Solihull Safeguarding Children Partnership

THEMATIC CHILD SAFEGUARDING PRACTICE REVIEW - Serious Youth Violence and Extra-Familial Harm

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1. Introduction

1.1 On 3rd August 2022, Police received numerous calls of Young People running around a carpark in Solihull with machetes and reports of stabbings. At the scene, Police found four young people, three victims having varying degrees of stab wounds, which was potentially life threatening for one young person. Subsequent police investigation and criminal proceedings indicate that the four young people had been travelling in a stolen car and encountered a rival group in a second car, both groups alighted the vehicles and a fight ensued involving knives and machetes.

1.2 In line with Working Together, Solihull Safeguarding Children Partnership (SSCP) undertook a 'Rapid Review[1] and scrutinised the effectiveness of, agencies involvement, the system and processes by which children and young people are safeguarded. This initial review recognised the potential to improve the way agencies worked together to safeguard young people and notified the National Child Safeguarding Practice Review Panel of the decision to commission this Local Child Safeguarding Practice Review (LCSPR), outlining the key lines of enquiry as follows:

1. The extent to which information sharing between partner agencies and cross border issues impacted on the effectiveness of the safeguarding response.
2. The extent to which adverse childhood experiences (ACEs) and trauma-informed approaches were considered in seeking to engage positively with the young people and their families.
3. To consider the barriers to safeguard young people when they/or their parents are unwilling or unable to recognise the risks.
4. To consider compliance with the Solihull Exploitation Reduction procedures and the effectiveness of the procedures in addressing serious contextual safeguarding risks.
5. To consider any additional barriers to these young people engaging with professionals and how these might be addressed.
6. To identify the points at which comprehensive mapping of information about relationships and family functioning could have occurred to enable a better understanding of the risks.

1.3 An independent author was appointed to work with the safeguarding partners in a thematic review of safeguarding practice and structures. In addition to considering the four young people from the incident of August 3, 2022, the independent Reviewer was directed to review the emerging themes across another young person (five in total) who had been involved or exposed to serious youth violence.

1.4 The additional young person to be considered within this review did not sustain harm, however, was the perpetrator of a serious (initially considered life threatening) harm on another young person in January 2022 whilst in the care of Solihull Local Authority and placed in another West Midlands Local Authority (LA) area.

1.5 The criminal investigation in this case has concluded; the young person has been found guilty of attempted murder and sentenced to a significant prison term.

1.6 A Rapid Review for this case was undertaken within the residing LA with attendees from Solihull on 4th March 22, with the outcome jointly agreed across the two areas that the threshold for a LCSPR was not met. This decision was shared with the National CSPR Panel who disagreed and asked for the 'rapid review panel' to reconsider the decision made.

1.7 In reconsidering the case in September 2022, Solihull Partners have decided not to conduct a separate LCSPR for the case, however, did recognise similarities in common with the incident

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1108887/Child_Safeguarding_Practice_Review_panel_guidance_for_safeguarding_partners.pdf

involving the four young people mentioned above and identified a number of thematic safeguarding issues in common which are to be the basis of this Local Thematic Child Safeguarding Practice Review as follows:

1. To identify opportunities to strengthen responses to children and young people who may be at risk of extra familial harm and serious youth violence.
2. Seek to understand the lived experience of five young people who have been involved in two separate incidents where young people have been injured as a result of serious violence or perpetrated serious violence towards other young people.
3. Seek the understanding from professionals of the contextual safeguarding systems and analyse the effectiveness of these arrangements to reduce the likelihood of escalating extra familial harm in Solihull.
4. Make recommendations to strengthen the whole system.

2. Methodology

2.1 The model and approach adopted, together with the terms of reference for this review was agreed by Solihull partners and the independent lead reviewer.

2.2 Chronologies via single organisation scoping returns were provided by agencies, with a series of organised thematic focus groups of frontline practitioners and strategic leads for key service areas. Local practice guidance, and procedures were used to support the analysis of practice, identify barriers or challenges and the existence of adultification in the local responses to contextual safeguarding issues for young people in Solihull, and consider how changes to practice are to be made to ensure improved and effective future responses.

2.3 To ensure this report is informed by the views of young people, particularly how processes and procedures impacted upon them, the independent reviewer met separately with two from the five young people that are included in this review, six young people accessing support from the Youth Justice Service in Solihull, and a further two young people looked after by Solihull Local Authority.

2.4 This report outlines the strategic recommendations in a concise format for consideration by the safeguarding partners. It is written with the intention of publication and as such does not contain information which may identify the young people and /or connecting family members. A snapshot of each Young Person's journey is included to provide some context and evidence for any learning and improvement work that is identified and included in this report.

2.5 Extensive information has been viewed, however, these are held in additional documents and retained by the Solihull Safeguarding Children's Partnership.

3. Young People's journey and the support of services in Solihull

3.1 The experiences of five young people have been essential to inform the review and the analysis of practice. Each young person was considered individually, allowing the review to identify common safeguarding themes experienced in their childhood and in their adolescent years. However, it should be noted that all the young people had previous contact with Children's Services, and over the scoping period, intervention was limited, with each referral met with a response requiring no further role for children's social care.

3.2 Despite the levels of contact with Police across these 5 young people, only two in this cohort have had contact and support with the Youth Justice Service pertaining to offence specific 'Orders'. In both cases the young people engaged well, completed their 'Orders', and viewed these contacts as 'good'.

3.3 While all the young people were at some point on roll at educational settings within Solihull, each experienced multiple fixed-term, or permanent exclusions. In addition, there were hospital attendances due to serious youth violence by all five young people at different times over the scoping period.

3.4 The following sections are short synopsis for each young person (referred to from A through to E) and provides the foundation and context to this report.

Young Person A

3.5 Young Person A (White British background) was 17year+ the time of the incident in August 2022 where he sustained potentially life-threatening injuries. There was limited contact with statutory services prior to 2020, with the first contact to Solihull Children Services prompted by an exclusion from school following reports of drug dealing in school. The referral questioned exploitation, however significant harm or extra familial harm was not identified and no further action was taken.

3.6 In 2021, a referral stating exploitation concerns made by the school to the Multi-Agency Safeguarding Hub (MASH) was directed to the Exploitation & Missing Team (EMT). The outcome to offer of Early Help preventative support was declined by parents.

3.7 In April 2022, Young Person A was attacked by 3 males on bikes in a neighbouring authority and again came to the attention of EMT. A single agency S47 enquiry was initiated where the risk of exploitation was considered and an Exploitation Screening Tool completed, subsequently Young Person A was discussed at the Vulnerability Tracker meeting.

Young Person B

3.8 Young Person B (mixed ethnic background) was 17years+ was one of four young people involved in the altercation with a rival group but managed to protect himself from sustaining any injuries.

3.9 Information known in respect to Young Person B sees many years of exposure to potential / known traumatic events/situations to evidence ACEs[2].Young Person B was known to multiple services across Solihull, including intervention from children social care from an early age, being named a subject (along with siblings) of a child protection plan dating back to 2008; this ended in 2009 following the successful application of a Special Guardianship Order (SGO) awarded to grandparents. This remained in place up to the time of the incident in August 2022.

3.10 Across services in Solihull Young Person B was known as a victim of exploitation; there was evidence of involvement in criminality, both as a victim and perpetrator; gang affiliation; cannabis use and supply; and on more than one occasion, Young Person B was involved in altercations where weapons have been used.

3.11 In 2021, following a youth conditional caution, and the order to involve Solihull Youth Offending Service, Young Person B engaged positively with services, agreeing and completing a drug education programme, receiving support from CAMHS and requested/accepted support with a gym membership and with a college application. Two referrals to EMT led to a programme of direct work to educate grandparents of gang grooming and criminal exploitation.

3.12 A subsequent Social Work Assessment concluded that a Multi-Agency Adult and Child Exploitation (MAACE) referral was not required and there was no further role for Children's Services as grandparents were using appropriate strategies to manage behaviour.

[2] https://mft.nhs.uk/rmch/services/camhs/young-people/adverse-childhood-experiences-aces-and-attachment/

Young Person C

3.13 Young Person C (black Caribbean and British ethnic background) was 18+ at the time of the incident in August 2022. Young Person C and sibling were first known to Solihull Children's Services from an early age in 2002 in regard to being exposed to domestic abuse incidents in parent's relationship, parental mental health, volatile behaviour and parents being suspects of selling Class A drugs.

3.14 Between 2017 – 2019 Young Person C along with his sibling were made subject to child protection plans following concerns that Young Person C, along with his sibling, were members of a known street gang and were selling cannabis from the family home, with parents taking the money from them. No Exploitation Screening Tool was completed, and the risk of exploitation was not identified at that time.

3.15 A referral in 2021 found Mother was seeking housing and that Young Person C and sibling were staying with maternal grandmother in a neighbouring authority when grandmother was admitted to hospital having taken a mixed overdose. No action was taken by Solihull Children's Services.

Young Person D

3.16 Young Person D (mixed ethnic background) was 18+ at the time of the incident. Young Person D was known to multiple agencies across Solihull with the first encounter with Solihull Children's Services in 2011 due to concerns about mother's mental health, parental substance misuse and domestic abuse.

3.17 In 2018 a S47 investigation was completed following concerns about domestic abuse, and in 2021, Young Person D was the victim of a robbery where he was attacked with a machete and needed minor medical attention. The outcome of the S47 investigation was the recommendation for further assessments through the Multi-Agency Adult and Child Exploitation (MAACE) process. Parents would not consent to any further assessment or intervention. However, via the MAACE process a trafficking assessment was completed and a referral made to the National Referral Mechanism (NRM) before the case was closed.

3.18 In late 2021, Solihull Children Services received another referral from EMT that named Young Person D as the victim of County Lines/ drug running and information placing him in a property out of area that belonged to a vulnerable person. The social work assessment, which was completed within weeks of Young Person D's 18th birthday, found Young Person D to be a victim of criminal exploitation. A referral was made to Adult Services Exploitation Team and a MAACE meeting was recommended to enable professionals to identify a plan in order to keep Young Person D safe from further harm post 18.

Young Person E

3.19 Young Person E (White British background) was 17years+ and in the care Solihull Local Authority when he was arrested and charged in January 2022 with attempted murder of another 17year old and for the possession of an offensive weapon.

3.20 Young Person E became known to Solihull Children Services in 2013 following a disclosure made by a sibling, however further enquiries found no role or further action was required from Solihull Children Services at that time.

3.21 In 2021, Young Person E reported himself homeless and was offered the opportunity to be looked after by Solihull local authority, which was initially refused, however shortly afterwards Young Person E agreed to be a looked-after child under section 20 of the 1989 children Act[3].

[3] https://www.nelsonslaw.co.uk/section-20-voluntary-accommodation-of-children-care-proceedings/

4. Feedback from Practitioner Focus Groups, Young People and their Families

Practitioner Focus Groups

4.1 The focus groups provided opportunities to reflect on the systems to reduce exploitation across Solihull with the information obtained from the focus groups adding to the picture to develop the true understanding of service delivery afforded to young people considered in this review.

4.2 Members in the focus groups shared their concerns in relation to inconsistency in agencies attendance and engagement in multi-agency meetings, and such forums not attended by the most relevant people to support effective, well-informed decisions.

4.3 Members in the focus groups were able to articulate improvements that have been made to the multi-agency structures to effectively manage and respond to extra familial harm. The MAACE process was said to have improved significantly since a consistent Chair has been appointed, with messages and actions now being progressed in a timely manner, and there is more information sharing which in turn will enable increased opportunities to deliver effective interventions.

4.4 However, there was recognition that these young people were known to services from a young age and reflected on whether there are the structures in the early help space where positive intervention would make the difference. Members in the focus groups struggled to the see an 'early help offer' for contextual safeguarding.

4.5 There was a view of not enough focus on operational delivery and positive activities for young people. Core processes focus on young people coming into contact with services when an issue occurs or when mandated to because of an order. There is a need for resources and commitment from all partners to positively engage with young people. Service availability could be improved with further resources, including teachable moments, early help, peer mentoring, gang or peer group mentoring and interventions and greater connectivity to non-statutory organisations.

4.6 There are issues working with and trying to get the involvement of community-based organisations, this was described as very patchy with little availability of resources, and activities for young people accessible depending on the area and 'postcode'.

4.7 It was stated that the Thresholds of Need are not always understood where focus on risk is imperative. A review of the of the threshold document as published in 2022 would not concur with the point made, however given the feedback from the focus groups there is a need for further training to improve wider understanding of the levels of intervention and application of Solihull's threshold guidance.

4.8 Strategic leads were able to share elements of the plans in place to improve and strengthen the response to exploitation in Solihull, including accessing specialist services from outside of the local area in recognising that some young people need specific support which is not available in Solihull. They also talked of plans in place to move the vulnerability tracker to the exploitation triage meeting, this being a better way to monitor and respond to exploitation, as well as maintaining a joint integrated data analysis of the cohort of young people identified as being at risk of extra-familial harm by YJS and Police.

Police Specific Considerations

4.9 Police representatives who attended the focus group mentioned a lack of commitment, resources and timely information sharing from the force. It was reported that even though Solihull is much smaller than neighbouring local authority areas, with less staff, there is an expectation that they will follow the internal police procedures used in other areas, taking away any focus on localised multi-agency procedures for Solihull.

4.10 Members in the focus groups posed questions of each other to reflect on whether there is evidence of tangible growth in the local response to exploitation and timeliness of interventions to young

people. There was a view that responses are often as a result of an incident or offence and young people are seen and treated as offender first and not victim/survivors; with this approach reducing the likelihood for young people to engage with services. This is collaborated from the feedback from the young people who felt that they were not treated as victims and did not view the experiences of contact with services in Solihull to be positive or productive.

Education Specific Considerations

4.11 Feedback from mainstream education representatives in the focus groups expressed extreme difficulties for staff in schools to differentiate between persistent disruptive behavioural issues and those that are influenced by ACEs, Special Educational Needs and/or Disabilities (SEND), or poor mental health. Staff in mainstream education expressed a concern that difficulties accessing the Specialist Inclusion Support Service (SISS) meant delays in understanding the causes of specific patterns of behaviours and the ability to provide the right support.

4.12 It was shared that school exclusions rates had increased, and work was being undertaken to explore and understand this further. Whilst none of the young people considered in this review were at the time of the incident in education, they were all at some stage 'on roll' at an education provision and each had a series of exclusion whilst in education.

Young People's Focus Groups

4.13 There were two separate sessions attended by young people having had contact, service interventions and support from within the boundaries of Solihull.

4.14 Exploring the views of youth violence/knife/crime and whether they have concerns: including, what needs to happen to make things better, the young people were asked to talk about Solihull, different areas, no go places/areas, treatment of young people. The following is the summary taken from the young people in their focus groups.

- Effective support was not provided in their early childhood which may have helped to prevent them from suffering harm. Neglect and domestic abuse in the home made them more vulnerable to future exploitation.
- They felt let down by the 'system' and felt that some professionals were not interested in them as individuals. The services provided were inconsistent and did not provide them positive outcomes.
- They did not feel listened to. Often the only way to be heard was to act in a way that was subsequently termed disruptive by adults who were supporting them.
- It was clear that not having stable positive adult relationships in their life (parental or others) provided perpetrators the opportunity to exploit them. They describe feeling alone.
- There was a mistrust and dislike of the Police, who were often the ones who would 'force' them to go home after having been reported missing.
- The Young People spoke about the lack of safe places, spaces, activities and things for young people to do in Solihull and being left to their own devices.
- The looked after children spoken to felt let down by the vast majority of professionals who often asked for their views and made promises which were not fulfilled, with only being able to identify one positive professional who made a lasting impact, described as being supportive and would do what they stated they would do.

4.15 The future for the young people spoken to was bright and varied with some wanting the opportunity to have further education, employment, and to form positive stable relationships. They described wanting to take responsibility for improving their emotional health but wished to have support in helping them achieve this. The provision of accessing mental and emotional health support was a key issue.

4.16 Whilst each young person looked forward to greater independence at the age of eighteen, they identified the need for continued support from agencies into early adulthood.

Feedback from the five Young People and their Family Members

4.17 Feedback from the five young people and/or their parents /carer involved in this thematic LCSPR, of their experiences of services in Solihull, sees these young people being perceived by professional as 'offenders'. This has had a lasting impact on the young people and other family members not feeling respected by professionals and made to feel responsible for the harm inflicted on young people.

4.18 EMT was seen as the only service that was supportive in making the young people and families feel at ease to engage with them in a positive manner and approach.

4.19 Multi-agency meetings were said to be repetitive and intrusive and constantly going over what was said and done in the previous meeting and literally 'a waste of time'. There was the mention of the lack of input/ support and interest from some agencies especially during MAACE meetings, and no confidence in the safeguarding systems in Solihull.

4.20 One young person who at the time of this review is serving a significant prison sentence accepted a request from the independent reviewer for a professional visit. He spoke about his time at school and not being able to pay attention, classrooms were too busy with 30 plus pupils. His first fixed term exclusion was in year 6 for carrying 2 knives into school and was permanently excluded for having weed.

4.21 One family member summarised the involvement of services stating, "*they either don't care or cannot see the* damage *they cause to these young people"* and wondered whether treatment and lack of support was based on race and skin tone. In undertaking this review, including the scoping reports, focus groups, and the interviews with young people, the reviewer has found no evidence to concur with the view that treatment and lack of support by any agency in Solihull was based on race or ethnicity, however, this concern is explored further from section 5.18.

5. Themes and Analysis – Knowledge and Practice

Adverse Childhood Experiences (ACEs)

5.1 Research over the last decade has significantly heightened the awareness, knowledge and understanding of ACEs and the impact on adolescent and adult behaviour often being shaped by early years experiences. This is evident between people having no ACEs compared to people who have experienced four or more ACEs and are seen to be:

1. Four times more likely to have low levels of mental wellbeing and life satisfaction.
2. Seven times more likely to have been involved in violence.
3. Eleven times more likely to have used illicit drugs.
4. Eleven times more likely to have been imprisoned.

5.2x This is because brain development is affected by early relationships where there is abuse, neglect. The brain learns to respond to threat and unpredictability which means it may not work so well in an ordinary environment. For these children new experiences can be daunting and positive social skills can be missed, so it is harder to negotiate new social situations and learn to trust new people, so these situations can be challenging as too much focus on potential threat cues can mean positive social cues are missed or can cause an overreaction that can lead to conflict or violence.

5.3 Although outside of the scoping period it is very visible to see ACEs as a prevalent feature in the lived and childhood journey for most, if not all of these young people's story and journey up to the point of this review. For example, there was evidence of involvement in criminality, both as a victims and perpetrators, gang affiliation, county lines, cannabis use and supply, anti-social behaviour, trafficking large sums of money, and on more than one occasion, Young Person B was found in possession of weapons/involved in altercations where weapons have been used. Despite these indicators, there is no evidence to suggest that the impact of these experiences was ever used or considered in analysing potential risks and identifying meaningful support, and there is limited evidence of ACEs being considered and or used to inform MASH decisions following referrals made for any of these young people.

5.4 It was apparent that agencies tended to respond to the facts of a particular referral in isolation, focusing on addressing the behaviour described in that moment in time. This was at the expense of building an enriched picture to understand what was truly happening in children's lives and the underlying reasons for the referral. As a result, planning focused on delivering short term outcomes rather than addressing longer terms needs.

5.5 Each young person had suffered trauma in their childhood and had significant Adverse Childhood Experiences, a known significant risk of exploitation being the absence of supportive adult relationships. In not fully understanding how past events had affected the young people, their needs were not understood, and this compromised the effectiveness of initial planning. As a result, future safeguarding issues continued, and the risks escalated to the stage where they became at high risk of exploitation. At this time the young people lost confidence and trust in professionals, which made further support and building trust extremely difficult.

5.6 Many different factors are associated with an increased likelihood of children and young people being involved in violence. Those who live in an economically deprived community with high levels of crime are more likely to become involved in violence. However, a 2010 longitudinal study[4] found that, particularly for boys, negative interactions with family or peers and the mechanisms children and young people use to cope with these interactions, such as substance abuse, are more likely to lead to them being involved in violence as their needs are not being met.

Cannabis use

5.7 Four of the Young People specifically considered were known to use cannabis, yet there is limited consideration of cannabis use as a safeguarding risk.

- in the scoping information in 2022. Young person A presented at Accident and Emergency having sustained a stab wound and it was recorded he admitted to smoking cannabis that night.
- When Young Person B received a youth conditional caution (YCC) he admitted to smoking Cannabis every other day and did engage well with specialist services for drug education.
- Links to Cannabis for Young Person C, dates back over many years, with reports of him selling cannabis and smelling of 'weed' being the basis for referrals in 2017, 2018 and 2019,
- Young Person D was referred to Solihull Youth Justice Service for voluntary prevention in 2019 by a School. Concerns, amongst other indicators of exploitation, included missing school, and cannabis use. Support was offered via mother which was declined.

5.8 Across all the information provided by Solihull to inform this review, including professional, young people and or family members spoken to, there was no evidence or reference made to suggest strategies and approaches were used to explore young people's use of cannabis, or work undertaken to understand the normalisation of cannabis across these young people.

5.9 There is an absence of professionals being sufficiently curious and inquisitive, or to identify drug dens, hot spots and/or where young people obtained cannabis and any potential ramifications regarding Child Criminal Exploitation risks, either to themselves or others.

5.10 Understanding the impact of cannabis use on young people has been an area of growth in recent years, with much research having explored the relationship between cannabis use, mental health, and the rising numbers of exploitation amongst young people. The research highlights a 54% increase of young people admitted to hospital for cannabis-related mental health problems in the last 8 years, with researchers warning of a "blind spot" for the growing impact of cannabis use

[4] McAra L, McVie S. Youth crime and justice: Key messages from the Edinburgh study of youth. Criminology & Criminal Justice [Internet]. 2010 [cited 2023 Jan 17];10(2):179– 209. Available from: https://study.sagepub.com/sites/default/files/Mcara and McVie - Youth Crime.....pdf

among young people due to policy failure and the increased criminalisation of young dealers[5], rather than identifying effective strategies and approaches to offer support.

5.11 Each young person had links to cannabis use/distribution which was never a focus for attention or considered a potential risk and seemed to have been normalised over time when it should have been a 'trigger' for proactive intervention. There was reference made for only one young person receiving specialist service or dedicated input around cannabis reduction or cessation because of Youth Custodial Caution (YCC) support.

5.12 Despite concerns around potential gang association and personal cannabis use by all the young people, understanding each family dynamics and the links to extra-familial risk was not routinely considered and analysed within threshold decisions.

Domestic Abuse

5.13 Very limited evidence was viewed to indicate that early childhood exposure to domestic abuse was considered as part of analysing risks for any of the young people considered within this review.

5.14 In respect of Young Person E, it does not appear that efforts were made to understand the themes that fuelled the arguments between Young Person E and initially his mother, that led to the young person sofa surfing at his grandmothers during 2020, and prior to reporting himself homeless in 2021. Nor is there any understanding of the abusive elements in his behaviour that brought him in to the care of the local authority.

5.15 The reason for the attack on a peer causing serious harm, was said to be out of character and there did not seem to be an obvious motive for his attack on a 'peer', other than a growing interest and aim to convert to Islam and /or from the perspective of having to defend himself as a young person approaching/transitioning to adulthood.

5.16 Agency reports shows a history of frequent violence related contacts by Police to the family home dating back to 2013, for Young Person D.

5.17 The Victims Commissioner's review[6] found a strong link between domestic abuse and offending and a movement to recognise this connection. However, a direct causal relationship cannot be proven because of the many different types of experience and circumstances. Research found that children experiencing domestic violence may normalise violence, making them more likely to become violent in their own relationships. It also found that children with difficulties at home may seek alternative familial relationships elsewhere, with the potential to lead to childhood sexual abuse, gang affiliation and offending behaviour.

Intersectionality & Adultification

5.18 Two of the young people considered were aged 17yrs + at the time of the serious incident in August 2022 and the other two turned 18 earlier in the same year. Young Person E was 17+ when he used a weapon to inflict harm on a young person of a similar age.

5.19 One of the young people's ethnic origins was recorded on the scoping return as 'White British', across the other four scoping returns the ethnic origins were noted to be unknown, when in fact the ethnic background of all four young people is recorded on their social care file.

5.20 At a thematic level across a small cohort of young people, it is not possible to provide detailed analysis around how the cultural heritage of each young person was considered and how effectively

[5] https://www.york.ac.uk/news-and-events/news/2018/research/report-reveals-growing-impact-of-cannabis/

[6] https://yjlc.uk/resources/legal-updates/victims-commissioners-review-link-between-childrens-experience-domestic#:~:text=Research%20found%20that%20children%20experiencing,violent%20in%20their%20own%20relationships.

safeguarding responses for these young people considered their cultural backgrounds or where there was exploration, awareness, curiosity, and sensitivity in providing support and intervention.

5.21 It is difficult to understand or see a defensible rationale for the absence of the recording of ethnicity across every agency. The attempt from the reviewer to explore this omission further within the focus groups was also met with vague response of unknown.

5.22 It is difficult to comprehend how services and plans have considered in the absence of knowing the ethnicity, cultural, background, beliefs etc, of children and young people receiving services and support from agencies in Solihull. How can practitioners understand the ways that multiple forms of inequality or disadvantage may compound themselves and create obstacles for young people if they have not considered the ethnicity, cultural beliefs, identity, experiences & values of young people.

5.23 It is equally not possible to explore the presence and/or potential of 'adultification' without the knowledge of the specified characteristics, key to this being young people's ethnicity.

5.24 These five young people are not a homogenous cohort in terms of their circumstances and as such, would require a much wider, comprehensive dataset to understand any over or under-representation in terms of victims or perpetrators of crime and how this interacts with age, gender, and ethnicity demographics in Solihull[7]. This does highlight the need for a review of all age exploitation reduction strategy that will include development of a Problem Profile to enable a clear understanding of how young people are demographically represented as victims of child exploitation and serious youth violence, alongside potential perpetrators of serious youth violence.

5.25 The scoping return for Young Person E does have some of the characteristics as highlighted to be added indicators to the potential presence of 'adultification', as outlined by Jahnine Davis[8] – *"The concept of adultification is when notions of innocence and vulnerability are not afforded to certain children. This is determined by people and institutions who hold power over them. When adultification occurs outside of the home it is always founded within discrimination and bias. There are various definitions of adultification, all relate to a child's personal characteristics, socio-economic influences and/or lived experiences. Regardless of the context in which adultification takes place, the impact results in children's rights being either diminished or not upheld."*

5.26 Adultification is also noted to occur in other contexts, such as domestic abuse, homelessness and other circumstances that create risk for young people where adultification can lead to a diminished safeguarding response. This raises constructive queries about broader themes outlined in this report where responsibility is attributed for behaviour that may be influenced by exploitation or trauma. This is potentially evident in considering the circumstances of Young Person E, who was homeless for a period unknown at 16, suggesting limited professional recognition of the impact of this upon the young person, although from information considered Young Person E may have concealed homelessness for a period of time.

5.27 As part of the work currently underway to improve the systems, processes and practice response to child exploitation as described across the focus groups, there is an opportunity to meaningfully engage with issues such as over and under-representation of young people based on age, gender and ethnicity bases, whilst identifying potential causes of bias and discrimination that could impact upon an effective Child Exploitation response for young people in Solihull.

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[7] https://westmidlands-vrp.org/app/uploads/2021/07/Strategic-Needs-Assessment-Solihull-WM-VRU.pdf

[8] *"Adultification Bias within Child Protection & Safeguarding."* J. Davis, HM Inspectorate of Probation Academic Insights. June 2022. (https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2022/06/Academic-Insights-Adultification-bias-within-child-protection-and-safeguarding.pdf)

5.28 Intervention and disruption responses does need a reset, to included meaningful approaches that are delivered in a way that prevents young people from being drawn into exploitation and committing offences that inevitably impacts on their educational and social outcomes.

5.29 The review sought to consider the potential of adultification across the cohort of young people. However, the absence of the ethnicity being recorded in four of the five cases, together with the lack of awareness of the members across the focus groups as to the importance of recording ethnicity (and protected factors) of every child in the safeguarding system, restricted the opportunity to explore adultification. Adultification is claimed to be associated to Black young people experiencing exploitation and the need to reflect upon how to effectively identify and address potential sources of bias when identifying extra-familial harm and developing a collaborative strategic response to extra-familial harm.

5.30 Considering the circumstances of Young Person E, and the other young people in the absence of effective recording of their ethnicity, adultification could provide a helpful prism for analysis for Children's Services. Ultimately, it would not be surprising to find the presence of adultification for the young people of Black ethnicity in this thematic review cohort. A much deeper exploration would need to occur with practitioners, agencies, and young people themselves to understand these factors fully.

5.31 This review was asked to consider if adultification was a factor in the systems decision making. While it was not possible to answer this, it became very evident that there is a need for the partnership to be assured that the starting point for anyone working with a child and members of their family is to pay specific attention to their gender, race, ethnicity, sexual orientation, gender identity, disability, class and the lived experience of each individual, including the impact of harm through discrimination and how these may "intersect" to create unique dynamics and effects for each child and member of their family. This requires an understanding that systemic issues can create inequalities and differential access to health services, support services, school exclusion, social care experience and employment. An example of this would be the adultification of black children who are often viewed as older than they are and more likely to receive negative response to safeguarding needs.

Recommendation 1: Workforce Practice and Knowledge: SSCP, working with the Solihull Safeguarding Adults Board, to consider whether they need to agree a strategic approach to practice that includes Adverse Childhood Experiences and a Trauma Informed approach.

Rationale: For each person there were evidence of experienced significant Adverse Childhood Experiences (ACE). Common themes from their home environment included: Domestic abuse in the home, child neglect; parental mental and emotional health issues; parental use of alcohol and drugs, including dealing, history of social care involvement, gang affiliation, criminality, county lines, cannabis use, child to parent abuse. What was not evidenced is how any of the early childhood experiences or individual characteristics and life experiences were considered to devise plans, support or appropriate intervention, this was deemed a deficiency in practice and knowledge.

Recommendation 2: Workforce Practice and Knowledge: Review the existing SSCP language matters guide and disseminate across the partnership. This should be aimed at frontline practitioners and managers with a focus on upskilling the workforce around use of language and approaches to working with young people who are the victims of exploitation.

Rationale: Practitioners and the partnership must be able to constructively challenge colleagues and partner agencies to reflect upon how young people are viewed within the context of suffering child exploitation and modern slavery, whilst remaining mindful of potential adultification or other forms of bias that could potentially exist.

Recommendation 3: Workforce Practice and Knowledge: Alongside the findings of the January 2024 multi-agency supervision survey, review the existing guidance for managers across the partnership on utilising effective supervision, with emphasis on reflective discussions, diversity and unconscious bias.

Rationale: The starting point for anyone working with a child and members of their family is to pay specific attention to their gender, race, ethnicity, sexual orientation, gender identity, disability, class and the lived experience of each individual, including the impact of harm through discrimination and how these may "intersect" to create unique dynamics and effects for each child and member of their family. Practitioners and Managers should utilise effective reflective supervision to explore and understand any possible bias, and multi-agency audits and strong leadership should seek to identify, understand and address, not just accept, any systemic bias influences and issues.

Recommendation 4: Strategic Oversight: Review and re-launch the 'Thematic Exploitation Communication Strategy' to ensure the Multi-agency Practice Principles for responding to child exploitation and extra-familial harm is communicated and embedded within all partner agencies. This includes utilising resources and tools to support the identification, risk analysis, intervention and disruption of Child Exploitation.

6. Themes and Analysis – Procedures, Processes and Services

Solihull's All Age Exploitation Strategy and the Understanding of Gangs

6.1 There is evidence of the systems, structures, a suite of practice guidance, procedures, resources, publication /tools and learning opportunities across Solihull to respond to all age exploitation to support both the children and adult workforce in recognising and effectively responding to concerns of exploitation. For each of the young people considered in this review, agencies in Solihull at points had information, intelligence and/or concerns that directly linked each young person to incidents of involvement to be potential/actual victims of exploitation.

6.2 Solihull All Age Exploitation Reduction Strategy[9] cites contextual safeguarding as an approach that supports practitioners to recognise and respond to the harm people experience outside of the home. For the five young people considered within the review, there is evidence of extra-familial harm, each having a similar journey over the scoping period. Information provided by agencies showed prior knowledge connecting each to exploitative and gang associating behaviours as both victims and perpetrators of crime and prior to the incident in August 2022. In the case of Young Person C, information was known some 5 years prior, in 2017 when concerns raised linked this young person to selling cannabis from the family home.

6.3 The outcome of referrals to children social care did not work to effect change. Reports and referrals citing concerns in respect of extra-familial harm /risks associated to exploitation, often led to Early Help referrals or when a Social Care Assessment was completed, extra familial harm seemed to be considered as an isolated incident. This in turn led to most referrals of concern in the Scoping Period not leading to a longer period of ongoing Children's Services involvement, which may have supported co-ordination of multi-agency input via either Child Protection, Child in Need (CIN) planning and support. However, where Social Care Assessments were undertaken, the outcome featured little or no further role and action identified for Children Social Care, and there were no plans put in place to progress work to support these young people around exploitation risks.

6.4 However, is must also be recognised that responding to the harm young people experience outside the family home is often beyond the reach of parents and carers and can undermine the parent/ carer relationship with the child. Parents and carers themselves need to be supported as safeguarding partners when extra-familial harm is taking place.

[9] https://www.safeguardingsolihull.org.uk/lscp/wp-content/uploads/sites/3/2021/09/Solihull-All-Age-Exploitation-Reduction-STRATEGY-2020-22-Final-31-1.pdf

6.5 Across the scoping period, there was no formal activity undertaken to understand the links and associations of these young people to a local gang. Complex Strategy Meetings and mapping activity to consider associates and identify contexts where intervention and disruption was required, did not occur.

6.6 Solihull sits between both Birmingham & Coventry, an exploration of how safeguarding professionals understand local gang structures that exist or interface across Solihull and what it means for a young person to be part of or associated with a gang has highlighted the need for safeguarding agencies to have an informed understanding of local gang structures and knowledge of all disruption tools available. A means of regular strategic feedback from Police to partner agencies to refresh knowledge around gang activity and ongoing operational and strategic initiatives to disrupt gangs and keep young people safe is required. This will enable senior managers to support practitioners in developing a greater understanding of how gangs work in Solihull, how they are connected and cross with gangs in neighbouring local authority areas and implementing joint up procedures to include the most effective way to respond to concerns about gang involvement for a young person.

6.7 The National Child Safeguarding Practice Review Panel published its first National Child Safeguarding Practice Review in March 2020 which posed a series of questions at local partnerships; one of which asked that consideration is given to understanding the nature and scale of the problem in each local area and identifying children engaged with and at risk from criminal exploitation.

6.8 Solihull's response as tabled in a report to the Exploitation Reduction Board in December 2021 identified three significant priorities for work to be undertaken as follows:

1. Development of a dynamic problem profile using data and intelligence to support a shared understanding of exploitation in Solihull.
2. Coordinated approach to listening to the voice of children and adults who have experience of intervention to address the risk of exploitation.
3. Improve agency engagement in the MAACE process.

This review identifies that these are still areas that need to be prioritised for further work.

6.9 Solihull All Age Exploitation Strategy (23-26)[10] sets out a series of intended activities to improve the contextual safeguarding offer across Solihull which include:

1. Implementing a contextual safeguarding practices and processes that are reflected in local pathways.
2. Review the All Age Exploitation Reduction Multi-Agency Safeguarding procedures that were launched in March 2021 to identify any revisions required to reflect up to date and current practice as of 2023.
3. Improve the processes to ensure evidence of disruption plans are being used in addressing contextual factors which impact on victims (not just behaviours).
4. Effective use of data and audits to demonstrate improvements in identification, threshold application and response to those at risk of exploitation.

6.10 It is positive that the Strategy has recently been reviewed and there is evidence of a suite of resources including a training offer and pathway for child exploitation.

6.11 Although the reviewer was furnished with substantial evidence to demonstrate the systems, processes, procedures and practice model to support practitioner to understand and operate with a framework that promotes trauma informed and relationship-based practice, feedback from the practitioners focus group suggests that across the workforce, practitioners are unclear about what is available, or how /when these resources should be used to support a young person at risk of extra-familial harm.

[10] Exploitation - Solihull Safeguarding Children Partnership (safeguardingsolihull.org.uk)

6.12 Summarising the responses gathered from the three focus groups of professionals, there is limited awareness of the scale of the problem, or of the local profile of child victims of exploitation in Solihull. In order to target address this, there is a need to correlate the problem profile as produced by West Midlands Violence Reduction Unit (WM VRU) to assess the risk of people in Solihull experiencing violence and exploitation, especially children and young people. This draws on data from a range of sources and features the risk factors known to increase the likelihood of young people being drawn into violence and the threat of exploitation.

6.13 There does need to be opportunities to explore and develop a multi-agency dataset that covers, early intervention, and disruption approaches within different segments of the multi-agency system. This would support the ability to dynamically understand changes in data to understand the needs of young people at risk of Child Exploitation and extra familial harm.

Recommendation 5: Strategic Oversight: Review the Multi-Agency Procedures with particular attention to the contextual safeguarding approaches and to ensure the pathway for receiving referrals, assessing, planning and interventions for places, spaces, and peer groups is clear.

Recommendation 6: Strategic Oversight: Linked to the requirement for West Midlands Police to produce an annual problem profile, the partnership should develop a greater understanding of the activity of organised crime groups both within Solihull and cross border to identified entrenched and emerging networks and establish robust risk outside the home / extra familial harm pathways.

Disruption Activity

6.13 This review did not hear of any coherent disruption approaches to proactively respond to young people entrenched in exploitation in Solihull. It is vital that people working in frontline roles effectively spot the signs of exploitation of children and work together proactively with other agencies to disrupt offending and safeguard young people as 'victims'[11].

6.14 An essential part of any new delivery plan which underpins the All-age Exploitation Reduction Strategy must include disruption plans consisting of techniques, resources, tools and training to support frontline practitioners to safeguard children and young people under the age of 18 from sexual and criminal exploitation. An effective disruption plan should aim to focus on three key priorities:

1. The early identification of exploitation in communities through the review and analysis of partnership intelligence. Effective systems should be developed to provide problem profiles and also to respond to new partnership intelligence.
2. Multi-agency work with perpetrators to change behaviour, particularly where the person posing the risk also has vulnerabilities and specific needs and/or to assess and intervene in places, spaces where extra familial harm occurs.
3. Robust enforcement of offences committed by known perpetrators. This should also include proactive investigation strategies to disrupt offenders when substantive offences cannot be prosecuted due to evidential difficulties 7.

6.15 There is little evidence of intervention and disruption approaches or plans in place to distract or attempt to engage with these young people. Information gathered from the focus groups of strategic leads for key services referenced a range of new initiatives that are in the planning stage to address Extra-Familial Harm risks, including: A Young People's Plan and 'Think Family' Hubs in 2024.

11 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1101687/Child_Exploitation_Disruption_Toolkit_082022.pdf

6.16 The Police have a pivotal role and part to play in disruption and multi-agency discussions involving extra familial harm and exploitation. The effectiveness of the MAACE process in Solihull is highly dependent on information and intelligence and the Police are key to ensuring there is good information sharing and receiving in the context of structures and processes in Solihull.

6.17 Each of the young people considered in this thematic cohort had first response contact with Police over time for a range of concerns including involvement in robbery, carrying or use of knives, antisocial behaviour, being found in or entering cars of unknown males, arson, assault and (for some young people) suspected possession of drugs (and potential Possession with Intent To Supply). One young person was arrested regarding firearms offences. The police need to recognise and connect their contacts as part of the multi-agency safeguarding response.

6.18 Levels of police contact with each young person varies considerably; some young people seem to have less direct contacts with police due to extra-familial harm risks alongside additional police contacts relating to family history of parenting concerns when they were younger children.

Threshold Level Considerations

6.19 Consideration needs to be given to the threshold levels around exploitation with outcome from referrals for exploitation concerns not always meeting the threshold for s47/s17 intervention and the response and recommendations are at times for Early Help intervention. For two referrals made by school raising exploitation concerns within 3 months of each other for Young Person A, the outcome decision recommended early help support. This was subsequently refused by parents/carers, and this could be predicted to be the case, however, no further follow up made around potential unmet needs.

6.20 Inconsistency in multi-agency communication meant that key information about intra and extra-familial harm risks were not always passed on to MASH, Police, or key partner organisations.

6.21 Limited risk analysis and inappropriate threshold application meant that the young people were not subjected to meaningful multi-agency planning. In reviewing the intervention and disruption responses across the young people, thematically, disparate responses have been identified, with one young person subject to a substantial range of interventions and multi-agency oversight, in contrast to that of others reviewed.

Early Help & community organisations

6.22 Repeatedly seen throughout this review, Early Help was offered as continuation of support as children deescalate from statutory social care intervention. However, when the offer of 'early help' was refused, there was no contingency plan or follow up. The focus group referenced 'Early Help' being a crucial component to prevent children and young people being lured to exploitation, however, felt that whilst there are 'lots' of services that could provide early help, they could not see the links to contextual safeguarding. The current multi-agency procedures do not include a response to receiving referrals, assessing, planning and interventions for places, spaces, and peer groups, and only focuses on individuals, despite stating in the 2021 review that a wider contextual safeguarding approach was in development.

6.23 Interestingly, up and down the country there is a lack of free or affordable activities community-based spaces and places for children and young people becoming increasingly sparce. Reports blame cuts to youth services playing a part, with up to 1000 youth centre closures since 2010, and real-terms expenditure by councils on youth services has fallen by more than 70% in some areas. Solihull closed its Youth Service in 2015.

6.24 The significance of building relationships with community groups cannot be underestimated, as in most cases these types of provision are developed and rooted with support from within communities as an extension of families. With this, statutory services should develop and sustain meaningful interactive relationships with community groups so that they can contribute to

working to support children and families which is likely to be seen as less intrusive and/or stigmatising and therefore result in better engagement and improved outcomes.

Education

6.25 The national picture in respect of school exclusion rates also shows a rising trend as mentioned for Solihull. Research undertaken has highlighted year on year increase in school exclusions since 2014, and particularly so for certain groups, including children from low income households, children with SEND, and those from ethnic minority groups to name a few, with evidence showing that more than half of all children who are excluded from school have a recognised mental health needs.[6]

6.26 The work being undertaken to better understand the rising numbers of school exclusions will need to gather meaningful data to ensure that the systems in Solihull does not marginalise specific cohort/groups of children and young people as seen and reported nationally. There does need to be mechanisms and structures in place to ensure that if evident, disproportionality can be appropriately monitored and eradicated from the educational systems in Solihull.

6.27 There have been many studies undertaken that connects school exclusions to exploitation, criminality, and gang activity, especially where links to exploitation are already apparent. Research undertaken suggests that keeping young people in full time education should be used as a protective factor for preventing and reducing risks around child exploitation[7].

Solihull's Exploitation & Missing Team (EMT)

6.28 The Exploitation and Missing Team in Solihull Children's Services do not directly case hold, their role is to offer advice and expertise to practitioners and to carry out direct work with children, young people, and their families if exploitation is suspected. There is evidence in several of the cases that the EMT were involved, both carrying out direct work and offering advice. Examples from Child B show where direct work was carried out with grandparents, by a combination of telephone contacts due to Covid. Advice recommending a MAACE was also given to social workers, but unfortunately not followed up when the case was closed following their assessment.

6.29 EMT was involved when a MASH referral was received from out of area, and Young Person D was arrested for criminal damage and possession of an offensive weapon. Following screening within the MASH, EMT was asked to review the Exploitation Screening Tool and the risk of exploitation. The concerns related to Young Person D being found with a weapon and a significant amount of money, plus that he was associating with peers known to the Police and his family have links to criminality. EMT advised the social work team that there were significant indicators of exploitation identified and a recommendation was made that the MAACE process should be initiated, and consideration given to making an NRM referral. The allocated social work team closed the case having taken the decision that a MAACE was not required. Having recognised this young person as a victim of modern slavery & trafficking; it appears that parent consent prevented him getting the support he needed as the case was closed. If statutory guidance was followed then a cohesive multi-agency approach should have been recognised as essential to protecting child victims of modern slavery from further risk from their exploiters and of further exploitation. "The identification of a child who is a potential victim of modern slavery, or is at risk of being a victim, should always trigger the agreed local child protection procedures to ensure the child's safety and welfare."

6.30 The decision for a MAACE not to be progressed and to close the case was not consistent with the 'child Exploitation pathway'12. From the information gathered, it is not clear whether the decision made by the social work team was agreed by other agencies, or whether there was any challenge of the decision made by EMT or any other agency.

[12] https://www.safeguardingsolihull.org.uk/ssab/policies-procedures-resources/solihull-exploitation-procedures-and-guidance/

6.31 Strengths have been identified in appropriate intelligence-sharing capacity of the EMT who were well connected to the young people and their individual story. Although intervention and disruption planning would have been enhanced by lead practitioners and independent reviewers (such as Child Protection Chairpersons and Independent Reviewing Officers) and line managers ensuring that actions and decisions from the MAACE are integrated within other forums where plans are being reviewed.

Recommendation 7: Workforce Practice and Knowledge: Within the context of Early Help, agencies to agree be flexible in their pathways to enable the practitioner that is most trusted by the family to remain as the lead practitioner. This should be captured within procedures and process documentation.

Rationale: One of the most significant factors in young people's experiences was the lack of a positive, trusting, and supportive adult in their lives, this was despite multiple agency involvement to support them and their families.

7. Conclusions

7.1 This LCSPR Report has commented on a wide range of issues as borne out of the thematic analysis of five young people drawn into exploitation and youth violence. During the review there was clear evidence across the scoping documents that child protection concerns were identified quickly and referred to appropriate agencies. One of the key learning points is how these referrals were then assessed and the efficacy of subsequent planning.

7.2 Whilst it is not possible to say definitively that enhanced identification, threshold decision-making, assessment and intervention around extra-familial harm would have resulted in a different outcome for any of the young people in this LCSPR, there are specific areas requiring focused attention to either provide assurance of the strengths and effectiveness of the existing systems as well as increasing the visibility and involvement of young people in redesigning of services and/or evaluating the quality of existing processes.

7.3 For any improvements to be made and have a positive impact, it is important to consult with young people, as well as families/carers, to gain an understanding of their experiences of services, as well as to trial new/innovative approaches and strategies to combat extra-familial harm, which is of growing concerns not only for agencies in Solihull, but equally in neighbouring areas and 84%[13] of local authority areas reporting rising numbers of child exploitation.

7.4 The review does demonstrate the need for improvements in:

- the understanding across the tiers of need to the risks and indicators of exploitation/extra-familial harm,
- information sharing between partner agencies;
- increased focus, exploration and consideration of children's individual characteristics and lived experiences in decision making
- the application of trauma informed, relationship-based practice approaches to engage positively with the young people and their families
- and having strategies in place to safeguard young people when they/or their parents are refusing to engage.

7.5 There is evidence of good practice already being progressed and further work planned to strengthen and further improve the existing pathways, including an exploitation pathway which covers practice response at all Tiers of need.

[13] https://www.localgov.co.uk/Cuts-undermine-fight-against-child-criminal-exploitation-/53440

7.6 The fact that each young person openly disclosed their regular use of cannabis should have been of some concern to professionals in Solihull, and there does need to be some focused and improved understanding and consideration given on the impact and dangers of cannabis use amongst young people, and in particular to risks to exploitation and other potential extra-familial risks of intra versus extra-familial harm.

7.7 The primary conclusion from this thematic CSPR is that there is a need for the delivery of the Solihull All Age Exploitation Strategy to be informed by the Multi-agency Practice Principles for responding to child exploitation and extra-familial harm.

7.8 There is a definitive need for Solihull partners to develop the contextual safeguarding culture and approach to include enabling the referral, assessment, planning, and intervention into places, spaces, education establishments and peer groups, and to enhance the skills of the workforce to proactively and effectively respond to the needs and risk of young exposed to exploitation.

7.9 Throughout this review Solihull have referenced the development of the all age exploitation procedures which will be fundamental in achieving the improvements identified. In the construction of this development, it is crucial to consider the views and feedback from the focus groups, and the sessions with young people and parent's carers, in the following areas:

1. It is informed from consultation with young people, who have been at risk of or experienced child exploitation to enable service design that addresses extra-familial harm and Child Exploitation risks.
2. It includes the agreed practice framework that is communicated to all agencies to ensure consistency of practice and approaches to address extra-familial harm and child exploitation.
3. It includes access to regular data to understand the scale of the problem based on the Home Office 'Problem Profile' knowledge of the cohort of young people at risk of exploitation.
4. It addresses the gap in 'very early intervention' approach (identified as required through thematic focus groups)
5. Enhances practitioner knowledge of how to effectively support young people at risk of exploitation, in meaningful ways and takes consideration of family history and previous professional involvement, cannabis and substance misuse, the impact of ACEs, adolescent homelessness and an understanding of how young people are coerced and compelled into suffering ongoing Child Exploitation.
6. It includes reactive contextual disruption of gang activity and exploitation strategies, including increasing practitioner knowledge of all disruption options available at all tiers and levels of need.
7. It enhances awareness of potential for bias in considering extra-familial risks and the impact of trauma upon young people drawn into Child Exploitation.

7.10 Practitioners and strategic leaders identified the need to improve the working knowledge, refresh and embed the processes to respond to extra familial harm as well as reinforcing the risk pathways.

7.11 Good Practice has been identified around the role of health and education services in remaining connected to the young people during the COVID-19 pandemic to meet their health and educational needs as appropriate.

7.12 The final note has to come from the 5 young people considered in the review, who all come from a common place of years of feeling unsafe in Solihull and found themselves in a position of needing to protect themselves. They shared a common perception of how they felt services viewed them as criminals or problems and left them to their own devices.

7.13 The improvement areas identified have been translated into the recommendations and should be viewed as requirements that must be accomplished, rather than optional, if Solihull are to readdress the narrative that young people feel services have of them to show that Solihull are committed to the safeguarding needs and does value all children and young people within the borough.

8. Recommendations

The recommendations being made from this review are not new to Partners in Solihull. All have been identified from previous reviews, however, from this review, improvement work in response to exploitation have been found to be partly developed, or in some areas does need to be developed.

8.1 **Recommendation 1: Workforce Practice and Knowledge:** SSCP, working with the Solihull Safeguarding Adults Board, to consider whether they need to agree a strategic approach to practice that includes Adverse Childhood Experiences and a Trauma Informed approach.

8.2 **Recommendation 2: Workforce Practice and Knowledge:** Review the existing SSCP language matters guide and disseminate across the partnership. This should be aimed at frontline practitioners and managers with a focus on upskilling the workforce around use of language and approaches to working with young people who are the victims of exploitation.

8.3 **Recommendation 3: Workforce Practice and Knowledge:** Alongside the findings of the January 2024 multi-agency supervision survey, review the existing guidance for managers across the partnership on utilising effective supervision, with emphasis on reflective discussions, diversity and unconscious bias.

8.4 **Recommendation 4: Strategic Oversight:** Review and re-launch the 'Thematic Exploitation Communication Strategy' to ensure the Multi-agency Practice Principles for responding to child exploitation and extra-familial harm is communicated and embedded within all partner agencies. This includes utilising resources and tools to support the identification, risk analysis, intervention and disruption of Child Exploitation.

8.5 **Recommendation 5: Strategic Oversight:** Review the Multi-Agency Procedures with particular attention to the contextual safeguarding approaches and to ensure the pathway for receiving referrals, assessing, planning and interventions for places, spaces, and peer groups is clear.

8.6 **Recommendation 6: Strategic Oversight**: Linked to the requirement for West Midlands Police to produce an annual problem profile, the partnership should develop a greater understanding of the activity of organised crime groups both within Solihull and cross border to identified entrenched and emerging networks and establish robust risk outside the home / extra familial harm pathways.

8.7 **Recommendation 7: Workforce Practice and Knowledge:** Within the context of Early Help, agencies to agree be flexible in their pathways to enable the practitioner that is most trusted by the family to remain as the lead practitioner. This should be captured within procedures and process documentation.

9. Acronyms Explained

LCSPR – Local Child Safeguarding Practice Review
ACEs – Adverse Childhood Experiences
LA – Local Authority
NCSPRP – National Child Safeguarding Practice Review Panel
EMT – Exploitation & Missing Team
MAACE – Multi Agency Child Exploitation
SGO – Special Guardianship Order
ASB – Anti-social Behaviour
CAMHS – Child & Adolescent Mental Health Services
NRM – National Referral Mechanism
MASH – Multi Agency Safeguarding Hub
YCC – Youth Custodial Caution
YJS - Youth Justice Service
SISS – Specialist Inclusion Support Service
PTSD - Post Traumatic Stress Disorder