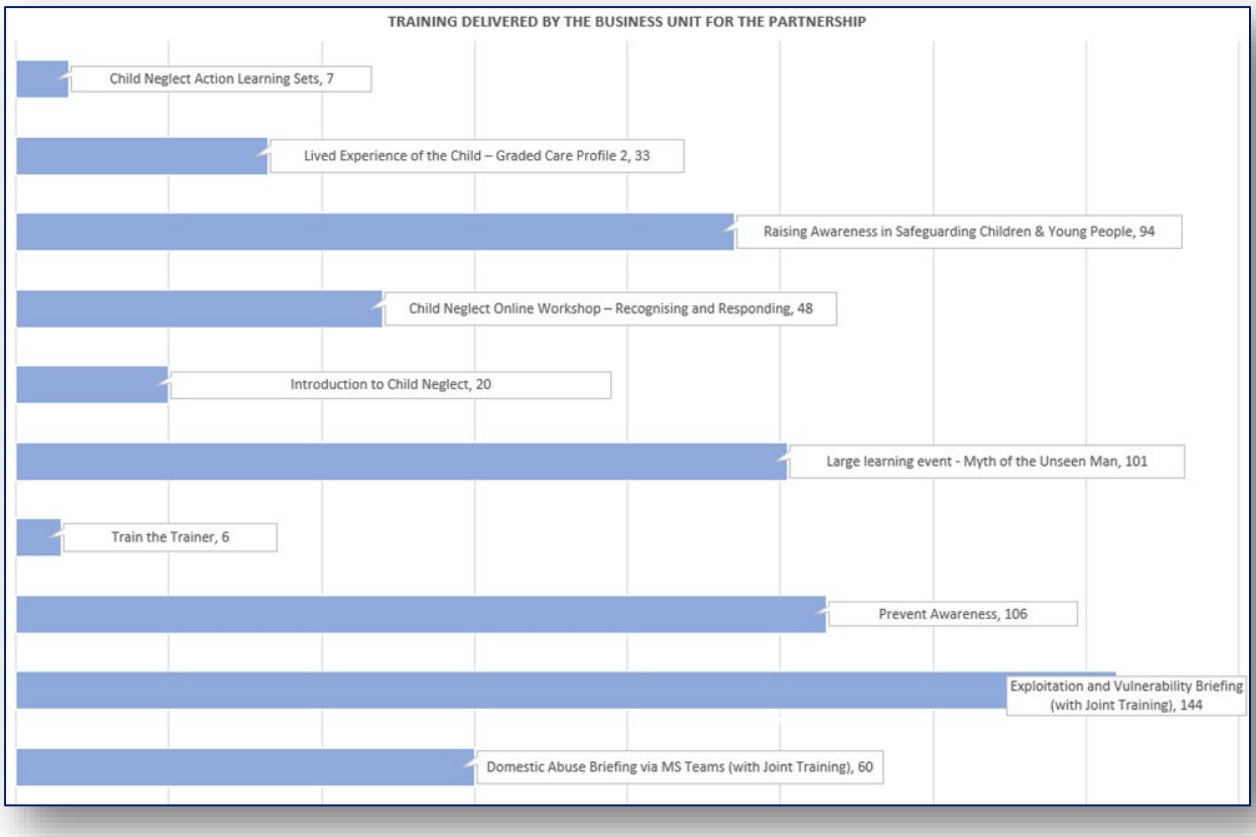
I am going to create a safeguarding policy for my private practice

I am going to be curious and alert to asking further questions if I am not happy about what I see or hear

I now know that for young people that sense they will still love the parent/perpetrator but blame themselves

Business Unit for the Partnership

619 people working across our safeguarding system completed training and events during this financial year.



What difference has this made? Participants told the Business Unit:

This made me think about the importance of training the whole organisation on child neglect, at every level, so that we do not miss what is right before us just because we are being presented with other forms of abuse

I am currently working with someone who this applies to and so I will consider this more when completing mental capacity assessments with her

I now understand the importance of evidence to support concerns so that factual evidence can be used

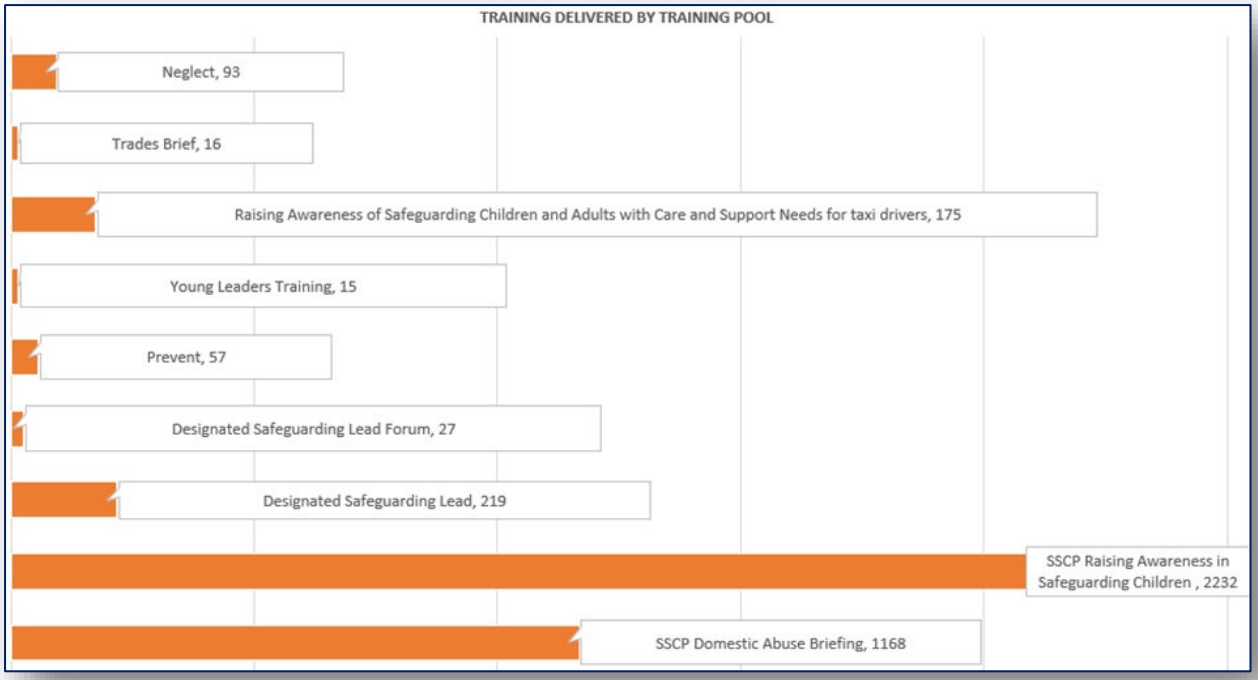
Shropshire Safeguarding Community Partnership's Training Pool

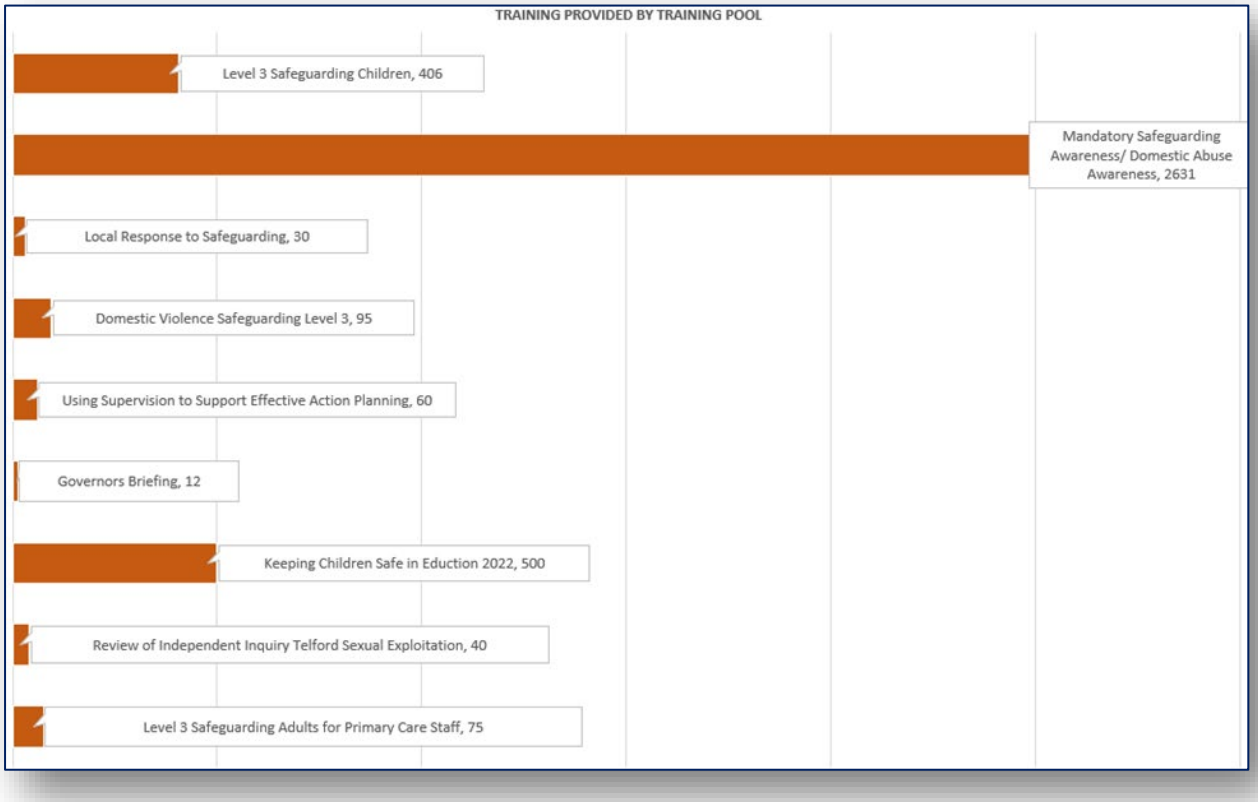
The impact and reach of the Partnership to raise awareness about Safeguarding and Child Protection Training across Shropshire is only possible because of the dedication and enthusiasm of the professionals who make up the Training Pool.

The Training Pool provide training not only within their own agencies but 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.

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 and Shropshire, Telford and Wrekin Integrated Care Board.


TRAINING DELIVERED BY TRAINING POOL
Neglect, 93
Trades Brief, 16
Raising Awareness of Safeguarding Children and Adults with Care and Support Needs for taxi drivers, 175
Young Leaders Training, 15
Prevent, 57
Designated Safeguarding Lead Forum, 27
Designated Safeguarding Lead, 219
SSCP Raising Awareness in Safeguarding Children , 2232
SSCP Domestic Abuse Briefing, 1168


TRAINING PROVIDED BY TRAINING POOL
Level 3 Safeguarding Children, 406
Mandatory Safeguarding Awareness/ Domestic Abuse Awareness, 2631
Local Response to Safeguarding, 30
Domestic Violence Safeguarding Level 3, 95
Using Supervision to Support Effective Action Planning, 60
Governors Briefing, 12
Keeping Children Safe in Eduction 2022, 500
Review of Independent Inquiry Telford Sexual Exploitation, 40
Level 3 Safeguarding Adults for Primary Care Staff, 75

What difference has this made? Participants told their trainers:

I'm going to review our policies and practices

I will be looking and listening much more carefully to students who are upset or indifferent, observing injuries with much more sensitivity

Many foster and connected carers said how the training will change their future practice

Throughout our training sessions 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

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

The Partnership continues to challenge performance and ask the difficult questions. This proactive approach is most powerful when it is the combined voice of all the partners.

The ability to scrutinise and demand improvement is consistently showcased by all the partners. This is evidenced in the Early Years intervention working and the series of strategic and tactical workshops that were actioned in the spring of 2023.

The Partnership has been effective in identifying barriers to partnership working and has also sought to work more closely with other key stakeholders away from the Partnership such as the Police and Crime Commissioner for West Mercia.

Tanya Miles, Executive Director of People, Shropshire Council

We know that working together in effective partnerships and collaboration is critical to achieving the best outcomes for our children, families and adults with care and support needs here in Shropshire.

Through our partnership working we have continued to strengthen and build our joint approach to safeguarding and community safety, to challenge where needed and focus on learning and improving performance and outcomes. We continue to constructively challenge ourselves to find solutions to areas where we need to improve. We do still have more work to do however to share learning and embed this in our practice and raise awareness in our communities but we will continue with passion and determination in our partnership to deliver improved outcomes for our population.

Vanessa Whatley, Interim Chief Nursing Officer, NHS Shropshire Telford and Wrekin Integrated Care Board

Through our partnership working, transparency and sharing of information we continue to strengthen our safeguarding arrangements.

Only through a continuous improvement process, careful measurement and detailed understanding of our challenges, can we work together with our partners to prevent tragic cases from occurring. We must maximise the learning from all cases, identify themes quickly and engage others in meaningful ways to respond in their everyday practice. We must capture this so we, as a partnership, can direct the next steps with conviction, curiosity and courage which we do on a daily basis.

Stu Bill, Superintendent, West Mercia Police

Collaborative working, with the right environment where agencies can hold each other accountable, is integral to effective partnership working. This isn't always easy and can strain relationships. I have however consistently seen passionate, dedicated people from all services, determined to make a real difference in the lives of communities in Shropshire. Indeed most members of the partnership not only serve the county, but also live here. This passion to do better for all can be seen daily.

We do need to recognise and respond however to areas of improvement. There have been tragic cases highlighted in Shropshire that should cause us all to stop and reflect on our roles and responsibilities. Only with a mindset of continuous improvement will we manage these risks and reduce the harm.

Thankfully, I remain firmly of the view that this is the case across all agencies in Shropshire and we will continue to deliver for those who need us most.

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

All statutory agencies and partners have been working hard to get to a place where we have a consistent, co-ordinated approach to reduce offending amongst the key priorities of serious violence, hate crime, re-

offending and anti-social behaviour, focusing on prevention in our work with schools and communities.

The mandate for reducing re-offending 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 2022 -2023 we have sought to identify crime trends and offending patterns to effectively put together a plan of action that aligns with our commitment to protecting vulnerable victims and reducing crime. We have seen a Government emphasis upon serious violence which promotes a multi-agency approach to understanding the causes and consequences of this crime, focused on prevention and early intervention. We are working with Office of the Police and Crime Commissioner in adopting a place based, public health approach, understanding that violence is preventable and identifying the reasons why people get drawn into crime.

We have an effective partnership arrangement in Shropshire and the ambition is to have swifter information flow, early identification and support for those at risk, increased involvement and co-production with communities and a reduction in the risk of communities experiencing anti-social behaviour.

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 2023/24

- Implement our new structure as a result of reviewing our priorities discussed on 3rd February 2023

- Ensure that each group has a Strategic Action Plan in place with success statements agreed.

- Respond to the consultation on the new Working Together 2023 to Safeguard Children document and begin our preparation for implementation.

Closing Scrutiny statement

Shropshire Safeguarding Community Partnership is constituted to deliver the functions of multi-agency safeguarding arrangements for children, the safeguarding adults board and the community safety partnership.

I am required by Working Together 2018 (refreshed in December 2023) to undertake independent scrutiny activity of the effectiveness on multi-agency safeguarding arrangements for children. The combined partnership gives me the opportunity to report similarly across the spectrum of the partnership's activity.

During the partnership development event all partners were asked whether they felt the combined approach should be retained. With the exception of a few individuals who expressed concerns about the robustness of community safety activity and the impact on children's safeguarding arrangements, all partners confirmed their commitment to the combined approach.

The statutory case review processes in Shropshire are effective, including the consideration of findings from the National Panel thematic reviews and the national thematic review of Safeguarding Adult Reviews. There are some challenges with the timeliness of the conduct of reviews, but I monitor these closely and support escalation activity where it is necessary. During this reporting year, the partnership actively considered the six practice themes identified in the national panel annual report. In addition the self-neglect group actively considered the findings from the national Safeguarding Adult Review.

The exploitation sub-group is working effectively to understand risks children face when outside the home and engage frequently with the

national advisor. The partnership reported to Shropshire Council's scrutiny committee on their work in this key area of practice.

This year there was a change in legislation which brought about the establishment of the Domestic Abuse Partnership Board, which sits within the single governance structure.

In my view there is a need for a discussion with national policy makers and departments regarding those adults who do not need a safeguarding adults approach under the terms of the Care Act, but do need support to address their vulnerabilities. I continue to press for this via the national safeguarding adult board chairs network. Interestingly in 2022, the Home Office introduced the 'changing futures programme' which resulted in the allocation of funding to support 'vulnerable adults', but this was not available to all areas, again I continue to press for further extension of this process.

There are two areas of challenge for the partnership those being the provision of multi-agency data and agreement on how the business unit which supports the partnership should be resourced. Both are subject to ongoing activity.

It is important that the data issue is resolved as currently it is a limiting factor in the partnership being able to fully demonstrate its effectiveness, and more importantly to show improved outcomes for children, families, adults and communities. I am hopeful that I will be able to report a much improved position in next year's report.

Finally I would like to place on record my thanks to all who work to safeguard children and adults and protect communities across Shropshire.

Ivan Powell
Independent Chair and Scrutineer