Safeguarding Children Joint Strategic Needs Assessment 2011-12

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1. Foreword

1.1 It was agreed at the Devon Safeguarding Children Board in June 2011 that a refresh of the 2010-11 Safeguarding Children Joint Strategic Needs Assessment (JSNA) was required to ensure that updated priorities which had been nationally agreed were incorporated into a revised document and that recommendations made in the original were revisited and updated.

1.2 There have been a wide range of documents published since the 2010-11 JSNA with regard to safeguarding issues and children. The vulnerability of children within the population has been widely highlighted. This JSNA aims to gather information about these groups in Devon. In addition, there has been substantial work undertaken around children with multiple or complex needs which, again, is identified within this JSNA.

1.3 There have been many changes within the local authority and nationally in the last two years. Structures within the local authority and the health service have altered significantly and will continue to do so in the foreseeable future. Whilst governance arrangements are being embedded it is essential that the safeguarding of children and vulnerable groups are not overlooked and remain a priority.

1.4 Serious Case Reviews are a rare occurrence in Devon. However, there remains strong evidence from national Serious Case Reviews that in many cases there is an association between harm to children and those families where the adult(s) has a mental health, learning disability, drugs and or alcohol problem, and problems of domestic violence and abuse exist. The previous local Serious Case Reviews within the County mirrored the themes and recommendations reported nationally.

1.5 Within the County, and the Peninsula, other strategies are in place in relation to safeguarding. Within Devon, the Multi Agency Case Audits (MACAs) investigate the effectiveness of partnership working of individual cases. These audits act as a check on partnership and single agency working and highlight aspects that work well and those where priority action is required. Devon has also been involved in the new Social Care Institute for Excellence guide to developing a multi-agency systems approach for case reviews.

1.6 There are some significant inequalities facing families at risk and disadvantage which all have a negative impact on children. At a local level our data mirrors national findings. It is vital to ensure action is taken to minimise the harm to children through stronger commissioning arrangements, better inter-agency working and accessibility. Support mechanisms must also be tailored to meet the needs of those facing the greatest social disadvantage.

1.7 Models of effective interagency working in Devon do exist, but more still needs to be done to strengthen links across and between adult and children's services to drive forward the principles of Safeguarding. This report identifies mechanisms for partnership working in Devon, and it is apparent that coordination between adult and children's services should remain a priority to ensure children are kept safe.

1.8 The recommendations within this report are intended to direct and inform a future joint commissioning safeguarding strategy and also highlights that services that are not directly commissioned by the local authority or the NHS still play an important role in safeguarding children.

1.9 The Devon Safeguarding Children Board established a quarterly safeguarding performance management report in December 2010. This is being further developed to ensure effectiveness is measured and that performance requirements are being met taking into account recent national guidance.

1.10 Devon Safeguarding Children Board should:

- request progress reports on the implementation of the agreed recommendations made in this safeguarding children joint strategic needs assessment

- ensure all agencies that signed up to the recommendations are held to account for their delivery.

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2. Executive Summary

Introduction

2.1 A Joint Strategic Needs Assessment (JSNA) is a process that identifies the current and future health and wellbeing needs of a local population, informing priorities and targets, and leading to agreed evidence-based commissioning priorities to improve outcomes and reduce inequalities. The Safeguarding Children JSNA covers a field where cross-agency arrangements require strong leadership, shared intelligence and appropriate joint commissioning arrangements to be effective.

2.2 Safeguarding means:

> "Protecting children from maltreatment, preventing impairment of children's health or development, ensuring that children are growing up in circumstances consistent with the provision of safe and effective care, and undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully."
> (Working Together to Safeguard Children, 2010)

Policy and Legislative Framework

2.3 The 'Working Together to Safeguard Children' guidance from 2010 sets out how organisations and individuals should work together to safeguard and promote the welfare of children. The 2011 Munro review of child protection made 15 recommendations for reforming the child protection system, focusing on a system that values professional expertise, clarifying accountabilities and improving learning, sharing responsibility for the provision of early help, developing social work expertise, and supporting effective social work practice. The need for interagency cooperation to improve safeguarding arrangements, early intervention, and improved support is well documented.

2.4 The Devon Safeguarding Children Board (DSCB) business plan describes the vision, priorities, principles, core functions and work plan from 2010 to 2013. The ambition is for children in Devon to be safer through protection from maltreatment, prevention of impairment to health and/or development, ensuring safe and effective care, and ensuring a safe environment.

The young population in Devon

2.5 The population of 0-19 year olds in Devon stood at 162,400 in 2010, and is set to rise by around 17,000 to just under 180,000 by 2033.

2.6 Social and economic circumstances play a critical role in shaping the life chances of children, with significant variations in breastfeeding, teenage pregnancy, smoking and other health related behaviours across Devon.

2.7 The age of transition from 'child' to 'adult' status varies across services locally and nationally. Whilst transition ages align with national policy and practice, this staggered movement to adult services itself can be seen as a safeguarding risk. Thresholds for service eligibility can vary across child and adult services meaning that in some cases support is effectively discontinued.

Protection from maltreatment

2.8 The 'needs of the population' section of the JSNA is based on the four DSCB themes, and the first of these is protection from maltreatment. Maltreatment includes actions that overtly cause harm (such as sexual abuse, and physical abuse) and neglect. Risk factors include substance misuse and mental health issues, and the exposure of children to domestic violence and abuse. Child sexual exploitation is emerging as a high priority for local areas, and work is ongoing to understand the scope and extent of the issue in Devon.

Protection from impairment to health or development

2.9 This theme is focused on direct risks to the health and wellbeing of children, and health and wellbeing outcomes which may be a consequence of maltreatment. This includes cases where the child may be at greater risk due to physical, sensory, communication, behavioural or learning disability. Other risks may emerge from unsafe situations and practices, such as substance misuse, youth offending, missing children / runaways, self-harm and sexually transmitted infections.

Ensuring safe and effective care

2.10 This theme is focused on the care provided by local authorities and other services to children in their care or referred to the services. There were 6,897 referrals to social services in 2010-11, with 644 children in care, and 453 children were the subject of a child protection plan. Important priorities include ensuring that privately fostered children are adequately protected, and monitoring the use of restraint in all settings where Devon children are accommodated.

Ensuring a safe environment

2.11 The 'ensuring a safe environment' theme is a broader category, which encompasses more indirect, but significant risks to children such as accidental harm. In particular, people in their late teens are at particular risk from unintentional injuries, including road traffic accidents, and of being victims of violent crime. Actions to ensure a safe environment can be more direct as well, such as referrals to the Local Authority Designated Officer (LADO) in cases where employees are suspected of abuse or inappropriate behaviour. Frequent accident and emergency attendances and missed health appointments can also indicate safeguarding issues in some cases.

Safeguarding Processes and Targeted Provision in Devon

2.12 Safeguarding children is a function of all agencies in Devon, and it is important that all commissioning is underpinned by a consideration of safeguarding, and that targeted provision exists to directly tackle safeguarding issues. Joint commissioning between adult and children services should ensure that agencies work together when considering a new service or contract to ensure that the safeguarding of children is included in any contract/service level agreement and should be evidenced before any contract is signed.

2.13 All members of staff who have contact with children, young people or parents should attend training at the level suggested by 'Working Together' as a minimum standard. Supervision of staff should happen on a regular basis.

2.14 Children, young people and parents should be involved in the development of the safeguarding policy of any commissioned service. Their needs and concerns should be identified and prioritised accordingly. All safeguarding policies should be accessible to any young person using the service.

2.15 Targeted provision in Devon includes a number of interagency processes including Multi-Agency Risk Assessment Conferences (MARAC), Multi Agency Public Protection Arrangements (MAPPA), the Multi-Agency Safeguarding Hub (MASH) and the Common Assessment Process (CAF). For these to work effectively the commitment and input of all partners is vital.

Recommendations

2.16 The recommendations within this report are intended to direct and inform future joint commissioning and safeguarding strategy and also highlight that services that are not directly commissioned by the local authority or the NHS still play an important role in safeguarding children. These are divided into four categories:

Commissioning	These recommendations involve changes to current commissioning processes.
Information	These recommendations require changes to data collection and reporting procedures.
Strategy	These recommendations relate to areas where strategies and policies need to be developed further.
Practice	These recommendations include changes to current working practices.

Recommendation 1 (Strategy) – The DSCB should ensure that a comprehensive mapping of service transition points between adult and children and within services is undertaken to ensure that multi-agency protocols are clear and appropriate care pathways are in place for referrals to and between services.

Recommendation 2 (Strategy) – Preventative work should include early intervention in relation to immunisation, school absenteeism, smoking and substance misuse in young families, and breastfeeding. This should link to the forthcoming early help strategy and JSNA.

Recommendation 3 (Practice) – The DSCB should be assured that the recommendations of the University of Bedfordshire review into child sexual exploitation and local reporting mechanisms have been considered when developing working practice.

Recommendation 4 (Practice) – The DSCB should assure itself that the arrangements for follow up of missing children are fit for purpose and that any themes emerging from the missing episodes are responded to by the relevant agencies.

Recommendation 5 (Information) – The lower levels of reported emotional development in Devon are at odds with the social and demographic profile of the

county and suggest the need for further analysis. Therefore, Devon County Council should conduct a detailed investigation of Early Years Foundation Stage Profile data on the levels of emotional development of five-year olds in the county to determine any action that may need to be taken.

Recommendation 6 (Information) – Further investigations should be undertaken into the reasons as to why children are brought into care and a strategy undertaken as a result of the findings.

Recommendation 7 (Information) – Clearer identification and recording of reasons why child protection plans are put in place should be developed in order to gain a deeper understanding of common issues and features, and assist in the development of future strategies.

Recommendation 8 (Information) – The DSCB should monitor the frequency and appropriateness of the use of restraints in all residential children's units and other establishments within and outside Devon where Devon children are being accommodated, to encompass those that are privately run and managed.

Recommendation 9 (Information) – Systems to alert GPs and other health and social care professionals in the event of missed hospital appointments or frequent accident and emergency attendances should be developed locally.

Recommendation 10 (Information) – The DSCB should commit partners to produce information required as agreed by the Peninsula Performance Management Information group.

Recommendation 11 (Commissioning) – The commissioning of all adult and children's services must consider the inclusion of a focus on potential risks and harm to children.

Recommendation 12 (Commissioning) – Whistleblowing procedures should be reviewed to ensure that children, young people and staff are able to access the procedures and are confident to use them.

Recommendation 13 (Commissioning) – No young person should be referred to any service (commissioned or non-commissioned) unless the referring agency has established the safety of the service provider with reference to safeguarding processes.

Recommendation 14 (Commissioning) – Systems should be put in place to ensure that the voice of children and young people is included in all agencies work around safeguarding, and agencies should be able to evidence that they have been taken into account and policies amended as required.

Recommendation 15 (Practice) – The DSCB should ensure that training and development resources for safeguarding are shared across agencies and kept up-to-date, and that internal and external providers of safeguarding training make use of policies and guidance within the DSCB website.

Recommendation 16 (Practice) – DSCB members should be directly notified if staff from their organisation fail to attend or produce reports for meetings relating to child safeguarding when requested.

Recommendation 17 (Practice) – The DSCB should alert partners to important recommendations from national research and new requirements from Government bodies, and facilitate their local implementation.

3. Introduction

3.1 A Joint Strategic Needs Assessment (JSNA) is a process that identifies the current and future health and wellbeing needs of a local population, informing priorities and targets, and leading to agreed evidence-based commissioning priorities to improve outcomes and reduce health inequalities.

3.2 The Local Government and Public Involvement in Health Act 2007 (http://www.legislation.gov.uk/ukpga/2007/28/contents) specified that local authorities and Primary Care Trusts should produce a Joint Strategic Needs Assessment of the health and wellbeing of the local community. The duty commenced on April 1st 2008. The role of the JSNA was reinforced in the 'Equity and Excellence: Liberating the NHS' White Paper (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353), which proposed that local authorities should be responsible for leading JSNAs, and promoting collaboration on local commissioning plans. This role was outlined in more detail in the 'Healthy Lives, Healthy People' White Paper (http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm), which places the process at the centre of commissioning and partnership processes, stating that local partners have an 'equal and explicit obligation' to prepare JSNAs, which would underpin the actions of the health and wellbeing board, and inform the joint health and wellbeing strategy prepared by the board.

3.3 The JSNA programme in Devon has been developed to include a dedicated website (www.devonhealthandwellbeing.org.uk); introducing a uniform format for topic information, covering the needs of the population, evidence of effectiveness, information about current strategy and provision, and commissioning recommendations, all underpinned by a detailed library of needs assessments, strategies, annual reports, reviews and other relevant documents.

3.4 Within this overarching JSNA work programme for Devon are a number of detailed JSNAs on particular topics where coordination across agencies is vital. This includes safeguarding children, where cross-agency arrangements require strong leadership, shared intelligence and appropriate joint commissioning arrangements to be effective. This report provides an update of the 2010 Safeguarding Children JSNA, and includes changes to the structure and format of the report in light of the ongoing development of the JSNA programme in Devon outlined above.

3.5 The recommendations in this report are divided into four categories

Commissioning	These recommendations involve changes to current commissioning processes.
Information	These recommendations require changes to data collection and reporting procedures.
Strategy	These recommendations relate to areas where strategies and policies need to be developed further.
Practice	These recommendations include changes to current working practices.

What is safeguarding?

3.6 Safeguarding means:

> "Protecting children from maltreatment, preventing impairment of children's health or development, ensuring that children are growing up in circumstances consistent with the provision of safe and effective care, and undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully."
> (Working Together to Safeguard Children, 2010, https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010)

3.7 There are a number of risks faced by children and young people. This JSNA focuses on and describes the potential harms caused to children and young people within the context of parental problems or families with multiple and complex needs that have been identified in national reports and case reviews. "Families at risk" is a shorthand term for families with multiple and complex problems such as worklessness, poor mental health or substance misuse. Risk factors include adult drug and alcohol misuse, domestic violence, mental illness and learning difficulties and or disabilities. Organisations need to be cognisant of those families who already have complex and ongoing problems as well as those who are at risk of developing them. However, it should be noted that the use of risk factors as indicators of potential need is considered to be problematic as their impact and interaction is complex.

A recent Government strategy revolves around Troubled Families. It is stated that £9 billion is spent per year on protecting the children of these 120,000 families and responding to the crime and anti-social behaviours the families perpetrate. Troubled Families Teams are being set up through the Department for Communities and Local Government. Government figures predict that there are 1,370 such troubled families in Devon.

In order to ensure that children and young people in Devon are safer, the views of children, their families and staff involved need to be considered throughout any commissioning process.

National Policies and Legislative Framework

3.8 The 'Working Together to Safeguard Children' guidance from 2010 sets out how organisations and individuals should work together to safeguard and promote the welfare of children (https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010).

3.9 The 2011 Munro review of child protection: final report: a child-centred system (https://www.education.gov.uk/publications/standard/AllPublications/Page1/CM%208062) has 15 recommendations for reforming the child protection system which are encapsulated within separate themes:

- A system that values professional expertise (Recommendations 1-4)
- Clarifying accountabilities and improving learning (Recommendations 5-9)
- Sharing responsibility for the provision of early help (Recommendation 10)
- Developing social work expertise (Recommendations 11-12)
- The organisational context: supporting effective social work practice (Recommendations 13-15)

3.10 The Children Act 2004 (http://www.legislation.gov.uk/ukpga/2004/31/contents) establishes a duty on Local Authorities to make arrangements to promote co-operation in order to improve children's well-being (Section 10) and creates a duty for the agencies who work with children to put in place arrangements to make sure that they take account of the need to safeguard and promote the welfare of children when doing their jobs (Section 11).

3.11 The Equality Duty Act 2010 (http://www.homeoffice.gov.uk/equalities/) is a further development from the Gender Equality Duty but will continue to place public authorities under a legal obligation to identify and take action on the most important gender equality issues. Under the Act there are now nine 'protected characteristics' of which it is unlawful to discriminate against. The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Act brings in a single objective "justification" test which replaces the various different tests previously in use.

3.12 'Call to End Violence against Women and Girls' is a strategy published by the Home Office in 2010 (http://www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls/). In 2009/2010, women were the victim of over seven out of ten incidents of domestic violence. 36% of all rapes recorded by the police are committed against children under 16 years of age. The focus of the strategy is based on the UN Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). The strategy is the first time that the government will be working towards a single definition and they will be specifically including girls in the approach. The vision is for a society in which no woman or girl has to live in fear of violence. According to the strategy, to achieve this vision, society needs to:

- Prevent violence through challenging attitudes and behaviours and through early intervention.
- Provide adequate levels of support.
- Work in partnership to obtain the best outcome for victims and their families.
- Reduce the risk and ensure perpetrators are bought to justice

3.13 The report 'Ages of concern: learning lessons from serious case reviews' was published by OFSTED in 2011 (http://www.ofsted.gov.uk/resources/ages-of-concern-learning-lessons-serious-case-reviews). This was based on an evaluation of serious case reviews relating to children less than one year old and young people aged 14 or above. Recurring messages from the 482 serious case reviews carried out between April 2007 and the end of March 2011 identified that:

- There were shortcomings in the timeliness and quality of pre-birth assessments
- The risks resulting from the parents' own needs were underestimated, particularly given the vulnerability of babies
- There had been insufficient support for young parents
- The role of the fathers had been marginalised
- There was a need for improved assessment of, and support for, parenting capacity
- There were particular lessons for both commissioning and provider health agencies, whose practitioners are often the main, or the only agencies involved with the family in the early months
- Practitioners underestimated the fragility of the baby.

In relation to young people over the age of 14:

- Agencies had focused on the young person's challenging behaviour, seeing them as hard to reach or rebellious, rather than trying to understand the causes of the behaviour or the need for sustained support
- Young people were treated as adults rather than being considered as children, because of confusion about the young person's age and legal status or a lack of age appropriate facilities
- A coordinated approach to the young people's needs was lacking and practitioners had not always recognised the important contribution of their agency in making this happen.

3.14 Gaps within the children's and adults' services policy and legislative frameworks have largely failed to recognise parenting roles. The importance of adults' and children's services working together to address family needs had to a large extent not been addressed as indicated by a review by the Social Care Institute for Excellence (http://www.scie.org.uk/publications/knowledgereviews/kr11.pdf). Policy initiatives in recent years such as Think Family (http://www.aft.org.uk/home/documents/think_family_life_chances_report.pdf) were largely focused around addressing this.

Local Strategies

3.15 The Devon Safeguarding Children Board (DSCB) has a business plan that describes its vision, priorities, principles, core functions and work plan from 2010 to 2013 (http://dscb.info/downloads/DSCB-Business-Plan-2010-13-final.pdf). The latest business plan states that the DSCB has an overarching ambition:

For children in Devon to be safer through:

- Protection from maltreatment
- Prevention of impairment to health and/or development
- Ensuring safe and effective care; and
- Ensuring a safe environment

This JSNA has based the needs assessment section around these four categories. In addition it is recognised that there are some families who are resistant to help and those where there are multiple and complex needs within the family.

Peninsula work

3.16 Priorities and resources for safeguarding for more complex issue are also agreed on a Peninsula basis, such as Sudden Unexpected Deaths in Infancy (SUDI) and the Peninsula Sexual Assault Referral Centres Board. Increasingly it is acknowledged that Peninsula work is an effective way of working, ensuring that boundaries between Devon, Cornwall, Plymouth and Torbay do not affect the safeguarding of children who may use facilities in different areas.

4. The needs of the population

4.1 The young population in Devon

4.1.1 The population of 0-19 year olds in Devon stood at 162,400 in 2010 (ONS Mid-Year Population Estimate) and is set to rise by around 17,000 to just under 180,000 by 2033 (ONS Sub-National Population Projections). The proportion of residents aged less than 20 years of age in Devon (21.7%) remains below the national average of 23.8%, with only one of the eight local authority districts (Mid Devon, 23.8%) not below the national rate.

4.1.2 Many areas on the South coast of Devon have lower proportions of young residents, along with most rural areas. The highest levels of residents aged under 20 are seen mainly in parts of Exeter, and market towns such as Tiverton, Barnstaple, Bideford, Newton Abbot and Crediton.

4.1.3 Whilst the population figures above relate to those aged under 20, it is important to note that the age of transition from 'child' to 'adult' status varies across services locally and nationally. Services for care leavers and persons with learning disabilities continue until the age of 25, whilst adult services for substance misuse start at age 19, and mental health at age 18, which also means that this JSNA does not use a uniform age banding. Whilst these transition ages align with national policy and practice, this staggered movement to adult services itself can be seen as a safeguarding risk. Thresholds for service eligibility can vary between child and adult services as well meaning that in some cases support is effectively discontinued. Whilst transition protocols exist, such as the protocol for transition from child to adult mental health services, planning for transitions between different types of services and for those with multiple vulnerabilities needs to be improved.

Recommendation 1 (Strategy)– The DSCB should ensure that a comprehensive mapping of service transition points between adult and children and within services is undertaken to ensure that multi-agency protocols are clear and appropriate care pathways are in place for referrals to and between services.

Life Chances

4.1.4 Not all safeguarding risks arise from direct or intentional harm. Social and economic circumstances play a critical role in shaping the life chances of children. The 2010 Indices of Deprivation shows a 20 fold difference in levels of income deprivation affecting children between the 10 highest areas in Devon (40% plus in parts of Exeter, Ilfracombe, Teignmouth and Barnstaple) and the 10 lowest areas (around 2% in more prosperous urban suburbs).

4.1.5 Life expectancy at birth varies considerably across the county, with a 14 year difference between the wards with the longest (Chagford at 88.4) and shortest (Ilfracombe Central at 74.7) life expectancies in 2005 to 2009. This great variation in life expectancy in relatively small geographic areas reveals the impact deprivation has in terms of inequalities in health throughout life.

4.1.6 Factors affecting the life chances of children occur before a child is even born. Poor nutrition, smoking and substance misuse during pregnancy can have a major impact on birth weight and the health of the child. Excessive alcohol use in pregnancy can lead to foetal alcohol syndrome which leads to

brain damage and possible facial abnormalities along with hearing and sight problems. Smoking during pregnancy increases the risk of miscarriage and still birth, contributes to premature and/or low birth weight births and associated health risks, and an increased chance of lung problems. Further to this parents who do not make use of prenatal care services are less likely to have problems identified and addressed and the welfare of the child may suffer. Joint protocol and practice guidance on pre-birth assessments written by Women's Health and Children and Young People's Services is available on the DSCB website (http://www.dscb.info/wp-content/uploads/downloads/2011/11/Pre-birth-Protocol.pdf). Mental health issues can also come to the fore soon after birth with around one in eight mothers suffering postnatal depression affecting just over 900 mothers per annum in Devon.

4.1.7 At birth, within Devon 9.4% of women were known to be smokers at the time of delivery in 2010-11. Smoking remains the main cause of preventable disease and premature death in the UK. About 8.5 million people still smoke in England today, and over 80,000 deaths a year are due to smoking in England alone. Smoking is more common in younger women with almost a third of teenage mothers smoking at the time of delivery, and is also more common in more deprived areas.

4.1.8 In 2010-11, 51.2% of children were known to be fully or partially breastfed at six to eight weeks. Breastfeeding provides many health benefits for both baby and mother, including improved protection against infections. This ranged from 32.8% in the most deprived areas to 59.6% in the least deprived areas, meaning that the nutritional and health benefits associated with breastfeeding are not equally shared across the county.

4.1.9 Childhood immunisation uptake rates vary considerably across the county. For example, MMR uptake rates are highest in East Devon and parts of Exeter, and lowest in parts of North Devon (Ilfracombe, Braunton, South Molton) and Southern Devon (Totnes, Ashburton, Buckfastleigh, Tavistock). Low immunisation rates are associated with a greatly increased likelihood of outbreaks of infectious diseases, such as the measles outbreak in the Ashburton area in 2011. There is no direct relationship between immunisation rates and deprivation, with the rate at Wonford Green in Exeter (96.5%), which covers one of the most deprived areas in the county, well above the WHO gold standard of 95%, and Devon rate of 84.9%.

4.1.10 Whilst teenage conception rates in Devon are significantly below the national average, there is great variation within the county, reflecting the four fold difference seen nationally between rates in the most and least deprived areas. In 2006 to 2008, the highest conception rates were seen in the wards of Ilfracombe Central, Priory and Exwick in Exeter, Bushell and Buckland & Milber in Newton Abbot, Teignmouth West and Exmouth Littleham. Teenage pregnancy is strongly associated with the most deprived and socially excluded young people and having a child at a young age can result in poor health outcomes and limit education and career prospects for a young woman.

Recommendation 2 (Strategy) – Preventative work should include early intervention in relation to immunisation, school absenteeism, smoking and substance misuse in young families, and breastfeeding. This should link to the forthcoming early help strategy and JSNA.

4.2 Protection from maltreatment

4.2.1 The Devon Safeguarding Children Board business plan for 2010-13 (http://dscb.info/downloads/DSCB-Business-Plan-2010-13-final.pdf) outlines four themes for its work to make children in Devon safer. These are protection from maltreatment, prevention of impairment to health and/or development, ensuring safe and effective care, and ensuring a safe environment. This needs assessment is based around these four themes, and this sub-section looks at protection from maltreatment. Maltreatment includes actions that overtly cause harm (such as sexual abuse, and physical abuse) and neglect. The risk factors identified in this section are largely, but not exclusively, focused around parental factors which may contribute to, or increase the risk of maltreatment.

Child Sexual Exploitation

4.2.2 There is little local data collected on Child Sexual Exploitation. It is not currently recognised as a specific crime although recently it has become a high priority and efforts are being undertaken to understand the scope and extent of the issue. There are also clear links between children who go missing and the risks of sexual exploitation. The University of Bedfordshire has recently published findings of a research study concerning the extent and nature of local safeguarding boards' response to safeguarding children from sexual exploitation (http://tdh-childprotection.org/documents/whats-going-on-october-2011-to-safeguard-children-and-young-people-from-sexual-exploitation), and the study's recommendations are summarised below.

What is going on to safeguard children and Young People from Sexual Exploitation?

Recommendations from University of Bedfordshire Review

1. There is an urgent need to review how the court process impacts on young people who are victims of child sexual exploitation, learning from the experiences of recent prosecutions.
2. All pre- and post qualifying training for professional working with young people should include child sexual exploitation.
3. All LSCB chairs and Directors of children's services should receive training on child sexual exploitation
4. Inspections of LSCBs should include progress on the dual aim of a child sexual exploitation strategy.
5. The Department for Educations should lead an assessment of the availability and appropriateness of specific forms of accommodation provided by local authorities in response to the needs of looked after children who have experienced sexual exploitation
6. A national database providing information on the nature and prevalence of sexual exploitation should be maintained and monitored
7. Each LSCB should use the 2008 guidance to develop a multi-agency strategy with a coordinator, a sub group with lead professionals and a service for children and young people.
8. Each LSCB should work with local partners to develop and implement and awareness raising and training strategy programme that reaches practitioners and, important, young people, their families and communities
10. Each LSCB should scope child sexual exploitation in their area to identify its nature and prevalence and use the monitoring tool developed through this research to provide an annual return of data to CEOP.
11. Each LSCB should work towards having a co-located team.

Source: Pearse et al. 2011

4.2.3 Torbay LSCB have commenced a Serious Case Review in relation to an investigation named Operation Mansfield which revealed a number of young people living in Torbay who appear to have been groomed for the purpose of sexual exploitation. Devon Children's Social Care and NHS Devon will be providing information in relation to 'Looked after Children' who featured in the investigation.

Recommendation 3 (Practice) – The DSCB should be assured that the recommendations of the University of Bedfordshire review into child sexual exploitation and local reporting mechanisms have been considered when developing working practice.

Bullying

4.2.4 Bullying can have a great impact on the health and wellbeing of children, and tackling bullying is identified as an important aspect of safeguarding. Twenty five partner agencies across Devon have developed a joint Reducing Bullying Action Plan. 358 schools have achieved the Devon Healthy Schools Award which requires criteria to be met for Emotional Health and Wellbeing including bullying. Devon Transport Team have introduced a pupil "Code of Conduct" to set a minimum behaviour standard on home to school transport following a large number of admissions and transport appeals citing bullying as a reason for wanting to move schools or be transported to an alternative school. Racist incidents collated by the English as an Additional Language team numbered 47 for 2009/10 across 25 schools. A report entitled 'Reducing Bullying in Devon' was produced by Dr Annette Lyons in January 2011, outlining the data currently collected on bullying incidents involving children and young people in Devon. Information from this review is summarised below.

Reducing Bullying in Devon

Summary of locally available information

- 9/26 partners of the Reducing Bullying Steering Group have collected data.
- Only small numbers of children and young people are involved in the research.
- There are lots of mixed messages evident in the data gathered.
- Research carried out by the Behaviour and Attendance Consultants in 2009 revealed that 159 bullying incidents had been recorded in 17 secondary schools.
- In September 2010, as a result of the 'Stand Up Speak Up Meeting', young people presented to the Corporate Parent Forum their stories and experiences on bullying.
- The Devon Healthy Schools Team reported that 358 schools had achieved 'healthy school status' which required schools to address the issue of bullying.
- The Devon Transport Team data revealed a consistent number of bullying incidents have been recorded over the 3 years that the data had been collected.
- 47 racist incidents were recorded in the academic year 2009-10.
- 24 incidents of bullying against gypsies and travellers were recorded between 2008 and 2010
- Research by the Intercom Trust in 2007 reported that schools remain the most dangerous of all environments in which young lesbian, gay, bisexual and transgender people move.
- The safer Devon Partnership in 2010 received 3 bullying 'Third Party Hate Crime Reports' related to children and young people.

Source: Lyons, 2011

Domestic Violence and Abuse

4.2.5 Last year police in Devon attended an average of one domestic violence incident every hour (8,798 incidents in 2010-11).

4.2.6 Children and young people can be impacted by domestic violence and abuse as a victim, a witness or a perpetrator. In some cases they can fall into more than one of these categories.

Table 1, Reported Domestic Violence in Devon

Year	2006/07	2007/08	2008/09	2009/10	2010/11
Incidents	8,601	8,925	9,362	9,151	8,798
Crimes	2,858	2,508	2,381	2,352	2,415
% incidents recorded as a crime	33%	28%	25%	26%	27%
Incidents with Children	4,248	4,290	4,504	4,259	3,420
% incidents with children present	49%	48%	48%	47%	39%

Source: Devon and Cornwall Police DV1 Incidents

4.2.7 Domestic and sexual violence or abuse can be frequent and persistent with the highest repeat victimisation of any crime. The British Crime Survey responses suggest that 7% of women and 4% of men were victims of domestic violence or abuse in the last 12 months with 30% of women and 17% of men having been a victim at some stage since the age of 16.

4.2.8 Children and Young People are often present or in close proximity to incidents. There were children present at 39% of domestic violence incidents attended by Devon & Cornwall Police in 2010-11. Nationally, the Home Office estimate that three quarters of a million children witness domestic abuse every year. The precise number of children living with domestic violence is not known. A special check of 121a forms issued for 'Domestic' or 'Domestic Concern Welfare' from 1st April 2010 to 31st October 2010 identified 2,468 issued in this period relating to 2,030 individual children.

4.2.9 National figures indicate that nearly three quarters of children with a child protection plan live in households where domestic abuse occurs (Confidential Enquiry into Maternal and Child Health, 2007). In Devon 65% of children on a child protection plan were living in a household with past or ongoing domestic violence.

4.2.10 In the 12 months to April 2011 729 cases, assessed to be at very high risk, were taken to Multi Agency Risk Assessment Conferences (MARACs) in Devon. 19% of these were repeat attendances (NI 32 criteria). There were 979 children and young people associated with these cases.

4.2.11 The impact of violence and abuse can be devastating. Many victims suffer physical harm, which is fatal in extreme cases. Death may result from the violence itself or through suicide because the abuse and subsequent mental illness has made their life difficult to bear. Other victims may lose their home, be unable to hold down a job or a relationship, and become isolated from friends and family. Children may also be at risk, either by witnessing violence or by being victims of abuse themselves.

4.2.12 In relationships where there is domestic violence, children witness about three-quarters of the abusive incidents. About half the children in such families have themselves been badly hit or beaten (Edelson, 1999, The overlap between child maltreatment & woman abuse, http://www.bvsde.paho.org/bvsacd/cd67/AR_overlap.pdf). Sexual abuse and emotional abuse are also more likely to happen in these families (Herrenkohl et al, 2008, The Intersection of Child Abuse and Children's Exposure to Domestic Violence (http://www.americanbar.org/content/dam/aba/migrated/domviol/pdfs/0908/Intersection_of_Child_Abuse_Childrens_Exposure_to_Domviol.authcheckdam.pdf).

4.2.13 Domestic abuse is a child protection issue. The impact of domestic violence and abuse on an individual child will vary according to the child's resilience and the strengths and weaknesses of their particular circumstances. On both a national and local level (locally from serious case reviews in Devon) there is evidence that serious injury or death can occur as a consequence of domestic violence. There have been four child homicides subject to serious case reviews in Devon since 2006 of which the reports into three of the deaths found domestic violence as a contributory factor (http://www.dscb.info/serious-case-reviews/).

4.2.14 Children and young people will be distressed by living with domestic violence and may show a range of mental and physical symptoms. In younger children they may show developmental regression including bed wetting or temper tantrums. They may also become anxious and complain of stomach-aches. Older children react differently with boys much more outwardly distressed such as being more aggressive and disobedient, increasing likelihood of risk taking behaviours in adolescence including school truancy and start to use alcohol or drugs. Girls are more likely to internalise issues by withdrawing from social contact and become anxious or depressed. They are more likely to have an eating disorder, or to self harm. Children of all ages with these problems often do badly at school. They may also get symptoms of post-traumatic stress disorder, for example have nightmares and flashbacks, and be easily startled.

4.2.15 In the longer term children who have witnessed violence are more likely to be either abusers or victims themselves echoing the behaviour which was normalised within their household. The repetition of violence is not a forgone conclusion but even for those who break the cycle, children from violent families often grow up feeling anxious and depressed, and find it difficult to get on with other people.

Neglect

4.2.16 Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (including the use of inadequate care-givers)
- ensure access to appropriate medical care or treatment

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

4.2.17 Neglect is hard to define and varies by type, severity and chronicity as well as by the child's age. Because of this it can be hard for professionals to identify, particularly when it comes alongside other forms of child maltreatment. Some children are particularly vulnerable to neglect. At risk groups include children born prematurely, children with disabilities, adolescents, children in care, runaways, asylum-seeking children and children from BME communities where a lack of cultural understanding may be a barrier to identification.

4.2.18 Nationally neglect is the most common reason for children to be taken into Local Authority Care. Of the 341 children starting care in Devon in 2010/11 46.9% of those cases were for Abuse/Neglect. Of the 453 children with a child protection plan in 2011 49.0% of children were recorded under the abuse category of "neglect", with a further 39.7% recorded under "emotional" abuse.

4.2.19 Neglect can lead to profound negative and long-term effects on brain and other physical development, behaviour, educational achievement and emotional wellbeing including difficulties in forming attachment and relationships, serious developmental delay, lower educational achievements, an increased risk of substance misuse, higher risk of experiencing abuse as well as difficulties in assuming parenting responsibilities later on in life.

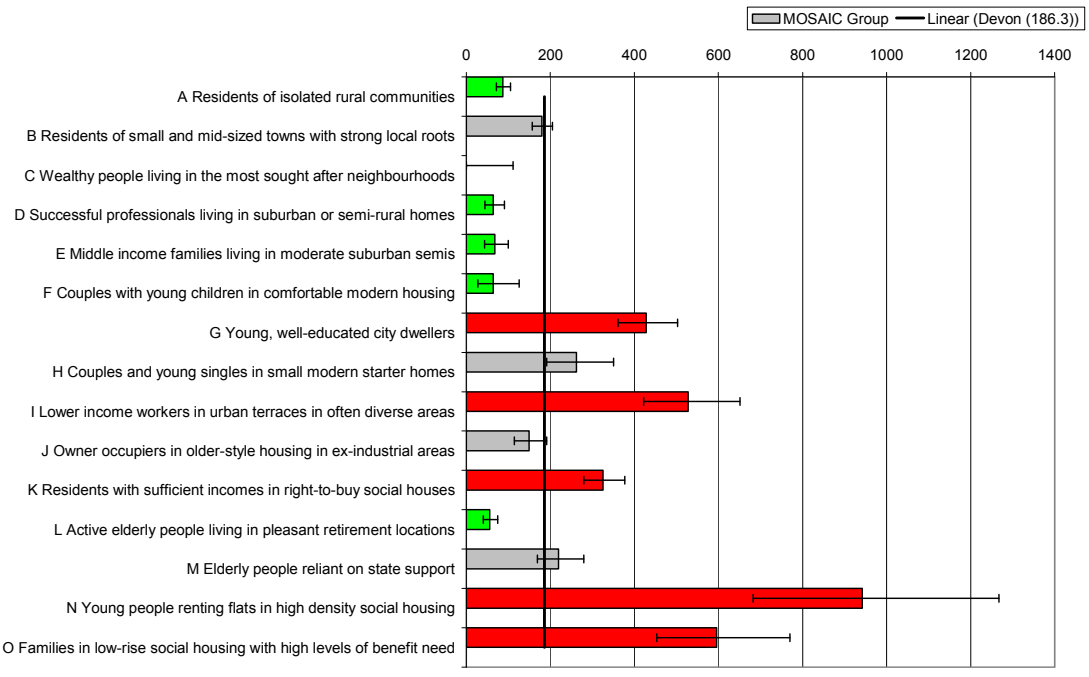
Parental Substance Misuse

4.2.20 Children are at greater risk of harm when they are living in households with parental substance misuse problems, with a greatly increased risk of domestic violence and abuse, a poor home environment and exposure to unsafe substances. Associated issues include social isolation, emotional neglect and abuse, behavioural problems, inconsistent and disturbed care and routines, poor school attendances, difficulties with adult relationships and a much greater risk of adult substance misuse (Alcohol Concern 2006 http://www.alcoholandfamilies.org.uk/briefings/13.8.pdf). There are currently an estimated 119,000 adults in Devon at increased risk of harm from alcohol due to regularly drinking more than recommended limits. Whilst most of these people are currently in reasonable health their chances of developing problems due to alcohol consumption in the future is greatly increased. An estimated 26,000 fall into the higher risk category where the current level of alcohol consumption is likely to have an adverse impact on their current health (www.devonhealthandwellbeing.org.uk/jsna/topics/alcohol). In Devon, there are an estimated 2,400 opiate and crack users in the 15 to 64 population (http://www.nta.nhs.uk/uploads/sw[1].pdf).

4.2.21 The pattern of alcohol consumption and the related health risks vary significantly by age. This is illustrated by the pattern of alcohol-related admissions by age. The peak age for acute admissions, such as alcohol poisoning or injuries for alcohol-related accidents are late teens and 20s. Admissions for mental conditions due to alcohol peak for people in their 40s and 50s, whilst admissions for chronic long-term conditions relating to alcohol use such as chronic liver disease and hypertension are much more likely in those aged over 60, highlighting the impact of continued increased alcohol use on long-term health. Younger children are more likely to be exposed to parents experiencing problems due to current use, and mental health problems which have arisen due to their increased alcohol use. Problem alcohol use is more prevalent in deprived area with a nine-fold difference between the area of Devon with the highest hospital admission rate for alcohol-related conditions (part of central Exeter) and the lowest (Western fringes of Sidmouth).

4.2.22 The peak ages for persons in drug treatment or being admitted to hospital for a drug related problem are 20s and 30s, with a fairly sizeable proportion of older users also in the treatment system. There were just over 1,200 problem drug users (opiates and/or crack) in drug treatment during 2010-11, and over 500 hospital admissions for drug-related reasons. In 2010-11, 25% of persons starting drug treatment in Devon had children (119 persons in total). Levels of drug treatment and drug-related hospital admissions were over 10 times higher in the most deprived areas of the county compared to the least deprived. This age and deprivation related pattern is illustrated in the chart below which presents drug treatment rates by MOSAIC group and highlights high levels of drug treatment for persons living in social housing, low income areas, and in areas with young populations and a high number of households in multiple occupancy.

Figure 1, Persons in Drug Treatment per 100,000 population by MOSAIC Group (Open Episodes), 2010-11

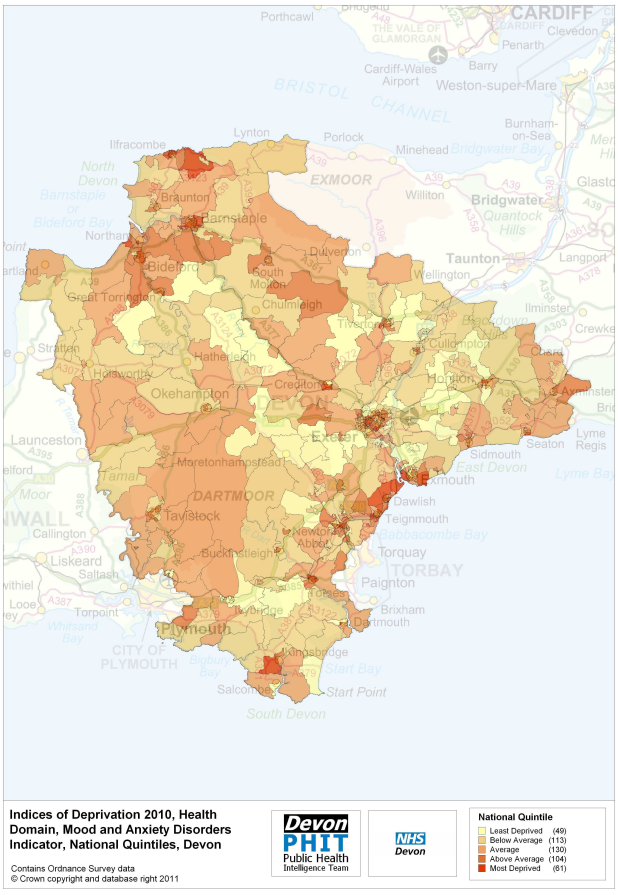


Source: HALO database, 2011 and MOSAIC Public Sector, Experian

Parental Mental Health

4.2.23 Poor parental mental health can have a detrimental effect on the health and development of children, leading to an increased risk of mental health problems for the children themselves. Around one person in six adults in England had at least one common psychiatric disorder with women more likely to experience common psychiatric problems than men, and the peak ages being between 25 and 54 for men, and 16 to 34, and 45 to 54 for women. Only around a quarter of those with a common mental health condition were receiving treatment for their condition. Psychotic disorders, such as schizophrenia and affective disorder, are also more common in younger age groups, with the peak age being 35 to 44 for both men and women. (Psychiatric Morbidity Survey of Adults, 2007, http://www.ic.nhs.uk/pubs/psychiatricmorbidity07). Within Devon, 67,300 persons were registered with depression at their GP practice, and 5,200 persons were registered with a serious mental illness (Quality and Outcomes Framework, 2010). The anxiety and mood disorders indicator from the Indices of Deprivation 2010 shown in figure 2 below highlight the pattern of mental health needs across the population, highlighting particular concentrations in Exeter, Exmouth, Teignmouth, Dawlish, Newton Abbot, Totnes, Ilfracombe, Bideford and Barnstaple. The prevalence and age distribution of common mental health problems highlight the need for a family focus in adult mental health services, and also the need to increase access to treatment.

Figure 2, Indices of Deprivation 2010, Mood and Anxiety Disorders Indicator, Devon areas in national context



Parental Learning Disability

4.2.24 Whilst there is no direct correlation between parents with learning disabilities and child abuse and neglect, early and continued intervention is required to make sure the family have all the support they need. Parents with learning disabilities will need support to develop the understanding, resources, skills and experience to meet the needs of their children. There is also greater potential of risk from unsafe adults because parents with learning disabilities may fail to recognise the threat they pose, or lack the self confidence to prevent them having access to the child (Working Together to Safeguard Children 2010). In Devon there are an estimated 10,800 adults aged between 18 and 64 with a learning disability of which around 2,400 have a moderate or severe learning disability (POPPI and PANSI, 2011). The total number of children in Devon whose parents have a moderate or severe learning disability is not known, although national estimates would suggest a number of around 250 in the county. Whilst the numbers of persons with a moderate or severe learning disability does not vary significantly by area, rates may also be higher in areas where large learning disability institutions existed or where current services are located.

Sexual Violence and Abuse

4.2.25 Sexual abuse involves forcing or enticing a child to take part in sexual activities, including prostitution, regardless of whether or not the child is aware of what is happening. Such activities may involve physical contact, including non-penetrative and penetrative acts (e.g., rape, buggery, or oral sex). Alternatively, the activities may not involve physical contact, e.g. having the child look at sexual images or watch sexual activities; involving the child in the production of sexual images; or encouraging them to behave in sexually inappropriate ways. National estimates suggest that 16% of children aged under 16 experience sexual abuse during childhood. In Devon this would equate to around 25,000 children. Of children subject to a child protection plan to Devon County Council in 2009-10 (at 31 March 2010), 3.8% were recorded under the abuse category of sexual abuse; this compares to around 6% nationally (31 March 2009, source CPR3). It is likely that some of those in the other need categories have an element of sexual abuse.

4.2.26 Sexual Violence (including rape) is sexual contact without the consent of the person. Perpetrators range from total strangers to relatives and intimate partners, but most are known in some way. It can happen anywhere including in the family/household, workplace, public spaces, social settings and education settings.

4.2.27 The Devon and Torbay Sexual Assault Referral Centre has been established to offer support to victims and undertake forensic examinations. Between September 2009 and August 2010 284 victims were examined by a SARC across Devon and Cornwall, 18.5% of these were children under 16.

4.2.28 Latest figures from Devon & Cornwall Police show that in Devon in 2010-11 there were 601 sexual violence offences reported (205 of which were recorded as rape). Of the of sexual offences that were reported within 14 days of the offence, of these, 41% of victims were under 18 years of age and 69% under 25 years of age, only around 1% were aged over 60.

Table 2: Reported Sexual Offences (2008/09 to 2010/11)

Area	2008/09	2009/10	2010/11
Teignbridge & South Hams LPA	111	133	135
Exeter LPA	148	140	137
East & Mid Devon LPA	113	153	174
North & West Devon LPA	135	150	155
Devon	507	576	601

Source: Devon and Cornwall Police CIS based on Local Policing Areas (LPA)

4.3 Protection from impairment to health and/or development

4.3.1 The second theme underpinning the work of the Devon Safeguarding Children Board is protection from impairment to health and/or development. This theme is focused on direct risks to the health and wellbeing of children, and health and wellbeing outcomes which may be a consequence of maltreatment.

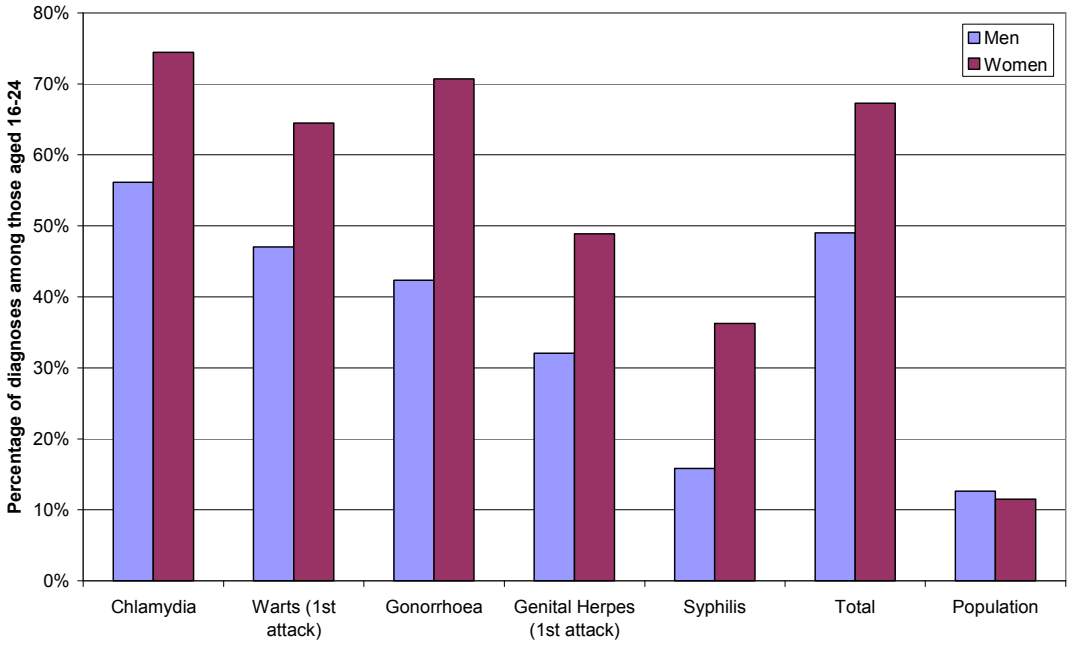
Teenage Pregnancy

4.3.2 Teenage pregnancy is strongly associated with the most deprived and socially excluded young people and having a child at a young age can result in poor health outcomes and limit education and career prospects for a young woman. While young people can be competent parents, babies born to teenagers are more likely to experience a range of negative outcomes in later life and are up to three times more likely to become a teenage parent themselves. Most teenage pregnancies are unplanned and around half end in abortion. In the three year period 2007 to 2009 there were 1,288 under 18 conceptions in Devon, of which 49% ended in abortion. Over this period the rate per 1000 females aged 15-17 was 32.0 for Devon as a whole, varying from 19.1 in the South Hams to 47.4 in Exeter. Half of all the conceptions in England occur in the 20% most deprived wards, with teenage pregnancy rates in the most deprived 10% of wards four times greater than in the least 10% deprived wards. The most deprived areas also have the lowest proportion of conceptions leading to abortion. Deprived areas with a higher number of teenage maternities are disproportionately affected by the poorer outcomes associated with teenage parenthood. Poorer outcomes for teenage parents include poor maternal nutrition, higher smoking levels, less breastfeeding, higher levels of postnatal depression, higher risk of partnership breakdown, and poorer housing and employment prospects (Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies 2006, http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_4137536)

Sexual Health

4.3.3 A risk to health which disproportionately affects younger people is sexually transmitted infections. One important aspect of safeguarding in relation to health and development is therefore ensuring that steps are in place to highlight and promote safe sex and practices to younger people. Figure 3 shows the proportion of persons with selected sexually transmitted infections aged between 16 and 24 by gender. This highlights that people in this age group are much more likely to have a sexually transmitted infection than the rest of the population, and particularly Chlamydia, Genital Warts and Gonorrhoea. This also reveals differences between males and females, with females much more likely to have sexually transmitted infections at a younger age than males.

Figure 3, Percentage of sexually transmitted infections diagnosed among young people (16-24), United Kingdom, 2008



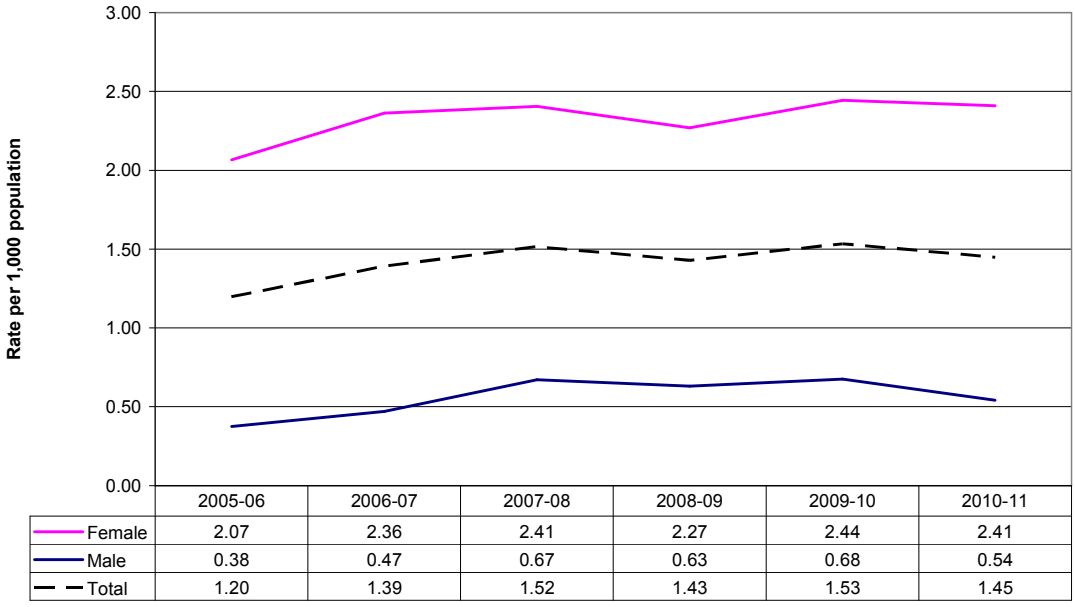
4.3.4 A health needs assessment on Sexual Health in Devon was produced in 2011 (http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2011/07/Sexual-Health-Needs-Assessment-2011.pdf). This highlighting that the highest STI rates were in Exeter, the Central ward in Barnstaple, Heanton Punchardon just outside of Barnstaple and Bickleigh and Shaugh in the South. The lowest rates were around Tiverton, Axminster, Torrington, Ottery St Mary and parts of Exmouth and Ivybridge.

4.3.5 The health needs assessment identified a number of effective sexual health promotion strategies for young people including targeting those in a relationship, promoting condom usage should be a core message throughout all campaigns, increasing knowledge on how condoms are used, using local GPs are a highly credible source for advice and testing and using the Internet and particularly social media as a source of information around sexual health.

Self-Harm

4.3.6 Self-Harm amongst younger people is one of the most direct forms of impairment to health or development. It includes overdoses (self poisoning) and self-mutilation, such as cutting, burning, and scalding. Self-harm can also be indicative of other underlying safeguarding issues, such as those outlined in the protection from maltreatment sub-section. Reliable figures on the prevalence of self-harming are difficult to obtain, although work by the Social Care Institute for Excellence, suggest around 1% of children with a mental health problem (http://www.scie.org.uk/publications/briefings/briefing16/). In Devon, 137 males and 310 females aged 0 to 19 attending accident and emergency departments as a consequence of self-harm in 2010/11, and 40 males and 168 females aged 0 to 19 were admitted to a hospital bed due to self-harm related injuries. The following chart shows the trend in admission rates by gender over recent years, highlighting that admission rates were four to five times higher in this age group for females than males.

Figure 4, Hospital admissions for self harm by gender and year, persons aged 0 to 17, rate per 1,000 population



	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Female	2.07	2.36	2.41	2.27	2.44	2.41
Male	0.38	0.47	0.67	0.63	0.68	0.54
Total	1.20	1.39	1.52	1.43	1.53	1.45

Higher rates of self-harm admissions are typically seen in more deprived areas, although the pattern is not uniform. Areas of Devon with higher admission rates include Honiton, Barnstaple, Bideford, Exeter, Exmouth and Teignmouth.

4.3.7 This pattern of self-harm does not directly translate to the pattern of suicide, where there are three male victims for every female, and peak ages are 45 to 55. This suggests that self-harm in young people is indeed frequently a 'cry for help' rather than an indication of actual suicidal intent.

Young Carers

4.3.8 A Young Carer is a young person who cares for or gives support to someone at home such as their parent, sister, brother, grandparent or a family friend. This care could include looking after someone who is unwell, disabled or has a mental health problem, or providing care for and support to a member of the family affected by drug or alcohol misuse. The care provided could involve a young carer helping with washing, dressing, shopping, cooking, dealing with money and bills, cleaning, giving medicine, or providing emotional support. Based on the 2001 Census there were around 1,100 young carers aged 0-15 in the Devon County Council area. In 2001 there were an estimated 175,000 young carers in the UK, with around a third caring for a person with a mental illness. It is likely the actual number is higher and research has suggested that around a third of young carers are involved in inappropriate and excessive caring with consequent knock-on effects on schooling and other areas of their lives (www.devonyoungcarers.org.uk).

4.3.9 Caring responsibilities can place a great deal of pressure on the carer and this can be compounded when the carer is a child or young person. The risks include the risk of truancy, under-achievement, isolation, mental and physical ill health, poverty and stress. Potential negative consequences and risks associated with caring responsibilities include:

- Absence from school can severely interrupt a young person's education and life chances. Anecdotally, young carers' services regularly receive referrals of young people who are missing most or all of their schooling in order to care for someone. 7,269 persons aged under 16 in England and Wales were identified in the 2001 census as providing care for over 50 hours per week, including 76 in Devon.
- Young carers, especially those caring for adults with mental health or substance misuse issues, are likely to go on to become service users themselves. They are also more likely to become known to social care and to become a child in care.
- There is evidence that young people who are carers are less likely to disclose things that are impacting on their own health and wellbeing such as unreasonable expectations of care delivery or a safeguarding concern.
- Physical ill health can stem from injury. Caring can carry the risk of physical injury from lifting and carrying. This includes joint and back problems and muscle damage.
- Inappropriate caring tasks can represent a safeguarding concern. It could be inappropriate if a child or young person is undertaking personal care for an adult of the same or opposite gender. This risk is compounded if they are they only person having physical contact with that adult.

Substance Misuse in Young People

4.3.10 The support, advice and treatment for children and young people who are misusing substances have an important role in relation to safeguarding. The Drug Strategy 2010 (http://www.homeoffice.gov.uk/drugs/drug-strategy-2010/) states 'Young People's drug use is a distinct problem. The majority of young people do not use drugs and most of those that do, are not dependent. But drug or alcohol misuse can have a major impact on young people's education, their health, their families and their long-term chances in life.' The report further highlights that around 24,000 young people accessed specialist

support for substance misuse nationally in 2009-10. This is a reduction in figures from the previous year.

4.3.11 Within Devon an annual needs assessment is undertaken followed with a Substance Misuse Plan which elaborates on the findings of the needs assessment and the requirements from the National Treatment Agency. The young people substance misuse service undertakes targeted prevention work and care planned treatment.

4.3.12 Of the 256 young people in treatment for 2010-11 eleven were recorded as non-white (4.2%). Data from DCSF School Census at January 2010 suggests ethnic minority pupils are around 5.2% of the total school population.

4.3.13 Whilst the gender split within Devon schools is almost exactly 50 per cent; within the young people's treatment services the split for 2010-11 was 66% male to 34% female (National Drug Treatment Monitoring Service monthly returns).

4.3.14 The main referring agencies into treatment for 2010-11 were youth offending (39%) and universal education (20%). 11% of all referrals were either self referrals or referrals from relatives which is considered to be a very positive outcome suggesting that the service is seen to be accessible by the young people or their families. Referrals from 'children in care' services appear to be low but as around 10% of clients in services are children in care it would appear that other agencies are referring or they are self-referring.

4.3.15 Parental engagement is encouraged, with the young person's agreement, when working with young people who have substance misuse. The service also supports families who request help around their child's substance misuse issues and will do so even if the young person is not currently accessing services.

4.3.16 In addition to the work with young people with substance misuse issues the service will also provides support for children whose parents are misusing substances

4.3.17 Targeted prevention work is also undertaken by the young people's substance misuse service, proactively working with groups of vulnerable young people where the risk of using substances is higher, e.g. where pupils are using the Devon Personalised Learning Service.

4.3.18 There are some important areas of work that should continue which are outlined below:

- work with children of substance-misusing parents needs to continue and develop
- parental engagement with young people's services needs to continue using family interventions when appropriate
- early intervention work with targeted groups should continue

4.3.19 The Devon Safeguarding Children Board Substance Misuse Sub-Group has representation from a range of partners including adult and young people

treatment services. A task and finish group, including representation from the sub group in addition to adult services working with parents who have mental health issues, learning disabilities or victims of domestic violence, was set up to develop guidance for adult and children's services where the parental issues could impact on the health and safeguarding of children within the household. This guidance has been signed off by the Devon Safeguarding Children Board.

Missing Persons/Runaways

4.3.20 Monitoring and reducing the incidence of missing children is important due to both the high risks they face whilst missing and the potentially serious reasons lying behind the choice to go missing. Over recent years there has been little alteration to the percentages for repeat incidents or the age groups of those concerned. Young people go missing for a wide variety of reasons. Common reasons for young people to go missing include domestic violence at home, peer pressure, bullying, sexual exploitation, offending behaviour, conflict with a parent or carer, and running away from local authority care. For children in local authority care, a common reason they are reported missing is staying out later than recommended by their care plan. The Children Society (2007) in the 'Stepping Up' report estimate that 100,000 children nationally run away each year all of whom are, to varying degrees, in need of support and services. The numbers reported missing in Devon are shown in the table below:

Table 3: Devon Missing Persons Aged Under 18 (2009/10 - 2010/11)

Missing Persons (Aged Under 18)	2009/10				2010/11			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Missing Persons Reports Reported	682	629	508	670	799	880	535	576
Number of Missing Persons Reported	392	318	273	317	358	407	284	266
Number of Repeat Missing Persons Reported	112	89	82	103	112	130	84	78
% of Missing Persons Reports classed as Repeats	29%	28%	30%	32%	31%	32%	30%	29%

4.3.21 The majority of persons under 18 reported missing were found within 24 hours. Young people who go missing are vulnerable to harm, including Internet Grooming, Sexual Exploitation, Drug Misuse, Crime, and Educational Disengagement.

- Many of those who go missing are already known to social care, either as a looked after child or with an allocated social worker.
- During this period all of these missing juveniles were successfully located.
- Most have some involvement in crime (as a victim or a perpetrator),
- Up to 80% are disengaged in education with poor aspirations
- 70% of these young people are Children in Care

Table 4: Devon Found Reports - Time between reported missing and found

Time Period	2009/10				2010/11			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Less than 24 hours	607	528	419	551	664	597	474	503
24 - 48 Hours	49	63	42	80	82	68	48	52
3 - 6 days	49	26	19	25	32	18	10	13
More than 7 days	7	8	<5	7	10	6	<5	<5

4.3.22 Young people may run away or go missing from home (or from care) following grooming by adults who seek to exploit them sexually. Evidence suggests that 90 per cent of children subjected to sexual grooming go missing at some point. Going missing for other reasons also puts young people at risk of being identified by dangerous adults looking for vulnerable young people.

Recommendation 4 (Practice) – The DSCB should assure itself that the arrangements for follow up of missing children are fit for purpose and that any themes emerging from the missing episodes are responded to by the relevant agencies.

Children with Additional Needs

4.3.23 Children with additional needs are any children or young people up to the age of 18 with a physical, sensory, communication, behavioural or learning disability, or a long-term or life-limiting condition. This may also include children with emotional health and wellbeing needs where there is an impact on their daily life, including those with more significant mental health problems. There were 11,198 children and young people receiving support for additional needs in May 2011. They are supported through a number of routes including Statements and School Action Plus at school, the County Special Education Team, disabled children known through Devon Integrated Children's Services (Multidisciplinary services for disabled children, Mental Health and Wellbeing services, and Public Health Nursing) and disabled children in specialist fostering and residential placements.

4.3.24 Children and young people with additional needs may be more vulnerable to safeguarding risks for a variety of reasons including variations in their perceptions of risk and danger, their ability to articulate concerns and their ability to recognise inappropriate behaviour. Due to their additional needs they may not be able to articulate whether they are happy and feel safe with the care they are receiving. The most frequent occurring problems for children with additional needs cover communication, emotional wellbeing and learning.

4.3.25 People may have lower expectations of safeguarding for those with additional needs. Research by Kennedy (Kennedy, M. (1992) Children with Severe Disabilities: Too Many Assumptions. Child Abuse Review, 1, pp185-187) identified beliefs that disabled children were less likely to be damaged by abuse than other children. A failure to acknowledge and promote disabled children's human rights can lead to abusive practices being seen as acceptable. For example tying up or locking a child in a room or using physical restraint would be recognised as abusive for a non-disabled child but may be seen as an acceptable means of managing challenging behaviour for a disabled child.

4.3.26 In order to care for a young person with substantial additional needs the young person may be in contact with a larger number of significant adults. This increased exposure increases risk in itself. It also changes their perception of trust, when a young person is used to being cared for by a large number of adults they may be more willing to trust a new adult and allow physical contact with a new adult to a greater extent than a young person without mobility or personal care needs.

4.3.27 Characteristics of certain conditions may mean that the young person has a lack of inhibition and therefore may place themselves in risky situations whilst being unable to recognise the risk, these conditions include those with acquired brain injury or ADHD.

> "The available UK evidence on the extent of abuse amongst disabled children suggests that disabled children are at increased risk of abuse and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect"
> (Working Together to Safeguard Children, 2006, paragraph 11.28).

4.3.28 Conversely concerns over safety and safeguarding can go too far and can actually limit young people's life opportunities when parents and carers become so risk averse that they don't push the young people to achieve their full potential. For example, young people remaining at home into adulthood when they have the capabilities to learn how to live independently.

Children with Mental Health Problems

4.3.29 Mental health problems in children can severely impair health, wellbeing and development. In September 2011 the South West Public Health Observatory published the 'Children's and Young People's Mental Health in the South West' report, which sets out patterns and issues in the region http://www.swpho.nhs.uk/resource/item.aspx?RID=83804. The following table highlights the percentage of children in Great Britain with mental disorders in 2004. This highlights that more boys than girls are affected, particularly at younger ages (5-10 years), where boys are twice as likely as girls to have a diagnosed mental disorder.

Table 5, Percentage of children with mental disorders by age and sex in Great Britain, 2004

Type of Disorder	5-10 year olds		11-16 year olds	
	Boys	Girls	Boys	Girls
Emotional disorders	2.2%	2.5%	4.0%	6.1%
Conduct disorders	6.9%	2.8%	8.1%	5.1%
Hyperkinetic disorders	2.7%	0.4%	2.4%	0.4%
Less common disorders	2.2%	0.4%	1.6%	1.1%
Any disorder	10.2%	5.1%	12.6%	10.3%

Source: Office for National Statistics 2004, cited in South West Public Health Observatory 2011 (http://www.swpho.nhs.uk/resource/item.aspx?RID=83804)

Notes
Emotional disorders – include separation anxiety;
Conduct disorders – include unsocialised conduct;
Hyperkinetic disorders – children may be hyperactive, inattentive and impulsive;
Less common disorders – include eating disorders, tics, autistic spectrum disorders and selective mutism.

4.3.30 The report cited above highlights that an estimate 21,700 children and young people in Devon are likely to have problems which can be addressed in every day settings, 10,100 are likely to need targeted or individual support, 2,700 would require the involvement of more intensive targeted support, and 120 would require highly specialised and inpatient care.

4.3.31 The Early Years Foundation Stage Profile collects data on the emotional development of children aged five, based on teacher assessments of individual children. These are reported annually to the Department for Education, and the latest published results for 2010-11 indicate that whilst 83% of children nationally and 83% of children in the South West had a score indicating good emotional wellbeing, this figure was lower in Devon at 79%. This highlights that issues around the emotional development and wellbeing of children in Devon may require further attention.

Recommendation 5 (Information) – The lower levels of reported emotional development in Devon are at odds with the social and demographic profile of the county and suggest the need for further analysis. Therefore, Devon County Council should conduct a detailed investigation of Early Years Foundation Stage Profile data on the levels of emotional development of five-year olds in the county to determine any action that may need to be taken.

Perpetrators of Crime/Offenders

4.3.32 For the purposes of the Safeguarding JSNA, and in view of the Ofsted report noted above, it may be appropriate to understand the vulnerabilities of the perpetrators of crimes rather than the offences that have been committed. The following tables show the number of offenders that have been in care, or have had a child protection plan.

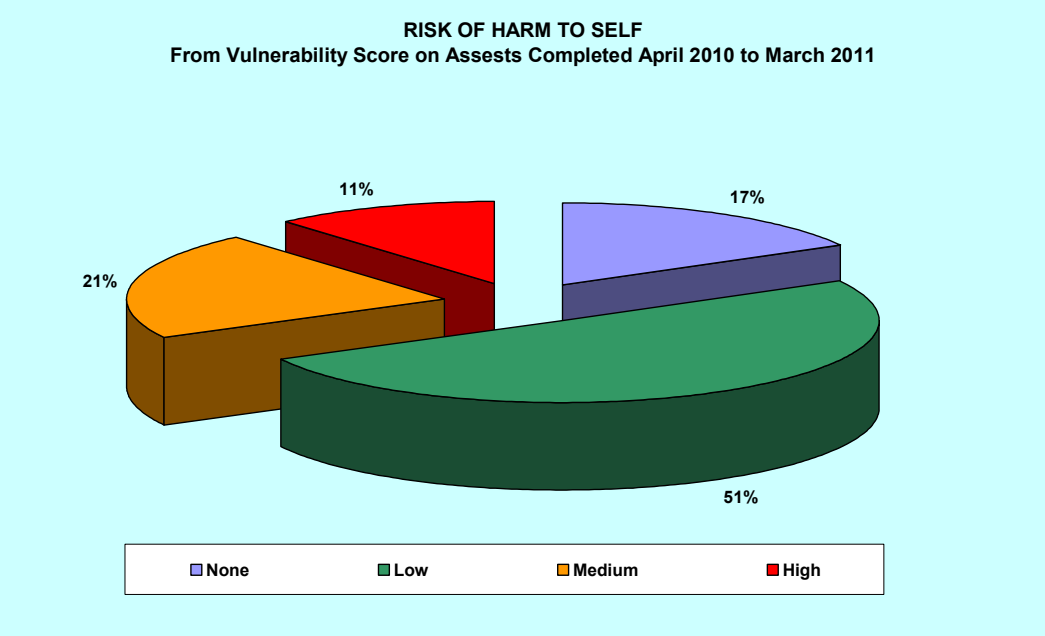
Table 6, number of young perpetrators of crime by looked after child status, 2010-11

Status	Accommodated by Voluntary Agreement	Subject to Care Order	On the Child Protection register
Currently	74	44	34
Previously	43	11	76
Never	451	513	458
Total	568	568	568

Source: Devon Youth Offending Service, 2011

4.3.33 The figure below shows the risk of harm to self by all young offenders. The fact that 83% are considered to be at risk of harm to themselves may need to be considered as a safeguarding issue.

Figure 5, Risk to harm to self, young perpetrators of crime, 2010-11



Source: Devon Youth Offending Service, 2011

4.4 Ensuring safe and effective care

4.4.1 The third theme underpinning the work of the Devon Safeguarding Children Board is ensuring safe and effective care. This theme is focused on the care provided by local authorities and other services to children in their care or referred to the services.

Children Referred to Social Services

4.4.2 6,897 referrals were received in 2010-11, an 8.7% reduction from 7,557 for the previous year, although referral numbers remain higher than pre-2009-10 levels (referral numbers had risen by 31.5% between 2008-09 and 2009-10.) However, with the introduction of the Multi-Agency Safeguarding Hub (MASH) the expectation is that referral numbers may be lower in future, by directing enquiries not meeting the referral threshold for social care to other appropriate agency.

Children in Care

4.4.3 644 children were in care to Devon County Council at 31 March 2011, the 2010-11 reporting year-end. This is an increase from 620 children a year previously, which was in turn was a rise from 539 children at 31 March 2009. Numbers of children in care have therefore risen by 19.5% over two years. Boys are more likely to be in care than girls. 57% of young people in care are male compared to 51% of the general population.

4.4.4 Devon continues to have an older 'children in care' population than the national average with 69.1% aged 10-17 in Devon compared to 60% nationally, and 30.9% aged 0-9 compared to 40% nationally (31 March 2010). The most significant rise in numbers is in respect of 16 and 17 year olds, following the 2009 Southwark Judgement. Two years ago, at 31 March 2009,

20.8% of Devon's children in care were aged 16-17 years (112 children). At 31 March 2011, 16-17 year olds comprised 32.8% of Devon's care population (211 children).

4.4.5 A lack of continuity of care and placement stability can have a detrimental impact on the health and wellbeing of young people. 15.8% of children in care had three or more separate placements during the year to 31 March 2011. Older children are less likely to have stable placements. Amongst children in care aged 16-17 at 31 March 2011, 20.4% had three or more placements, compared with 13.6% of children aged 0-15.

4.4.6 To maintain links with their family and community most children are placed near to their home address. The average placement distance at 31 March 2011 was 14.5 miles from the home address on entry to care. Distances ranged from 0 to 172 miles with 33.2% of children placed less than five miles' distant and 52.7% overall placed less than 10 miles' distant.

4.4.7 Of the 340 children who started to be looked after during the year ending 31st March 2011 47% came under the category of need of abuse or neglect compared to the overall England rate of 54%. Whilst this was the highest reason for coming into care 23% of children in Devon became looked after under the category “Family in acute stress” which is markedly different from the England rate of 11%.

4.4.8 81% of children who came into care in Devon were accommodated under Section 20. This compares with England rate of 63% and the South West rate of 72%. Interim care orders were the reason for just 7% of children in Devon coming into care compared with 20% for England and 15% for the South West.

4.4.9 6.3% of children in care for at least 12 months at 31 March 2011 were identified with a substance misuse problem during the year, higher than the 2009/10 England average outturn of 4.3%.

Recommendation 6 (Information) – Further investigations should be undertaken into the reasons as to why children are brought into care and a strategy undertaken as a result of the findings.

Children subject to a Child Protection Plan

4.4.10 453 children were subject of a child protection plan at 31 March 2011, an increase from 418 children a year earlier and from 303 children at 31 March 2009. Child protection plan numbers have therefore risen by 49.5% over two years. At present the reasons for child protection plans are not clearly and comprehensively recorded on electronic systems.

Recommendation 7 (Information) – Clearer identification and recording of reasons why child protection plans are put in place should be developed in order to gain a deeper understanding of common issues and features, and assist in the development of future strategies.

Privately fostered children

4.4.11 Private fostering is when a child under the age of 16 (under 18 if disabled) is cared for by someone who is not their parent or a 'close relative'. This is a private arrangement made between a parent and a carer, for 28 days or more.

4.4.12 The Children Act 1989 (http://www.legislation.gov.uk/ukpga/1989/41/contents) gives all children's services in the country a legal duty to safeguard the wellbeing of privately fostered children. This includes making sure they are:

- safe and well looked-after
- healthy
- receiving a proper education
- being encouraged to reach their full potential
- keeping in touch with people who are important to them
- living with someone who helps them value their culture and sense of identity
- properly supported when they become independent.

4.4.13 Despite this, many private fostering arrangements remain hidden, leaving children vulnerable to abuse and neglect - Victoria Climbie was privately fostered. There are no accurate numbers for the actual number of children living in these arrangements; when the Department of Health last collected data on private fostering in 1991 there were about 2,000 such arrangements known to local authorities. It is estimated that between 10,000 and 20,000 children may be living in private fostering arrangement (Philpot, 2001, A Very Private Practice - an investigation into private fostering).

4.4.14 In Devon 106 notifications of new private fostering arrangements were received in the year to 31 March 2011, a 23.3% increase from 86 in 2009-10.

4.4.15 Of the 104 children commencing a private fostering arrangement in 2010-11, 32 (30.8%) originated from the United Kingdom, 60 (57.7%) from elsewhere in Europe and 12 (11.5%) from Asia. The Devon breakdown is very different from national 2010/11 figures: 60.5% United Kingdom, 14.9% elsewhere in Europe, 6.2% Africa, 14.0% Asia, and 4.5% other.

Restraint

4.4.16 The third joint chief inspectors report on arrangements to safeguard children recommended that the Department for Children, Schools and Families and the Youth Justice Board should provide guidance to staff working in custodial and residential settings on the behaviour management of children and young people. Such guidance should include a model behaviour management strategy and emphasise that restraint should only be used as a last resort and should not be used solely to gain compliance. The guidance should make clear that methods of restraint should not rely on pain compliance.

4.4.17 There is active monitoring of the use of restraints within local authority children residential homes and the local authority secure children's home (Atkinson unit). It would be appropriate for other commissioned private children homes and other communal establishments to provide information around restraints that have taken place within their setting. Figures from DSCB monitoring reports suggest a reduction in the use of restraint in Devon local authority settings during 2010-11, with the most substantial reductions in use seen in the Atkinson Unit and Blossom Corner.

Recommendation 8 (Information) – The DSCB should monitor the frequency and appropriateness of the use of restraints in all residential children's units and other establishments within and outside Devon where Devon children are being accommodated, to encompass those that are privately run and managed.

4.5 Ensuring a safe environment

4.5.1 The final theme underpinning the work of the Devon Safeguarding Children Board is ensuring a safe environment. This is a broader category, which encompasses more indirect, but significant risks to children such as accidental harm.

Child Deaths

4.5.2 There were 42 deaths of children and young people in Devon in the year 2010-2011. Of these 25 were infant deaths and 17 aged 1-17. (South West Peninsula Child Death Overview Panel (CDOP) Annual Report 2010-11)

4.5.3 The 2010-11 deaths show that, in line with previously established patterns of childhood deaths, the majority of deaths are to be found in the first year of life and the majority of these associated with three categories of cause of death which are predominately present in early life. Of these only three were thought to be modifiable. This compares with the causes of deaths found in mid-childhood years in which the majority of deaths are related to medical conditions, in particular malignancy, whilst in older children and young people the majority of deaths are related to externally inflicted / mediated physical harm. It is not surprising that the highest numbers of modifiable factors are found in this age group and are due to road traffic accidents. These findings are in keeping with those seen when the 2009-10 data was analysed at a national level.

4.5.4 Overall 15% of reviewed cases across the Peninsula were deemed to have modifiable factors. Of these cases four were under a year of age, one 5-9 year old, three 10-14 year olds and four 15-17. Seven deaths were as a result of road traffic collisions and these were all in the age range 10-18

4.5.5 Sudden Unexpected Death in Infancy (SUDI) involve infants under the age of one. In 2010-11 there were 12 cases thought to be due to SUDI, making it the third most common cause[1]. Research into SUDI has demonstrated clearly identifiable risk factors which are found to be present in cases. These risk factors include:

- premature birth
- low birth weight
- co-sleeping
- babies put down in positions other than on back
- inappropriate sleeping arrangements e.g. sofa sleeping
- temperature - overheating
- parental alcohol and / or substance abuse
- parental mental health issues
- smoking within the house

[1] It should be noted that only three cases from 2010-11 have been to full panel, therefore the assigned category of causation of death may change at Panel review. They are provided here for completeness of information and based on the information given to the CDOP coordinator.

4.5.6 A review of the four SUDI cases that have been to full panel this year identified the presence of these risk factors in three cases including prone sleeping, warm room, smoking, substance abuse and mental health issues. Domestic abuse and poor socio-economic circumstances were also identified. All of the three cases had more than one risk factor present.

4.5.7 There is good evidence that by changing patterns of infant care the risk of SUDI can be reduced. Risks may well cluster, and this may be particularly so in families with additional and more complex needs.

4.5.8 National data show that there is a significant socio-economic gradient to infant mortality, and reducing the inequalities gap is a means to reducing the numbers of deaths. Modelling has identified seven interventions that will contribute to reducing the gap. The interventions are:

- reducing the prevalence of obesity in the routine and manual occupational (R&M) group to the current levels in the population as a whole;
- reduce smoking in pregnancy prevalence from 23% to 15% and meeting this target in the R&M group;
- reducing sudden unexpected death in infancy (SUDI) by persuading one in 10 women in the R&M group to avoid sharing a bed with their baby or putting their baby to sleep prone (on its front);
- achieving the teenage pregnancy strategy to reduce the under-18 conception rate in the R&M group by 50% compared with 1998 levels;
- meeting the child poverty target to halve the number of children in relative low-income households between 1998–99 and 2010–11, by increasing the income in the R&M group by an average of 18%;
- reducing housing overcrowding in the R&M group through the effect on reducing SUDI;

Promoting early antenatal booking among disadvantaged groups will also help reduce infant mortality.

Unintentional injuries affecting children

4.5.9 Unintentional injury is the leading cause of death amongst young people aged one to 14 years and causes more children to be admitted to hospital each year than any other reason. The Preventing Unintentional Injuries to Children and Young People in Devon Strategy highlighted some important issues and challenges (http://www.devonhealthandwellbeing.org.uk/health-and-wellbeing/lifestyles/unintentional-injuries/).

Accident and emergency attendances

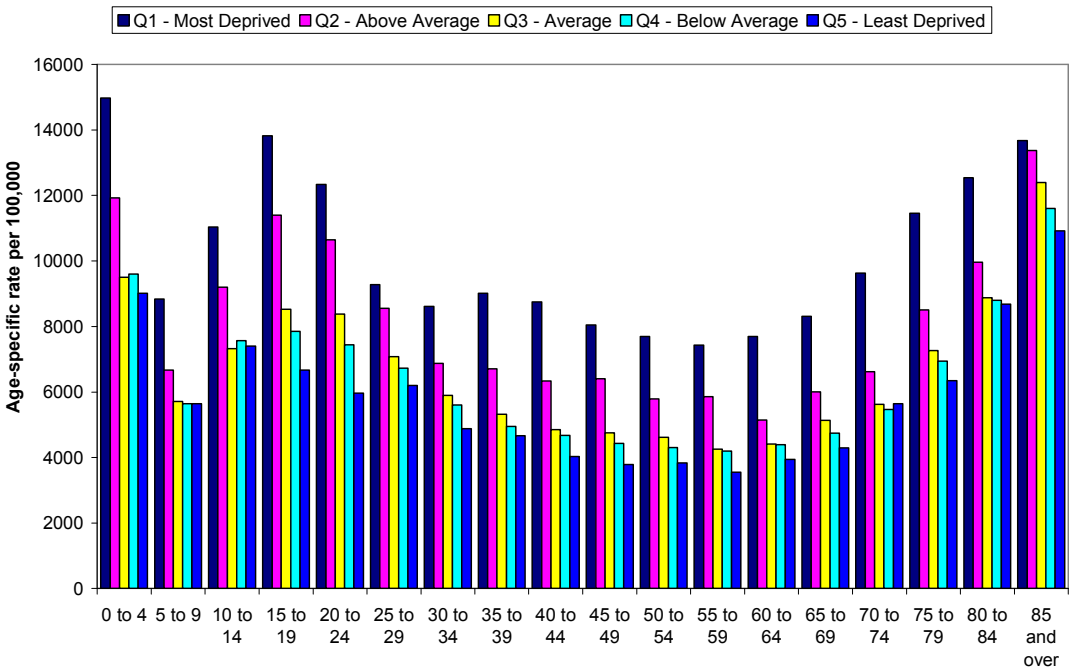
4.5.10 Attendance statistics for accident and emergency departments provide an indication of both accidental and deliberate harm affecting young people and the magnitude of particular risk factors. Table 7 shows overall numbers by gender and category for Devon, highlight that there were almost 70,000 attendances for persons aged under 20 in 2010-11. The pattern varies markedly by gender, with males much more likely to attend as a result of assault, a sports injury, and to a lesser extent a road traffic accident. Females are more likely to attend as a result of self-harm.

Table 7, Accident and Emergency Attendances in Devon by gender and category, persons aged 0 to 19, Devon, 2010-11

Category	Female	Male	Persons
Road Traffic Accident	309	404	713
Assault	163	494	657
Deliberate Self-Harm	310	137	447
Sports Injury	914	2,806	3,720
Firework Injury	32	42	74
Other Accident	15,647	20,330	35,977
Other	12,966	13,068	26,034
Unknown	865	1,284	2,149
Grand Total	31,206	38,565	69,771

4.5.11 Figure 6 shows age-specific attendance rates for Devon by deprivation, highlighting that attendances are particularly frequent for children, with the peak age being 0 to 4, with a secondary peak between the ages of 15 and 19. Attendances are also more likely in more deprived areas at all ages, highlighting the impacts of both social deprivation and age on attendance rates.

Figure 6, Accident and Emergency Attendances per 100,000 population by Age and Deprivation, Devon, 2010-11

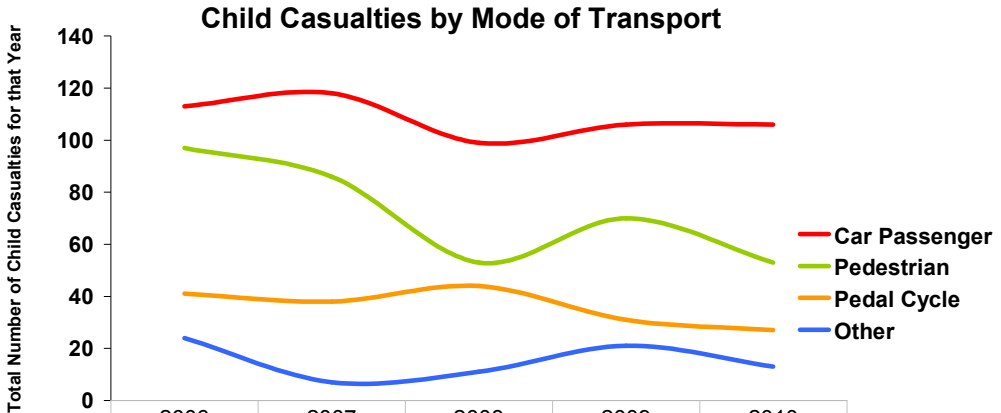


Road Traffic Accidents

4.5.11 A further environmental risk to children is from road traffic accidents, where children under the age of 16 are at risk as passengers, pedestrians and cyclists, with even greater risk of harm as younger adults when they become drivers and motorcyclists themselves. In 2010-11 there were 713 accident and emergency department attendances for persons aged 19 or under following a road traffic accident. In 2010-11 268 persons aged 0 to 19 were

admitted to a hospital bed following a transport accident, including 149 aged 0 to 15 and 119 aged 16 to 19. In Devon, collision data is collected by Devon and Cornwall Police. This covers only those accidents recorded by police where the casualties were aged under 16, and where Devon is defined as the place of occurrence of the accident rather than the place of residence of those involved, so do not provide a direct match to health data. The figure below highlights that there were 199 casualties recorded in 2010, of which 106 (53%) were car passengers, 53 (27%) were pedestrians, 27 (14%) were cyclists, and 13 (7%) were using other modes of transport. Both pedestrian and cyclist accidents appear to have fallen in recent years, which may relate to the increased use of school travel plans and cycle training schemes such as Bikeability.

Figure 7, number of children injured on Devon roads by mode of transport and year, 2010



	2006	2007	2008	2009	2010
Car Passenger	113	118	99	106	106
Pedestrian	97	86	53	70	53
Pedal Cycle	41	38	44	31	27
Other	24	7	11	21	13

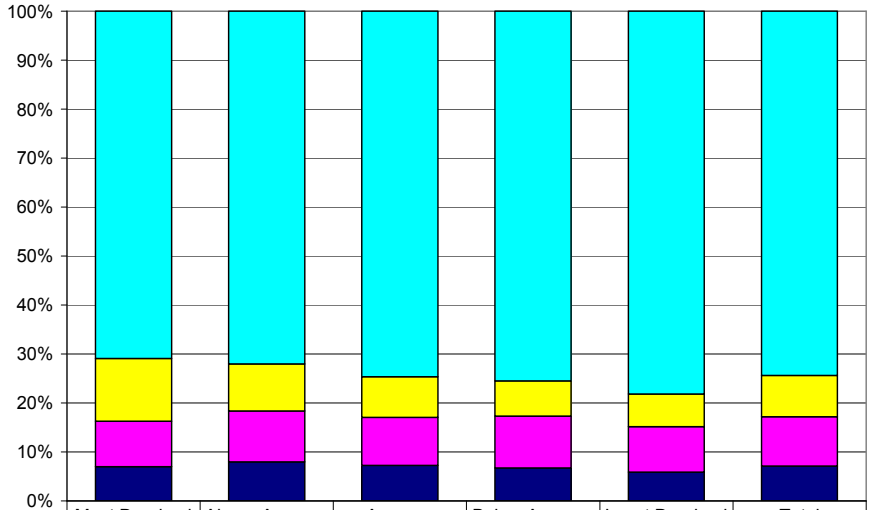
Year

4.5.12 In Devon there were 143 transport accident deaths in persons aged 0 to 19 in the decade between 2001 and 2010. 30 were under the age of 16, and 113 aged between 16 and 19, with car (87) and motorcycle (27) accidents the most frequent cause, followed by pedestrian accidents (15) which were also more frequent between the ages of 16 and 19. Whilst death rates following road traffic accidents have fallen over recent years, in 2010 there were still 13 deaths in persons aged 19 and under. Risk varies by type with greater risk to pedestrians and cyclists in urban areas, and greater risk of serious injury to car occupants and motorcyclists in rural areas. National reports such as the annual Reported Road Casualties in Great Britain published by the Department for Transport (http://www2.dft.gov.uk/pgr/statistics/datatablespublications/accidents/casualtiesgbar/rrcgb2009.html) and the South West focused report, 'A Heavy Toll' (http://www.swpho.nhs.uk/default.aspx?RID=33445) highlight higher levels of collisions for young drivers.

Missed Health Appointments

4.5.13 Another risk of harm to children is through missed medical appointments, which can lead to ill health due to non-treatment of health conditions, and in some cases may indicate neglect. In Devon in 2010-11, of the 43,636 first outpatient appointments for 0 to 15 year olds, 3,698 did not attend (8.5%), 4,391 were cancelled on behalf of the patient (10.1%), and 3,095 were cancelled by the provider (7.1%). The pattern varies by age, with the highest level of 'did not attends' in the 0 to 4 age group (1,999 or 10.62% of all appointments), with lower levels for older ages (7.69% for 5 to 11 year olds and 5.60% for 12 to 15 year olds). The pattern varies by deprivation as well, as illustrated in figure 8, which highlights that the highest 'did not attend' levels were in the most deprived areas (12.8%), and the lowest in the least deprived areas (6.7%).

Figure 8, First Outpatient Appointments by Attendance and Deprivation, persons aged 0 to 15, Devon, 2010-11



	Most Deprived	Above Average	Average	Below Average	Least Deprived	Total
Seen	70.9%	72.0%	74.6%	75.5%	78.2%	74.4%
Not Seen - Did Not Attend	12.8%	9.7%	8.3%	7.2%	6.7%	8.5%
Not Seen - Patient Cancelled	9.3%	10.4%	9.8%	10.6%	9.2%	10.1%
Not Seen - Provider Cancelled	6.9%	8.0%	7.2%	6.7%	5.9%	7.1%

Recommendation 9 (Information) – Systems to alert GPs and other health and social care professionals in the event of missed hospital appointments or frequent accident and emergency attendances should be developed locally.

Young people as victims of crime

4.5.14 In 2010-11 there were 657 accident and emergency attendances following an assault in persons aged 0 to 19. The likelihood of attendance increases significantly with age, with 12 attendances for 0 to 4 year olds, 17 for 5 to 9 year olds, 165 for 10 to 14 year olds, and 463 for 15 to 19 year olds. Males are much more likely to be victims of assault than females, and this increases with age with 109 attendances for females aged 15 to 19, compared with 354 for males. There were 51 emergency admissions to a hospital bed for

persons aged 19 and under following an assault in 2010-11, these show an even more marked pattern by age with 29 of the victims aged 18 to 19. The vast majority occurred in a public or unspecified location, with very few in the home. The pattern varies by age with schools and residential institutions (such as care homes) featuring prominently as the assault location for school-age children, and street and licensed premises setting becoming more prominent after the age of 16. This corresponds with police data on assault, which highlights that city and town centre locations and areas with licensed premises feature prominently. According to Devon and Cornwall Police statistics for 2010-11, there were 3,017 crimes were the victim was aged 0 to 18, including 302 sexual crimes, 863 thefts and 1,539 violent crimes. Nationally, statistics identify that young people aged under 18 commit 32% of recorded crime, but are victims of 50% of recorded crime. 60% of young people not in full time education commit crime whereas 61% of these young people fall victim of crime.

Local Authority Designated Officer (LADO) referrals

4.5.15 Referrals are made to the Local Authority Designated Officer (LADO) in cases where employees are accused or suspected of abuse or inappropriate behaviour. The Independent Safeguarding Authority (ISA) has warned that incidents and suspicions of abuse are going unrecorded as it emerged that referrals to the body have remained static, despite an extra five million employees and volunteers becoming subject to vetting and barring checks. In Devon there were 337 such referrals in 2010-11, of which 181 required further meetings and action, and 156 required no further action. This compares to 273 referrals in 2009-10, of which 194 required further meetings and action, and 79 required no further action. Figure 9 highlights the pattern of referral in 2010-11, which show that the bulk of referrals relate to teaching and caring professions, due to their frequent contact with children. In terms of the cases requiring a meeting, figure 10 highlights that whilst no further action was required in many cases, a number led to police and internal investigations and disciplinary action. The most common types of complaints related to physical abuse and inappropriate behaviour.

Figure 9, LADO referrals by profession and action, 2010-11

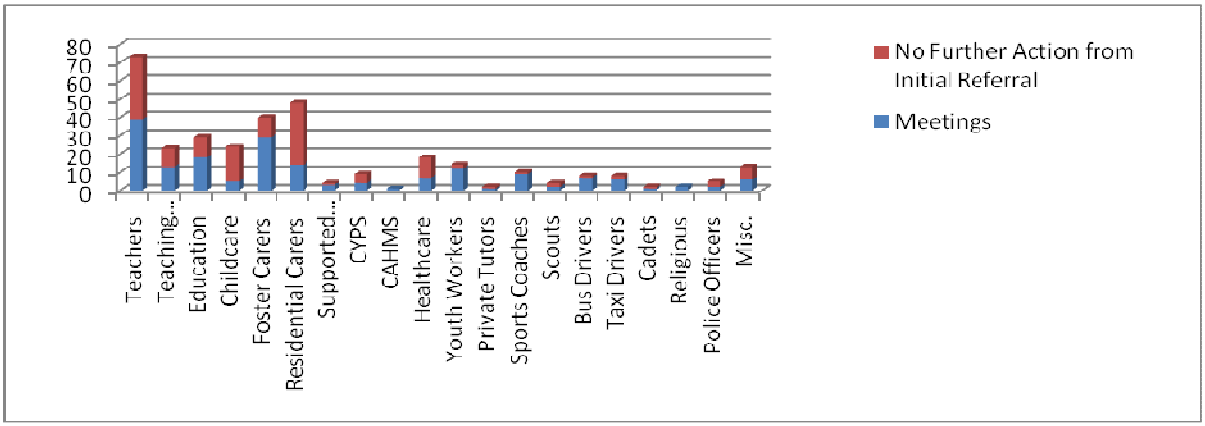
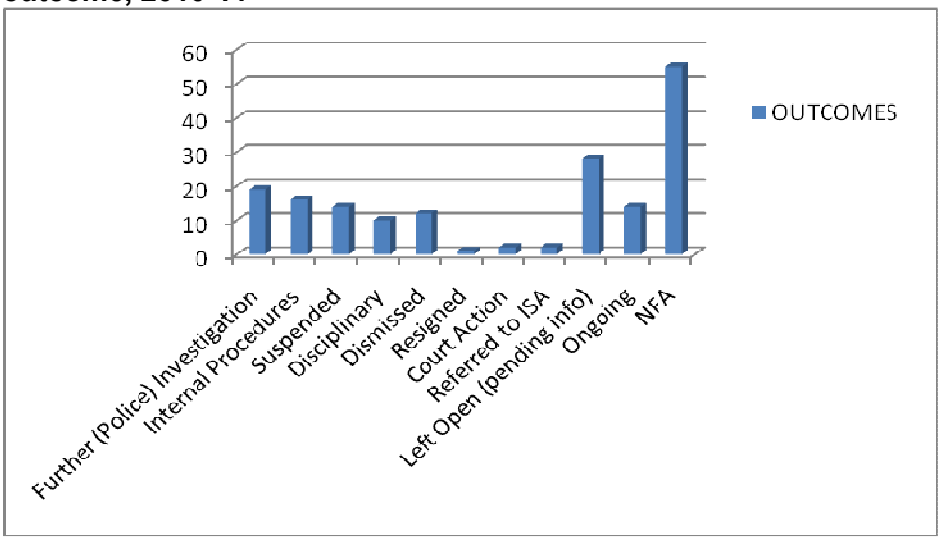


Figure 10, LADO referrals requiring meetings and further action by outcome, 2010-11



4.6 Complex and Multiple Needs

4.6.1 All the needs and issues recognised in this document can have profound impacts for safeguarding and these risks are increased where there are complex and multiple needs. Complex needs cover both the breadth of need (more than one need, with multiple needs interconnected) and the extent of need (profound, severe, serious or intense needs). These needs, and combinations of needs, can vary widely from family to family and span the full breadth of health and social issues.

4.6.2 A Devon study in 2010 of 101 young people with a Child Protection Plan found that 99% were living in families with multiple and complex needs.

With respect to the needs and risk factors in the young people's parents

- 33% of young people were affected by both domestic violence and parental mental health Issues
- 27% of young people had parents offending and parents with substance misuse
- 20% of young people had both poor housing (inc. homelessness, threat of eviction, unsafe/ overcrowded housing) and domestic violence.

4.6.3 In order to respond to the need for early intervention before social services thresholds are met work is currently being undertaken in Devon to establish the needs and risks impacting a wider range of families by creating a family needs profile of those using the Devon health visitor service. This work is still underway but initial findings suggest there are significant variations in needs, and combinations of needs between families, and that there are clear geographic hotspots for some of these needs. Of the 33 needs identified in the survey 30% of families had more than three needs identified and 12% had more than eight. Ilfracombe and parts of Exeter have a significantly higher percentage of families with multiple needs. For specific issues there was substantial variation by geographical location and by deprivation. Overall 13% of families were recorded as being impacted by domestic violence, rising to 30% in one area. It was most pronounced in areas of high deprivation (6% in the least deprived areas rising to over 25% in the most deprived areas).

4.7 General Information Recommendations

Recommendation 10 (Information) – The DSCB should commit partners to produce information required as agreed by the Peninsula Performance Management Information group

5. Safeguarding Processes and Targeted Provision in Devon

5.1 Safeguarding Processes and Joint Commissioning

5.1.1 Safeguarding children is a function of all agencies in Devon, and it is important that all commissioning is underpinned by a consideration of safeguarding, and that targeted provision exists to directly tackle safeguarding issues. This sub-section describes the underlying principles of safeguarding and joint commissioning in Devon, highlighting aspects of these processes which may require further development.

Strengths of Joint Commissioning

5.1.2 Joint commissioning between adult and children services should ensure that agencies work together when considering a new service or contract to ensure that the safeguarding of children is included in any contract/service level agreement and should be evidenced before any contract is signed.

5.1.3 Basic safeguarding requirements of any commissioned or non-commissioned service, if they are working with children and young people within the county, should be in place. A joint agreement on what the requirements should be needs to be clarified for both statutory and voluntary agencies. For agencies that are providing a service that is not commissioned, evidence of safeguarding policies should be secured before any young person is referred by statutory services.

5.1.4 When commissioning services, adult services should always consider the needs of children within a household and how the health of the adult can impact on the safeguarding of the child. This needs to be included in any tendering of services and services need to evidence that there is a safeguarding policy in relation to the children of clients. Under Section 11 of the Children Act 2004 there is a duty to cooperate by statutory agencies. These agencies include Local authorities, district councils, Connexions, Police, British Transport Police, Probation Service, Youth Offending Service, Prisons and Secure Training Centres and these agencies are required to evidence the safeguarding procedures on an annual basis.

5.1.5 All commissioned services will require providers to:

- Have a safeguarding policy following agreed lines (Section 11 or similar)
- Have a designated senior officer for child protection
- Have nominated champion for child protection
- Have an annual requirement to audit their safeguarding policy with an action plan in place as required which is referred and updated on a regular basis.

Challenges of Joint Commissioning

5.1.6 Priorities of different commissioning services may have differing emphasis. It is important that when any commissioning is undertaken, the needs of children and young people are highlighted as being of paramount importance whether the provision is for an adult or a child/young person.

Non-commissioned services

5.1.7 As more funding opportunities are made available to voluntary agencies it is essential that professionals within statutory agencies have confidence that any agency they refer to has safeguarding as a priority. As time progresses it is likely that there will be more services that do not come directly under local authority or health governance, including the rise in the number of academy schools throughout the county.

Workforce development

5.1.8 All staff and volunteers should work within the framework of the safeguarding policy that has been agreed and should be involved in the review of the safeguarding policy and annual audit. This would be one way of ensuring that the staff are kept up to date and have confidence in their way of working. A copy of the policy should be given to new members of staff at induction and should sign to evidence that it has been read.

5.1.9 All staff and volunteers will understand the confidentiality requirements of a service and when there is a need to break confidence. Information sharing arrangements between agencies should be made clear. All staff will have an understanding of the Multi-Agency Safeguarding Hub (MASH) process.

Recruitment policy

5.1.10 All agencies and providers of services will be fully compliant with the guidance on recruiting members of staff and volunteers and at least one panel member will have attended safer recruitment training.

5.1.11 All agency staff who work with children or young people will have an enhanced CRB check.

Whistleblowing

5.1.12 All providers of services will be able to evidence that a clear whistleblowing procedure is in place and that staff have the confidence to use the procedure if required.

Complaints procedure

5.1.13 All agencies and providers of service should be able to evidence accessible complaints procedures for their agency. This complaints procedure should be clear and understandable for children and young people. All Complaints that are received by the agency should be forwarded to commissioners with a report on what response has been made to the complainant. Commissioners will monitor complaint rates and response rates. The procedure will explain the process for complaints and the time that they will be acknowledged in. Further discussion within agencies and organisations should take place as to whether the complaints procedures are sufficiently robust to ensure vulnerable children and young people have the confidence to complain.

5.1.14 There will be a clear procedure if any allegations are made against staff or volunteers. The safeguarding lead will be made aware of any allegations and will understand requirements of when allegations should be reported to the Local Authority Designated Officer (LADO).

Workforce Development and Training

5.1.15 All members of staff who have contact with children, young people or parents should attend training at the level that Working Together suggest as the minimum standard. This training needs to be refreshed on a three year basis.

5.1.16 Supervision should happen on a regular basis. Safeguarding should be the basis of all supervision and should be recorded and signed on each occasion. Actions following the supervision should be recorded and checked to ensure they are completed.

5.1.17 The issue of the importance of supervision needs to be raised in order to ensure effective support to front line practitioners of whatever agency to ensure staff see the whole picture and focus on the needs of the child. Commissioners must ensure supervision is a recognised component of contracts.

5.1.18 Current patterns of demand suggest that safeguarding multiagency training is operating at full capacity. The 'Think Family' initiative alongside the need to focus on the needs of the child suggests the potential for additional opportunities for joint training between children and adult services. Joint training under the 'Think Family' agenda would help to embed the sharing of information about the family, where essential, as the norm.

Children's Voice

5.1.19 Children, young people and parents should be involved in the development of the safeguarding policy of any commissioned service. Their needs and concerns should be identified and should be prioritised within the policy. All safeguarding policies should be accessible to any young person using the service.

5.1.20 Children and young people should have the confidence to raise issues around safeguarding and know that they will be listened to and heard and concerns will be acted upon. Children will be advised around confidentiality and be made aware of any specific members of staff who have specific safeguarding duties.

5.1.21 The Children's Commissioner report highlights the need to hear the Children's Voice. Work is being undertaken within the DSCB and DCC in relation to this. Reconstruct is commissioned within DCC to work as advocates for children in care. Other questionnaires are completed on an individual basis but in some cases it is difficult to aggregate the findings of the individual cases. Work is continuing within the DSCB to look at the "journey of the child" while they are accessing services to check that children do feel "safer" after interventions.

Performance Monitoring and Assurance Arrangements

5.1.22 Quarterly reporting to the DSCB on a range of issues has been taking place over the last year. The Board is now developing this to achieve a more in-depth understanding of the child's journey while working with specific services such as domestic violence and substance misuse. This initiative is Peninsula wide to ensure those agencies that work cross boundaries are able to monitor coherently.

5.1.23 A risk register has also been put in place to identify areas where there are concerns around safeguarding and actions that need to take place to ensure that these risks are minimised.

5.1.24 There are many national indicators relevant to safeguarding children that are reported on with a likelihood of additional measurements in the future.

5.1.25 The Devon Safeguarding Children Board needs to ensure it has the right assurance processes in place to monitor improved outcomes for children and a reduction in inequalities.

5.1.26 The Devon Safeguarding Children Board should also ensure that local reporting mechanisms meet OFSTED and CQC reporting requirements.

5.2 Targeted Provision

5.2.1 Targeted provision covers specific interagency arrangements relating directly to safeguarding issues.

Multi-Agency Risk Assessment Conference (MARAC)

5.2.2 The main aim of the MARAC is to reduce the risk of serious harm or homicide for a domestic abuse victim and to increase the safety, health and wellbeing of other victims, both adults and children. In a MARAC local agencies will meet to discuss the highest risk victims of domestic abuse in their area. Information about the risks faced by those victims, the actions needed to ensure safety, and the resources available locally are shared and used to create a risk management plan involving all agencies.

5.2.3 MARAC is open to any agency to refer cases to where high risk victims have been identified by using the CAADA/DASH Risk Assessment process. All relevant agency workers should be trained in the usage of this process and make referrals to the MARAC co-ordinator accordingly. Cases that meet the High Risk threshold will be offered support by an IDVA. Those meeting medium risk will be offered support by Outreach Services. From April 2009 to March 2010 a total of 703 cases have been discussed at MARAC in Devon; 907 children and young people were associated with their cases.

5.2.4 There is a high degree of overlap between the cases reviewed at MARAC and those that are known to adult services, such as drug and alcohol treatment services. Representation from services will help other agencies at the MARAC by providing information on the impact of the adult's behaviours and how to support those involved.

5.2.5 Agencies should receive a MARAC meeting agenda from the MARAC co-ordinator. All agencies should have a contact point within their organisation to identify and respond with relevant information to the MARAC group about individuals who are being discussed at the meeting.

5.2.6 Disclosures to the MARAC are made under the Data Protection Act and the Human Rights Act. Information can be shared when it is necessary to prevent a crime, protect the health and/or safety of the victim and/or the rights and freedoms of those who are victims of violence and/or their children. It must be appropriate to the level of risk of harm to a named individual or known household.

5.2.7 Further information on MARACs is available at www.caada.org.uk and www.devon.gov.uk/adva-partnership

Multi Agency Public Protection Arrangements (MAPPA)

5.2.8 MAPPA represents a set of arrangements to manage the risk posed by certain sexual and violent offenders. They bring together the Police, Probation and Prison Services in Devon and Cornwall into what is known as the MAPPA Responsible Authority.

5.2.9 A number of other agencies are under a 'duty to co-operate' with the Responsible Authority. These include Children's Services, Adult Social Services, Health Trusts and Authorities, Youth Offending Teams, local housing authorities and certain registered social landlords, Jobcentre Plus, and electronic monitoring providers.

5.2.10 Offenders eligible for MAPPA are identified and information is gathered and shared about them across relevant agencies. The nature and level of the risk of harm they pose is assessed and a risk management plan is implemented to protect the public (Devon and Cornwall Multi Agency Public Protection Arrangements Annual Report 2008-2009).

5.2.11 The need for adult services to participate in MAPPA around the safeguarding of children and young people is vital. Further information can be found on www.devon-cornwall.police.uk or www.dcpa.co.uk

Multi-Agency Case Audit (MACA)

5.2.12 Multi agency case audits (MACA) have been taking place over the last year. Specific child protection cases have been identified and scrutinised in more detail on a multi-agency basis. From these case audits an action plan has been developed. In addition to these MACAs a new approach from SCIE is being undertaken at the current time to understand, following recommendation from the Munro report, in more detail a deeper understanding of the processes that are taken within agencies around child protection.

Multi-Agency Safeguarding Hub (MASH)

5.2.13 The Multi-Agency Safeguarding Hub (MASH) is the central resource for the whole of Devon receiving all safeguarding and child protection enquiries. The MASH is a partnership between Devon County Council children's social care, education and youth services, Devon NHS health services, Devon and

Cornwall Police and the Probation Service working together to safeguard children and young people.

5.2.14 Latest figures from the MASH show that 5,246 total MASH enquiries were recorded from 1 April 2010 – 31 March 2011. These enquiries related to 4,350 children. From these 5,246 enquiries 48.1% became a CYPS referral and 23.1% were referred to Early Response Services. There was no further action on 23.8% of the enquiries.

5.2.15 The MASH is still developing and monitoring of the MASH functions is undertaken regularly. This information is of great importance in understanding how individual agencies are working to the MASH guidance.

5.2.16 An enquiry should be made to the MASH when there are safeguarding concerns that may require children's' social care involvement. This includes:

- any concern about a child at risk of sexual abuse
- physical injury caused by assault or neglect which may or may not require medical attention
- incidents of physical abuse that alone are unlikely to constitute significant harm but taken into consideration with other factors may do so
- children who suffer from persistent neglect
- children who live in an environment which is likely to have an adverse impact on their emotional development
- where parent's own emotional impoverishment affects their ability to meet their child's emotional and/or physical needs regardless of material/financial circumstance and assistance
- where parents circumstance are affecting their capacity to meet the child's needs because of domestic violence, drug and/or alcohol misuse, mental health problems, learning disability and/or previous convictions for offences against children
- a child living in a household with, or having significant contact with, a person at risk of sexual offending
- an abandoned child
- bruising to a pre-mobile baby
- pregnancy where children have been previously removed
- suspicion of fabricated or induced illness
- where a child under one year is present in a home where domestic violence is a concern

Common Assessment Framework (CAF)

5.2.17 Effective arrangements for undertaking Common Assessments are essential to the delivery of effective safeguarding. They ensure early identification of need, multi-agency risk assessment and determination of thresholds and the involvement of children, young people and families in problem solving. The Early Help Strategy is being developed at the current time. Within this strategy there is a recommendation that the current CAF process is developed to ensure a more family focused procedure.

5.2.18 The Common Assessment Framework is the inter-agency process model of holistic assessment, action planning and review to be used in Devon. The Common Assessment Framework should be used as the common process

for assessing and meeting multiple additional need in Devon, and should precede specialist and / or statutory assessment except where there are safeguarding concerns or where a parent / carer does not consent to a Common Assessment Framework.

5.2.19 Practitioners should continue the work to build relationships with families who initially decline support, and should not close cases due to non–attendance and non–engagement. Smooth transition between practitioners and agencies ensures better support for families. The Common Assessment Framework process should not be a barrier to early assessment of urgent and complex need.

5.2.20 It is important that the Devon Safeguarding Children Board is made aware of this and action is being taken to ensure inequalities are being addressed. This is just one example of the need to review which Board sees what routinely gathered data exists to effectively performance manage local services. For any of the above targeted provisions to work well it is necessary for partners to work together and share information. All agencies need to provide relevant information, to attend meetings and to refer to relevant forums as and when required.

5.2.21 The Devon SEND Pathfinder programme is currently testing the integration of education, health and social care, including developing a single assessment process to replace the CAF assessment.

5.3 Commissioning and Provision Recommendations

Recommendation 11 (Commissioning) – The commissioning of all adult and children's services must consider the inclusion of a focus on potential risks and harm to children.

Recommendation 12 (Commissioning) – Whistleblowing procedures should be reviewed to ensure that children, young people and staff are able to access the procedures and are confident to use them.

Recommendation 13 (Commissioning) – No young person should be referred to any service (commissioned or non-commissioned) unless the referring agency has established the safety of the service provider with reference to safeguarding processes.

Recommendation 14 (Commissioning) – Systems should be put in place to ensure that the voice of children and young people is included in all agencies work around safeguarding, and agencies should be able to evidence that they have been taken into account and policies amended as required.

Recommendation 15 (Practice) – The DSCB should ensure that training and development resources for safeguarding are shared across agencies and kept up-to-date, and that internal and external providers of safeguarding training make use of policies and guidance within the DSCB website.

Recommendation 16 (Practice) – DSCB members should be directly notified if staff from their organisation fail to attend or produce reports for meetings relating to child safeguarding when requested.

Recommendation 17 (Practice) – The DSCB should alert partners to important recommendations from national research and new requirements from Government bodies, and facilitate their local implementation.

6. Conclusion and Recommendations

6.1 Conclusion

This Joint Strategic Needs Assessment has highlighted that the safeguarding of children is a multifaceted, cross-agency process, where coordination between agencies and strong leadership is essential. The 'needs of the population' section is structured around the four themes underpinning the work of the Devon Safeguarding Children Board; protection from maltreatment, prevention of impairment to health and/or development, ensuring safe and effective care, and ensuring a safe environment. These themes link to the principles set out in Working Together to Safeguard Children document (DCSF. 2010), and focus the work of the board on both direct and indirect sources of harm to children and young people. This report sets out commissioning principles for safeguarding, highlighting how the safeguarding of children needs to be the focus of all commissioning, regardless of whether the clients are children or adults. Targeted provision for safeguarding children in Devon, including multi-agency forums like Multi-Agency Risk Assessment Conference (MARAC), Multi-Agency Public Protection Arrangements (MAPPA) and the Multi-Agency Safeguarding Hub (MASH), alongside safeguarding processes like multi-agency case audit (MACA) and the common assessment framework (CAF) are already working to improve safeguarding locally. It is vital that these arrangements are maintained and strengthened into the future. Safeguarding is indeed everyone's business and the following set of recommendations highlight some actions for the next year to ensure that the work of the Devon Safeguarding Children Board continues to address local needs and emergent issues. All commissioning activities should reflect the recommendations from this JSNA.

6.2 Recommendations

Recommendation 1 (Strategy) – The DSCB should ensure that a comprehensive mapping of service transition points between adult and children and within services is undertaken to ensure that multi-agency protocols are clear and appropriate care pathways are in place for referrals to and between services.

Recommendation 2 (Strategy) – Preventative work should include early intervention in relation to immunisation, school absenteeism, smoking and substance misuse in young families, and breastfeeding. This should link to the forthcoming early help strategy and JSNA.

Recommendation 3 (Practice) – The DSCB should be assured that the recommendations of the University of Bedfordshire review into child sexual exploitation and local reporting mechanisms have been considered when developing working practice.

Recommendation 4 (Practice) – The DSCB should assure itself that the arrangements for follow up of missing children are fit for purpose and that any themes emerging from the missing episodes are responded to by the relevant agencies.

Recommendation 5 (Information) – The lower levels of reported emotional development in Devon are at odds with the social and demographic profile of the county and suggest the need for further analysis. Therefore, Devon County Council should conduct a detailed investigation of Early Years Foundation Stage Profile data

on the levels of emotional development of five-year olds in the county to determine any action that may need to be taken.

Recommendation 6 (Information) – Further investigations should be undertaken into the reasons as to why children are brought into care and a strategy undertaken as a result of the findings.

Recommendation 7 (Information) – Clearer identification and recording of reasons why child protection plans are put in place should be developed in order to gain a deeper understanding of common issues and features, and assist in the development of future strategies.

Recommendation 8 (Information) – The DSCB should monitor the frequency and appropriateness of the use of restraints in all residential children's units and other establishments within and outside Devon where Devon children are being accommodated, to encompass those that are privately run and managed.

Recommendation 9 (Information) – Systems to alert GPs and other health and social care professionals in the event of missed hospital appointments or frequent accident and emergency attendances should be developed locally.

Recommendation 10 (Information) – The DSCB should commit partners to produce information required as agreed by the Peninsula Performance Management Information group.

Recommendation 11 (Commissioning) – The commissioning of all adult and children's services must consider the inclusion of a focus on potential risks and harm to children.

Recommendation 12 (Commissioning) – Whistleblowing procedures should be reviewed to ensure that children, young people and staff are able to access the procedures and are confident to use them.

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Recommendation 17 (Practice) – The DSCB should alert partners to important recommendations from national research and new requirements from Government bodies, and facilitate their local implementation.

7. Appendix - Glossary

CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Service
CDOP	Child Death Overview Panel
CSE	Child Sexual Exploitation
CT	Children's Trust
DSCB	Devon Safeguarding Children Board
EAL	English as an additional language
GP	General Practitioner
ISA	Independent Safeguarding Authority
JSNA	Joint Strategic Needs Assessment
LADO	Local Authority Delegated Officer
LGBT	Lesbian, gay, bisexual, transgender
LSCB	Local Safeguarding Children Board
MACA	Multi Agency Case Audit
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MMR	Mumps, Measles and Rubella
NHS	National Health Service
NI	National Indicator
NTA	National Treatment Agency
ONS	Office of National Statistics
PANSI	Projecting Adult Needs and Service Information
POPPI	Projecting Older People Population Information
SARC	Sexual Assault Referral Centre
SCR	Serious Case Review
SUDI	Sudden Unexpected Death in Infancy
TAC	Team around the child
WHO	World Health Organisation
YOT	Youth Offending Team