



# Children's Annual Report

## 2019 – 2020

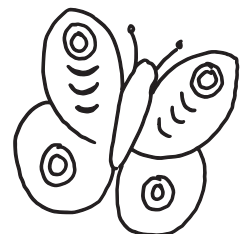




# Children's Annual Report Annual Report 2019 – 2020

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## Foreword by Ivan Powell (Independent Chair)

Welcome to the first annual report of the Shropshire Safeguarding Partnership and thank you for your interest in this important area of work.

Prior to the Children and Social Work Act 2017 and the publication of Working Together 2018, the safeguarding agencies in Shropshire had already commissioned work which resulted in combining the multi-agency safeguarding arrangements for children and strategic oversight of the safeguarding arrangements for adults in accordance with the statutory guidance of the Care Act 2014.

This is a unique reporting year in that whilst we had already moved to these combined arrangements in early 2019, we were not required to publish and therefore enact the arrangements for children until 29th September 2019. We are required by Working Together 2018 to publish an annual report covering a range of matters relating to child protection, including the effectiveness of our new arrangements from September 2019. It is for this reason that the Partnership have decided to publish separate annual reports for children and adults, a position which is likely to change in the future.

The Partnership approached the above reforms proactively and very positively and moved early to implement these new arrangements, but

necessarily much of that time has been focused on embedding the new arrangements and understanding the role and contribution that the Partnership and its member agencies can make. We therefore anticipate that it will take some time to realise the full ambition and benefits of this work. From my perspective we still have some way to go to ensure our partners make a shared and equal contribution particularly to ensure that the leadership, culture and learning can be used to evidence impact on the quality of service and improved outcomes for children and families.

In addition in February 2020, within this reporting period the Partnership agreed to incorporate the community safety duties as outlined in the Crime and Disorder Act 1998 within the Partnership's governance structure. This will add another dimension to the arrangements and again will take time to fully embed and realise the full benefits.

It is the right of every child to be safe, to thrive and achieve their potential. The Partnership brings together key partners from across the County to ensure we are working together effectively to prevent children and young people from coming to harm or that we take the necessary action where unfortunately this has happened. In addition we look to our communities who have an important role to play in being vigilant to the welfare of all our children and the information we give to the public is intended to assist in this. It is a fact that whilst for





many families, homes and communities provide support and safety for our children and young people, for some they are places of risk and danger and we need to ensure we all work effectively together to address these risk areas.

I am pleased to be able to report that following on from our independently commissioned work on the exploitation of children and young people, the Partnership now has a child exploitation multi-agency operational pathway beyond that which already existed for child sexual exploitation, and the Partnership exploitation group is now a joint arrangement between the children and adult's partnerships. This has enabled sharper focus on the aspects of contextual and transitional safeguarding.

We have also revised and updated our strategy to tackle childhood neglect across Shropshire, which still remains an area of significant concern and focus for the Partnership.

This reporting period has also seen the Partnership migrate from concluding serious case reviews commissioned in accordance with Working Together 2015, to carrying out Rapid Reviews and Local Child Safeguarding Practice Reviews in accordance with Working Together 2018. Rapid Reviews have been welcomed by all partners, with learning being identified much earlier than previously, enabling swift and decisive action to be taken and with the dissemination of learning being much closer to the processes in place at the time, leading to improved outcomes. The term 'rapid review' should not be mis-interpreted as being 'less work', I read all Rapid Review reports and they are detailed, thorough and robust.

During this reporting period the Partnership undertook one Serious Case Review and two learning reviews under the previous guidance. In addition two Rapid Reviews were undertaken with one resulting in a Local Child Safeguarding Practice Review and the other having identified all learning through the rapid review process. More detail is included in the main report.

I reported last year that from one of these cases Shropshire continues to seek to influence national policy regarding unaccompanied asylum seeking children who go missing. Disappointingly this has not progressed as efficiently as should be expected and I will be working with partners at a national level with a view to introducing an escalation process for central government to affect review recommendations which are outside the sphere of influence of safeguarding arrangements at our local level.

I consider myself to be very privileged to hold the position of Independent Chair and I will continue to both challenge and seek assurance from the Partnership on behalf of all children and families,



but equally will continue to recognise the sheer hard work and professionalism of those who give of their best every day."

**Ivan Powell,  
Independent Chair**







# Introduction

The Shropshire Safeguarding Partnership is a statutory body established under the Children Act 2004 and consists of senior representatives of all the principle stakeholders working together to safeguard children and young people in the county.

The Partnership carries out much of its work through a number of sub-groups and task and finish groups, supported by the Safeguarding Partnership Business Unit.

This is how we are structured:







Our groups are well supported by a wide range of agencies, including schools, colleges and voluntary sector organisations as well as the larger statutory organisations.

There are also a number of groups that contribute significantly to progressing the safeguarding agenda in Shropshire. These include:

- The Health Safeguarding Governance group, which brings together safeguarding leads from across all the NHS providers working in Shropshire and beyond its borders
- The Private Providers' Forum, which promotes safeguarding of looked after children placed within Shropshire from elsewhere
- The Schools Safeguarding Group, which provides a close link with schools across all phases, from early years to further education
- The Keeping Adults Safe in Shropshire Board.



# What we achieved this year

In our report for 2018-19, we described a number of areas of work that would continue as we implemented the new Partnership arrangements. Our particular focus was on:

- The Neglect of children
- Continuing work on our joint priority (with the Keeping Adults Safe in Shropshire Board) of Exploitation
- Strengthening our relationship with the Keeping Adults Safe in Shropshire Board and other Partnerships

We asked our partners to explain what they have been doing to support these priorities and this is what they told us.

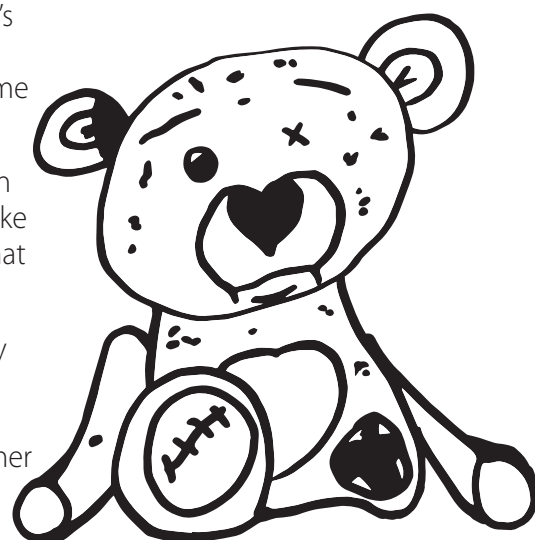
## The Neglect of Children

### West Mercia Police

At the end of 2019, a Shropshire school raised child safeguarding concerns in relation to one of their pupils. This was due to the child's mother being seen to be highly critical and aggressive towards her child. The school made the decision to monitor the child when 'home working' was instigated due to Covid 'lockdown' measures.

The child was not registering online for her classes which resulted in a teacher contacting the child via Microsoft Teams. The teacher spoke with the child who was extremely distressed, and they described that as a punishment they were being made to live in an 'outhouse'.

A Strategy Meeting was held and it was agreed that a single agency visit was initially required and Social Workers attended the child's home address. Upon attendance they found that the child had bruising to her back which she stated has been caused by her mother







hitting her. The poor living conditions were also noted as well as the presence of other children in similar circumstances and so the Social Workers contacted West Mercia Police, Shropshire's Protecting Vulnerable People department.

Police Officers from the unit attended the address and quickly established that the initial child involved was making a number of very serious allegations against both parents, including rape. The parents were subsequently arrested and all children were taken into police protection having disclosed offences, including cruelty. Items were seized from the address and photographic evidence of the poor living conditions was also documented.

Due to the varying ages of the children involved, a great deal of multiagency engagement took place to establish the correct pathways for all the victims, be that through adult or child services.

An extensive police investigation was undertaken and this tragic case is currently with the Crown Prosecution Service for finalising the criminal proceedings against both parents. Most importantly the children/young adults are now safe and in receipt of the appropriate care and support and in the case of the initial child, reassurance that the parents do not know where she now resides. Again, through strong multi-agency working practices, we have prevented further neglect and abuse of these very vulnerable children.

### **Shropshire Council; Public Health**

We have developed a protocol to support joint working across a range of children's health and social care services (including drug and alcohol services) as part of the suite of tools that will be used to support the early identification of neglect.

### **West Mercia Youth Justice Service**

Building open, honest and trusting relationships with the children we work with, may often lead them to disclosing a personal experience. A discussion is held with the child so they are fully assured of any actions and further discussions which will need to be held and their assessment/safety plan is updated to review and reflect any changes to their circumstances. The youth justice service will then list them for an emergency panel discussion with agencies and partners.



## Shropshire Clinical Commissioning Group

The Designated Nurse and Named GP are available for support and advice for any concerns GPs have on safeguarding issues, including supporting and training GPs to understand and raise issues as per the escalation policy.

## Shrewsbury and Telford Hospital NHS Trust

The hospital made more referrals for Neglect due to missed appointments than we have referred previously. We are unable to give numbers as the database has changed this year but going forward we will be able share numbers of children referred and in what category.

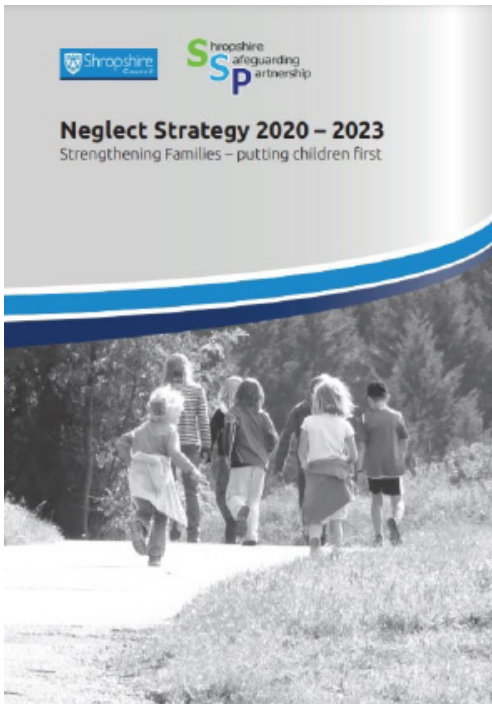
## Shropshire Council; Adult Social Care

The Emergency Social Work Team provides an emergency social work response out of hours to respond to the needs of children and young people at risk of significant harm.

The Preparing for Adulthood Team's work involves joint working between several partners including health and education and is developing close working links to ensure that young people who will potentially require support from Adult Social Care are identified early to ensure close working between all services.







## Neglect Conference (January 2020)

It had been three years since our last Neglect Conference and more has been learned about Neglect in that time.

This was an opportunity to continue to build on what we already knew and to explore best practice in supporting children and their families.

Shropshire's reviewed Neglect Strategy was relaunched at this conference along with the introduction of the partnership's Neglect Screening Tool and other useful practitioner support tools.

105 people attended and we only received a total of 28 evaluations which was very disappointing from a partnership perspective.

However, from the comments we received, it is clear that those attending benefited from it. Here is some of what they told us:

*"The event was very well organised. Good speakers, good venue and great food. Thank you for the effort you put in to ensure that participants felt valued"*

*"I met several different agencies, shared various issues and points of view and contact details"*

*"There was a lot of information shared; the morning was particularly useful with Jan Horwath speaking and the launch of the screening tool. I felt the afternoon was quite rushed with not really enough time to digest the information shared and speakers had limited time to fully present their information"*

*"It was great to be able to talk to health professionals, early help, social workers and other schools."*

*"I don't feel that there was enough time for the contents of the day."*

*"It developed my understanding of the Graded Care Profile 2 which I recommended as an Independent Chair but have not used professionally."*

*"We have cases when neglect is or has been a feature. It was useful to remember that even though the presenting issues may have been solved, there may be more enduring after effects."*

*"Jan Horwath provided a compelling description of neglect, reminded professionals that older young people are not less effected due to 'resilience' and need to be considered as fully as younger children."*

*"I was pleased to hear that chronologies that evidence long term neglect are being looked at by social workers. As a practitioner this can be frustrating as we have lots of information and evidence of neglect and are often told it doesn't meet threshold until something significant happens"*

## How serious is Neglect in Shropshire?

Percentage of Child Protection Plans under category of Neglect

**54%**

Neglect identified in % of assessments

**40%**

Higher than stat neighbours (21%) and national average (17%).





## Exploitation

Exploitation remained a joint priority with the adult's partnership for this financial year. This is what our partners told us about their work in this area:

### West Mercia Police

We have invested in an Online Child Sexual Exploitation Team (OCSET) who lead on investigations into children who are abused online, and where indecent images of children maybe being shared as a result in the rise in this area of criminality.

Where children and adults are exploited as a result of organised crime and those linked to 'County Lines', the Force has invested in a dedicated intelligence function within the Force Intelligence Bureau to identify and map those at risk. This intelligence is shared with partners through the local Serious and Organised Crime Joint Action Group (SOCJAG).

### Shropshire Council; Public Health

Public Health Nursing service have CHAT and a single point of access for young people as well as availability for one-to-one contact within schools. Their assessment includes the use of exploitation tool kits. Themes and case studies are collated to evidence impact for contract monitoring purposes.

The Teenage and Adolescent Mental Health Services programme of training helps professionals support children and young people's emotional health and well-being. It supports them to help children to develop good emotional health, resilience and self-esteem which helps to reduce the risk of exploitation.

Public health commission We Are With You Young People's Service who routinely screen for exploitation using the SMARTER screening tool. The tool has been adopted as part of the local safeguarding suit of tools to support the early identification of drug and alcohol misuse and associated behaviours.



## West Mercia Youth Justice Service

All young people entering the service are assessed and if any risks associated with exploitation are identified, the Child Exploitation Screening Tool is completed. Any child known to the service, including those most at risk of exploitation, who are assessed as at risk of high harm will be subject to a Risk Management Plan, which is reviewed and monitored through the service's multi-agency High Risk Panels.

Our service has also provided presentation to the Youth Court Panel (magistrates) on exploitation, the National Referral Mechanism and best practice with young people at risk of exploitation.

An example of our practice in relation to exploitation is provided in the following case study of a 15 year old referred for consideration for an Out of Court Disposal for an offence of possession of cannabis. Following an assessment, it was decided to offer the young person an informal disposal supported with an intervention programme.

The young person's family had informed the service that the child's behaviour was often chaotic, reckless and impulsive. Whilst working with the youth justice service the child did become subject to a Child Protection Plan, was referred to the National Referral Mechanism and was discussed in the Serious and Organised Crime Joint Action Group. There was intelligence suggesting the child had drug debts, was being coerced and there were episodes of them going missing.

The youth justice service interventions included support from the service's Education Officer to access a college course, a substance misuse programme and work on their emotional welfare and mentoring.

At the end of the work, there has been a distinct change in the child's behaviour, use of drugs and family relationships. The child continued to be supported by the mentor following the closure of the youth justice programme.



## Shropshire Clinical Commissioning Group

The organisation monitors all health care providers to ensure that the work to prevent or stop exploitation is a top priority. This includes discussing individual cases, training GPs on exploitation, ensuring that each provider has an agreed contract on standards of care and ensuring training recognition and actions are in place for any Child Protection concerns.

The Designated nurse for Looked After Children is an active member of the private provider forums, ensuring that children in care are supported with increasing complex care needs who are vulnerable to being exploited.

## Robert Jones & Agnes Hunt Orthopaedic (RJAH) NHS Foundation Trust

The children's team at The Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust delivered in-house training to the paediatric Unit to raise awareness of Exploitation in December 2019. This session focused on ensuring staff are aware of the possible signs of Exploitation and are able to consider this may be a possibility when dealing with a 'troubled' child. The Exploitation tool kits were shared and staff were encouraged to focus further learning around Exploitation.



## Shropshire Council; Children's Social Care

On receipt of Child Exploitation referrals, the information is recorded on a Child Exploitation Tracker. A weekly meeting is then held to discuss any new referrals and agree the risk level has been appropriately identified. Whether children are being responded to with the right level of support is also discussed and actioned. Existing referrals are also discussed and the tracker is then updated to reflect the current risk level. Professionals participating in Child Exploitation meeting include the Social Care Child Exploitation Operational Lead and representatives from West Mercia Police Child Exploitation Team, Early Help, Education, Health, Youth Justice Service and Addaction. The meeting allows us to:

- Share information
- Receive and give updates about children and investigations
- Have an overview of the picture of Child Exploitation in Shropshire and the effectiveness of work being carried out to reduce risk to children

All the Shropshire children identified with a risk level of medium and above are allocated social workers and their risk is addressed either through Children in Need Plans or Child Protection Plans.

## Exploitation Commission

Both the adults and children's partnerships identified the importance of working closely with the Community Safety Partnership in achieving this joint priority given the complexity of the issues in order to ensure a holistic and overarching response to exploitation in Shropshire.

In response to the strength of view from the multi-agency children's partnership, Shropshire Safeguarding Partnership commissioned a piece of work to focus on and develop a child exploitation multi-agency operational pathway beyond that which is already in existence for child sexual exploitation. In addition to this primary focus, the Independent Consultant commissioned for this piece of work was also asked to:

- Review current governance arrangements for exploitation and serious organised crime in Shropshire and
- Identify opportunities in the outline pathway to safeguard adults with care and support needs who are being criminally exploited/at risk of being exploited.

## Shrewsbury and Telford Hospital NHS Trust

Trust compliance with Level 2 Adult Safeguarding Training was 90% for those staff groups which included all nursing and medical staff and this training was provided to all patient and public facing staff groups.

The impact of the introduction of criminal exploitation training into the Trust has subsequently led to staff in the Emergency Department recognising and raising concerns in relation to potential modern slavery cases.

Over 400 staff have been trained to level 3 so the hospital maintains 90% of Level 3 staff compliance. Evaluations from staff include

- Very informative
- More observant
- Well delivered
- Excellent
- More aware of people's behaviour
- Videos very emotive.





Two workshops involving partners across the children and adult's multi-agency safeguarding partnerships and the Community Safety Partnership were held as part of this commission.

During the workshops there was a multi-agency consensus that the partnership Governance arrangements for responding to exploitation need to be clear. It was proposed that the Community Safety Partnership consider the development and implementation an overarching Violence, Vulnerability and Exploitation Strategy; through the initiation of a Violence, Vulnerability and Exploitation Strategy Strategic Group.

The Community Safety Partnership met on 3rd July to consider this proposal but did not accept the proposal. They were unable to see what the role of such a group would be in the structure that was proposed as they felt that there might be duplication of work and actions with other groups. They also expressed concern about establishing another group when all agencies are struggling to maintain attendance at existing groups.

As a result of the commission, the following happened:

- The Child Exploitation Group was developed and launched.
- The Exploitation Group was asked to continue as a joint arrangement between the children and adult's partnerships.

Shropshire Safeguarding Partnership recognises this will change in the next financial year as we come together with the Community Safety Partnership.

## How serious is child Exploitation in Shropshire?

Number of new  
exploitation referrals

**106**

Gender split

**55 male**

**51 female**

Level of risk

**Low Risk: 60**

**Medium Risk: 42**

**High Risk: 5**

Social Work Assessments  
where Child Sexual  
Exploitation (CSE)/Gangs

**96 Child Sexual  
Exploitation**

**73 Gangs**

Of the 107 assessments of risk  
undertaken for new Exploitation  
referrals, 43 (40%) were about Child  
Sexual Exploitation and 64 (60%)  
about Child Criminal Exploitation.





## Strengthening our relationship with the Keeping Adults Safe in Shropshire Board and other Partnerships

A successful strategy and priority setting day was held with partners on 13th February 2020 and the following priorities were identified for the next three years:

- Joint priorities are Domestic Abuse, Exploitation and Transitional Safeguarding (the period of moving from Children's Services into adulthood)
- The Adult priority is Self-Neglect
- The Children's priority is Neglect
- The Community Safety priorities are Preventing Offending and Drug and Alcohol Misuse.

This work will result in the formation of a single governance structure for the Shropshire Safeguarding Partnership (children's and adults) and the Community Safety Partnership. Working in a joined-up way between our key Safeguarding Partnerships offers us opportunities to:

- Understand risk for individuals, families and communities from an all age, family and community perspective
- Embed the concept that keeping our communities, adults with care and support needs and children safe, is everyone's responsibility.
- Plan our response to risk more efficiently and reduce duplication
- Share risk across the health and social care system .

Although it is recognised that the legal frameworks for Adults and Children and Community Safety are different, there is a need to strengthen joint working particularly when the following factors are apparent:

- Adult's and Children's services work with the same families or a person is moving from Children's to Adult Services
- The presence of Mental Health issues
- Alcohol and/or drug use.

You will be able to read more about this work in the next annual report.



## The effectiveness of these arrangements in practice

An effective Partnership understands both what it is good at and what it needs to work on and learn from. This report offers a balanced view of our effectiveness. The training offer is wide ranging. The rigorous approach and analysis of course evaluations provides assurance that the right modules and range of training is being delivered to Shropshire's workforce to support an effective safeguarding system.

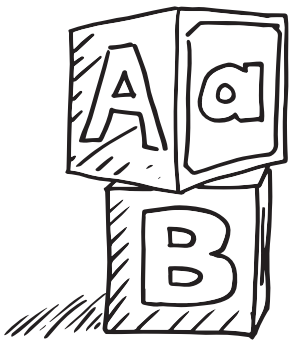
The SSP (through the Business Unit) is an active member in the West Midlands Safeguarding Procedures Group. The group has devised a two-year rolling programme for the revision of procedures unless learning, or changes in legislation mean we need to make more immediate changes. The procedures that were revised during 2019-2020 included:

### Level A statutory procedures

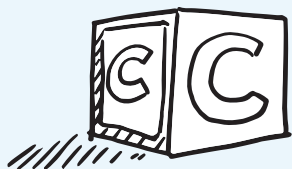
- Child Death Overview Panel arrangements

### Level B regional procedures

- Children missing from care, home and education
- Children affected by exploitation and trafficking (including gangs)
- Children with disabilities
- Children of parents with mental health problems
- Disguised compliance, coercive control and families who are hostile or resistant to change
- Information sharing and confidentiality
- Online safety: Children exposed to abuse through digital media
- Recruitment, supervision and training
- Safeguarding children and young people against radicalisation and violent extremism







- Female genital mutilation
- Sexual activity in children and young people (including under-age sexual activity and peer on peer abuse)
- Persons posing a risk to children
- Children and families moving across local authority boundaries
- Neglect
- Bullying.

### Level C local procedures

- Child safeguarding practice reviews tools and pathways
- Exploitation tools and pathways
- Substance misuse tools and pathways
- Multi-agency referral: reporting concerns
- Neglect tools and pathways.

The Regional Safeguarding Procedures Group also worked to ensure that the procedures were more easily accessible to practitioners and to identify where there was commonality in local procedures that could potentially become regional Level B procedures.

There is also a regular review of the analytics of the procedures site to:

- Assure partnerships of the effectiveness of the procedures pages

- To make changes where needed, informed by users search results and
- To pick up any other issues of usability.

During this period there were 48,913 (a 24% increase on last year) visits to the West Midlands Safeguarding Procedures site across the region. The number of visits has steadily increased each quarter with the procedures largely being accessed by desktop users, followed by those using mobile devices and then tablets.

Of the nine partnership areas in the consortium Shropshire consistently had a number of procedures that featured in the "Top 10 Downloads" listed across the region as follows:

- Multi-agency Referral Form = 946 downloads
- Child Sexual Exploitation Risk Assessment tool = 616 downloads (a 38% increase on last year)
- Suicide Prevention Care Pathway = 386 downloads (a 12% increase on last year)
- Child Sexual Exploitation Practitioner Guidance = 403 downloads
- Thresholds Guidance = 360 downloads (a 20% increase on last year).

This is because of the promotion of certain tools and pathways in multi-agency training and learning briefings.





Our work on Policy and Procedures offers further evidence of effectiveness and preparedness for being up to date with legislative changes and emerging themes in practice, particularly because of the increase in interest of particular tools as demonstrated above.

## There is of course a BUT...

### Serious Case Reviews

(undertaken when a child dies or is seriously harmed because of abuse) make us realise we are not always as effective as we would want to be in protecting children from death and serious injury.

With the changes to safeguarding partnership arrangements also came a change in national guidance as to how partnerships improve child protection and safeguarding practice by learning from case reviews. The Serious Case Review process was replaced by Local Child Safeguarding Practice Reviews, which are undertaken when a child dies or is seriously harmed because of abuse. Rapid reviews were also introduced as a new process to quickly identify learning and establish if a case of serious harm meets the criteria for a Local Child Safeguarding Practice Review.

During this period SSP undertook a serious case review and two learning reviews under previous guidance. Two rapid reviews were undertaken with one resulting in a Local Child Safeguarding Practice Review and the other having identified all learning through the rapid review process.





## Child F Learning Review

### Summary

Child F was a new-born who sustained serious non-accidental injuries at just 21 days old. Both parents were teenagers and concerns had previously been raised about their ability to parent. The review focussed on how agencies worked together following the notification of the pregnancy, the diagnosis of the father's learning needs/learning disability and concerns about their parenting.

Following a Police investigation, it was not possible to determine who inflicted the injuries to F and she remained in the care of foster parents.

### Lessons

- Where it is thought that a parent has learning difficulties and there are concerns that this impacts on their capacity to parent, practitioners should seek to confirm the diagnosis and to understand the impact
- No formal pre-birth assessment took place in this case. This was a missed opportunity during pregnancy, particularly given the vulnerabilities of the mother as she was a child herself. A timely pre-birth assessment would have enabled an appropriate support package to be put in place for the family
- There were a number of concerns that should have been escalated by agencies where health professionals remained concerned following referrals to Children's Social Care that didn't meet the threshold for intervention. There was also concern regarding the mother declining a mental health assessment and this too should have been escalated
- Good practice was identified with established communication channels between health agencies in Powys and Shropshire. Information was shared cross-border and this was seen as effective. However, information sharing cross-border between local authorities was limited
- It was felt that health visitors and midwives understanding of different terminology across England and Wales could be improved, in particular the meaning of Early Help differs and is not well understood
- Where there has been an injury to a child with no reasonable explanation, practitioners should make an immediate referral to Children's Social Care and remain with the child until the social worker and/or Police arrive.





## Learning Review – Teenage Suicide

### Summary

This young person who died by committing suicide had a long history of Children's Social Care involvement dating back to March 2014 when she was made subject to a child protection plan due to neglect and parental substance misuse. She became looked after before moving on to semi-independent living. It was known that she had suffered childhood trauma, struggled with her mental health and self-harmed.

### Lessons

- The review found that the young person was frequently self-presenting at A&E due to being intoxicated or self-harming, but there was no information sharing with other agencies and in particular no communication with Children's Social Care regarding these A&E attendances.
- It was acknowledged that the transition process for this young person was started too late and it was established that there is no formal transitional pathway from the Leaving Care Team to Adult's Services. This an area for improvement.
- The young person was on the waiting list for the core CAMHs service having previously been referred but not assessed by the service. The review concluded that this young person would have benefited from care co-ordination.





## G Children Serious Case Review – currently underway

### Summary

This Serious Case Review examined the circumstances of agency contact and involvement with six children in a family who ranged from the ages of 2½ years to 16½ years. The eldest child experienced neglect, abuse and maltreatment, whilst the other children experienced neglect and maltreatment to varying degrees; all children experienced considerable instability in their home and school life.

The serious case review has been completed and learning shared with practitioners and managers, however the Partnership have taken the decision not to publish the report at this time due to the case being heard in the High Court.

## Child J Local Child Safeguarding Practice Review – currently underway

### Summary

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.

The review is currently on-going and will be mapped against the findings from the Child Safeguarding Practice Review Panel's themed report on criminal exploitation: 'It was hard to escape' 2020.







## Impact on Children and Families in Practice (including hearing the voice of Children and Families)

The Partnership also understands impact by undertaking multi-agency audits. Three were undertaken during this year on the following themes:

- Parents separated in private proceedings
- Child sexual abuse in the family environment
- Children who had become Looked After without any early help support.

### **Parents separated in private proceedings**

The audit looked at five cases, of which, three were graded “Requires Improvement” and two were graded “Good”. Although the cases were chosen from a random sample, common features of the cases included domestic abuse between parents and parental substance misuse.

Overall, it was found that:

- Action had been taken to keep children safe
- There was good consideration of parental alienation and parental acrimony
- Parents were found to be supported with substance misuse issues
- There could be improvements in considering and supporting both parents who have alleged domestic abuse.



## Child sexual abuse in the family environment

The audit looked at five cases, of which one case was graded "Outstanding" one was graded "Good with elements of Outstanding", one was "Good", one was "Requires Improvement with elements of Good" and the last one was "Requires Improvement".

Overall it was found that:

- Appropriate action had been taken to respond to sexual abuse within the family environment
- Learning from the Joint Targeted Area Inspection appears to have embedded across organisations
- There was evidence of good and tenacious responses by professionals. .

As the first family discussed at audit had been in and out of children's social care for a number of years, it was discussed that families who had been involved with services for over ten years should be subject to a multi-agency audit in the future.

## Children who had become Looked After without any early help support

The audit looked at six cases. One case was graded "Good", one was "Good with elements of Requires Improvement", two were "Requires Improvement" and two were "Inadequate".

There were recurring risk factors across cases:

- We found substance misuse in four cases. There was a lack of home visits by professionals reported by the mother in one of these four cases and in another of the cases we found that health care professionals did not recognise risk factors for children associated with adults participating in substance misuse
- Domestic abuse in five of the cases with only one family known to Domestic Abuse services
- County lines in three of the cases

Other issues included physical abuse, sexual abuse and Child Sexual Exploitation.



## What we know about children at risk in Shropshire

**529** Early Help Family assessments completed



**224**

Number of families allocated to Targeted Early Help



Contacts to COMPASS\*

**17,146**

Contacts have increased in 2019/20 partly due to a change in process.

\*COMPASS is the council's team that concerns are reported to

Referrals to Children's Social Care

**1,882**



**1,574**

**Children in Need**

A Child in Need is one who has been assessed (or is being assessed) by children's social care to be in need of services.



Rate of CP Plans **45** (per 10,000 U18's)

The number of children subject to child protection plans fell during 2019/20.

Number of children on a Child Protection Plan

**270**

at 31/03/20 - latest categories of abuse %:



Neglect: **54%**



Emotional Abuse: **33%**



Sexual Abuse: **7%**



Physical abuse: **7%**

Rate of Looked After Children

**399** Children Looked After at 31/03/20



At 31/3/20 Shropshire had a higher rate per 10,000 U18s than statistical neighbours (62) but lower than the national average (67)

**66** per 10,000 U18s (same as previous year)





## Training

Shropshire Safeguarding Partnership training courses are designed using the following training strategy tiers:

- Specialist including Train the Trainer, Approaches to Prevent Sexual Assault and Harassment and Neglect Grade Care Profile 2 to 296 learners
- Targeted including Child Sexual Exploitation, Domestic Abuse and the Impact on Children, Working with Substance Using Parents to 451 learners
- Universal including Raising Awareness in Safeguarding, Introduction to Substance Misuse and Relationship Based Child Protection Conference Briefings to 622 learners
- Mandatory induction including Parental Mental Health, An Introduction to FGM, Forced Marriage, Spirit Possession & Honour Based Violence, Collaborative working; a whole family approach and Understanding Pathways to Extremism and Prevent.

354 learners completed e-learning offered through Virtual College during this period. This is almost double compared to the 185 learners who completed e-learning during 2018/19.

Shropshire Safeguarding Partnership ensures that training delivered is informed by the findings of local and national reviews; guidance; and workforce needs identified through multiagency case file audits.

Training is delivered on both a multi and single agency basis.

### Multiagency training

From 1 April 2019 to 31 March 2020, the Shropshire Safeguarding Partnership Training Co-coordinator, Training Pool members and commissioned organisations, delivered 74 multiagency Universal, Targeted or Specialist training sessions to 1369 learners. This is an increase of 13 training sessions and an additional 28 learners from 2018/19.

Shropshire Safeguarding Partnership ensures that training delivered is informed by the findings of local and national reviews; guidance; and workforce needs identified through multiagency case file audits.

Post course evaluations for all multiagency training are completed online. Initial online evaluations must be completed before certificates of attendance can be printed out.

These evaluations aim to assess the quality of the training delivery, how effective it has been at meeting the set aims of the session and whether the training has increased the attendee's confidence in dealing with the subject matter.

Three months after attending any SSP multi-agency Universal or Targeted training modules, learners are asked to complete a second online evaluation. This has been developed to evaluate the impact the training has had on professional practice and ultimately the difference this made to children, young people and their families.

## This is only some of what people told us:

'I had to raise a safeguarding concern so I was glad that I was aware how to do this, and the process to follow.'

"I completed an assessment tool two weeks ago and although it was not my first, it was my first since attending the training and the assessment was very well received"

"It has helped me support my colleagues and challenge the misconceptions regarding Domestic Abuse."

"I am more aware to see possible vulnerabilities in young people and the signs that they may be being exploited."

"I went out to do an initial assessment with a young person, the concerns were around county lines. The young person spoke about hearing voices that told him to kill himself and the training meant I felt prepared for this new information and was able to explore this with him and assess the immediate risk"

"I used the tool (GCP2) to structure a professional discussion about a family to see if they met the threshold for onward referral."

"I feel that I am recording contacts and sharing information with a greater emphasis on clarity".

**This report recognises that the impact and reach of SSP Raising Awareness in Safeguarding and Child Protection Training across Shropshire is only possible because of the dedication and enthusiasm of the professionals who make up SSP Training Pool.**

SSP Training Pool train within their own agencies using the package supplied by the Shropshire Safeguarding Partnership Training Coordinator.

Examples of the agencies that make up SSP Training Pool include:

Clinical Commissioning Group; Connexus; Education Improvements; Education settings (Early Years; Primary; Secondary; Academy; Maintained; Independent; Special schools; and FE Colleges); Enhance; Family Information Service; Independent Care Providers; Independent Review Unit; Joint Training; Learning and Skills; Public Protection; Shire Services; Shrewsbury and Telford Hospitals NHS Trust; Shrewsbury Town Council; Shrewsbury Town in the Community; Shropshire Community Health Trust; Shropshire Council (Targeted and Early Help Children's Services); Shropshire Youth Association; Strengthening families through Early Help team; The Hive; and We Are With You.

**Thank you all!**



## Changes to published arrangements

The Board was working towards developing the new Partnership arrangements in preparation for submission to the Department for Education in April 2019 as required by Working Together to Safeguard Children 2018.

A new governance group "Shropshire Safeguarding Partnership" was established in 2018/19. There are no changes to our published arrangements in the financial year but please refer to our section titled "Strengthening our relationship with the Keeping Adults Safe in Shropshire Board and other Partnerships" for more information about our plans.

## What we want to achieve next year

Next year will see us focus on the following priorities:

- Joint priorities are Domestic Abuse, Exploitation and Transitional Safeguarding (the period of moving from Children's Services into adulthood)
- The Adult priority is Self-Neglect
- The Children's priority remains Neglect
- The Community Safety priorities are Preventing Offending and Drug and Alcohol Misuse.

# 2020-21

## Closing statement

I hope you've taken the time to read about the work of the Shropshire Safeguarding Partnership and its partners and what they have been doing to try and keep children safe from harm.

This report will be the last of its kind and we look forward to a new era of working in a more coordinated way as a single safeguarding arrangement to offer the best for the children, young people and adults of Shropshire.

Last year, I ask you to particularly read the children's stories and I'm asking the same of you again. We should never get used to abuse or become complacent and the Neglect of our children in Shropshire MUST come into much sharper focus for us all.

Please make sure you play your part in keeping Children safe and help us to stop it.



Thank you.

**Councillor Ed Potter**  
Shropshire Council's  
Portfolio Holder - Children's Services

**S**hropshire  
**S**afeguarding  
**P**artnership





# Children's Annual Report 2019 – 2020

