Derby Safeguarding Children Board

Review of Serious Case Reviews and Learning Reviews 2008 – 2014

By Ishmael aged 5

The aim of this report is to support multi-agency workforce development as part of the learning improvement framework

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1. Introduction

1.1 This report sets out the main themes that have emerged following an analysis of serious case reviews and learning reviews carried out by the Derby Safeguarding Children Board between 2008 and the end of 2014. The report will include a summary of the changes that have occurred to local practice and how outcomes have improved for children, young people and their families.

1.2 During this period the Derby Safeguarding Children Board has considered the circumstances in respect of the following number of children

- 13 children or young people (six serious case reviews)
- 40 children or young people (six learning reviews)

The total number of recommendations arising from the serious case reviews is 237 (of which 30 related to the DSCB and 207 related to individual agencies).

2. Undertaking Serious Case Reviews and Learning Reviews

2.1 Working Together to Safeguarding Children (2013) defines the circumstances in which reviews should be undertaken. A serious case review will be carried out where:
(a) abuse or neglect of a child is known or suspected; and
(b) either —

(i) the child has died; or
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Principles of Learning and Improvement

2.2 The Derby and Derbyshire Learning Improvement Framework sets out the range of learning and improvement activities carried out by the two Safeguarding Children Boards. The learning from Serious Care Reviews and Serious Incident Learning Reviews sits alongside other learning that includes: Child Death Overview Processes, Thematic Reviews and Audits, Single and Multi- Agency Audits, Peer Review and National Developments, Research and Reports

Serious Case Reviews

2.3 The LSCB has agreed that the Child Practice Review (CPR) methodology used in Wales will be trailed for Serious Case Reviews from 2013. The reports from reviews will place emphasis on the analysis and explaining why actions were or were not taken. Reviews will be proportionate to the incident. Whilst the decision has been taken to trail the CPR approach, other methodology may be recommended by the Serious Case Review sub group should they seem more appropriate for a particular incident.

Serious Incident Learning Reviews

2.4 Serious Incident Learning Reviews will be carried for incidents that do not meet the criteria for a SCR. The expertise of colleagues, particularly those in health, in Root Cause Analysis, will be employed where applicable.

3. National Findings

New Learning from Serious Case Reviews: A two year report for 2009-2011 (DFE RR226)

https://www.uea.ac.uk/centre-research-child-family/child-protection-and-family-support/new-learning-from-scrs

3.1 The fourth consecutive two yearly national analysis of serious case reviews (April 2009 - March 2011) includes key areas of learning that are reflected locally in Derby.

3.2 The findings of the national analysis of serious case reviews are set out in italics *(and referenced DFE RR226)* below to compare with the analysis and findings arising from the serious case reviews and learning reviews in Derby.

3.3 The national analysis identifies that only 42% of children were getting services from children's social care at the time of the child's death or the incident which prompted the review, and that a significant minority of 21% of children had never been known to children's social care. The remaining 37% of cases were either closed or had not been accepted at the point of referral.

3.4 This emphasises the importance of staff in universal services sharing responsibility for protecting children. This may be particularly pertinent for education staff in relation to primary school aged children, many of whom will have limited contact with other agencies.

4. Serious Case Reviews and Learning Reviews – what has been learnt and what has changed in Derby?

4.1 The learning that has arisen from the reviews carried out between 2008 and 2014 is set out below alongside the themes that have emerged from the national analysis of serious case reviews *(included in italics)* and evidence of good practice.

4.2 Whilst the learning has led to changes in advice to staff through training, local procedures and action being taken by agencies, the important question remains as to whether this has made a difference. The report sets out some of the key changes that have occurred and what difference they have made.

4.3 The reviews locally have broadly identified themes in the following two areas:

- **Working with babies and pre-school children**
- **Working with school age children and young people**

5 Working with babies and pre-school children

a) Practitioners concerned that a woman may be concealing a pregnancy should ensure that the Midwifery Service is informed of the concern.

b) Non mobile babies cannot inflict bruising on themselves and bruising is the result of significant force.

c) Be clear between what appears to be a “mark” on the skin and what has been medically determined to be a “bruise”.

d) Make sure information is not misunderstood. Medical terms need to be clearly explained in lay language and all agencies need to use clear language that cannot be subject to misinterpretation. Professional views must be clearly documented in terms understood by other agencies.

Since physical self-control and independent movement is very limited in young babies, it is extremely difficult for them to bruise themselves. An understanding of normal motor development in childhood is essential for evaluating the significance of bruising, and for distinguishing potentially abusive from non-abusive injuries, and the need for heightened concern about any bruising in any pre-mobile baby (up to the age of around six months) is explained through an understanding of the child’s physical development. (DFE RR226)

e) Work closely together with other practitioners and develop a shared understanding of the information available to you all and what means, without assuming that other agencies share the same view.

f) Escalate concerns if it is not possible to actively resolve professional difference of opinion, always put concerns in writing to ensure that they are properly understood.

g) Understand the implications of domestic violence on each member of the family, whatever their age and role in the household. This includes sharing information about vulnerable adults who may be in receipt of adult services.

Almost two thirds of the reviews featured domestic violence, nearly 60% featured parental mental ill health, and parental substance misuse was evident in 42% of cases. At least one of these characteristics was evident in 86% of the cases while all three factors were present in just over a fifth of the cases. (DFE RR226)

h) Multi agency meetings are essential to help understand and put in place contingency arrangements when faced with very unusual or challenging situations.

Almost 60% of the mothers were under 21 years of age when they had their first child. The vulnerability of these young mothers may be long lasting. (DFE RR226)

i) If a family member openly report that they feel they might harm a child, make sure that the high level of risk is not underplayed or not recognised because the person expressed concerns about their own behaviour.

Pockets of good development in maltreated young people do not necessarily signal resilience. (DFE RR226)

j) A question for agencies to ask themselves is: who is keeping the child safe? How do we know measures are adequate? Managers should be using these questions in supervision and sufficient time should be available to explore what these questions mean in complex cases.

k) Families who have babies with life threatening or complex health problems should be offered a multi-agency Early Help Assessment to establish whether a co-ordinated response from agencies is needed.

For disabled children there was a tendency to see the disability rather than the child. This can mean accepting a different and lower standard of parenting for a disabled child than would be tolerated for a non-disabled child. (DFE RR226)

l) Strategy meetings minutes should be taken by someone who is not chairing the meeting and the repeat use of strategy meetings can delay decision making about risk of harm and future action.

m) Written records are an essential requirement of good case management in all agencies and must be completed and kept up to date.

*Poor or faltering weight gain for babies and toddlers **should not be** treated as a mechanical feeding problem, without a contextual understanding of the differing reasons why the parents appear not to be nurturing their child. Questions about the emotional development, attachment and the parent-child relationship need to be raised. (DFE RR226)*

n) The involvement of male members of a family in the care of the child and their parenting capacity must be assessed and understood by practitioners working with that family.

o) Little is absolute in child protection work and all professionals should guard against certainty. Professionals should be confident in their own ability and analysis and work in partnership with each other to stay focussed on the child.

p) Give priority to an assessment being completed during the pregnancy and in good time to ensure that maximum preparation for parenting can be provided. This is particularly important if there are problems for parents requiring specialist assessment such as substance misuse, parental mental ill health or disability.

q) Use the Derby Safeguarding Children Board *Thresholds Document* and *Neglect: Graded Care Profile* to help decide how serious concerns are about

neglect and whether suitable progress is being made. Use Team around the Family meetings to help make sure all practitioners have a shared understanding of early concerns about possible neglect and what measures are being put in place to help.

r) Attend Derby Safeguarding Children Board multi agency training to improve skills and knowledge to be able to act on concerns about *Neglect*, including the specific use of chronologies in helping to identify risk and *Working with Highly Resistant Families*.

s) A Key message for all practitioners in both adult and children services is ***Think Family.*** Consideration of all family member's strengths, needs and risks helps co-ordinate and focus on problems affecting the whole family and improves outcomes for those families experiencing the most significant problems.

Good Practice

5.1 A practitioner who recognised the risk factors presented by a parent from their first home visit, and made every effort to communicate their concerns to other agencies and to her own managers. They were persistent when their concerns were not acted upon and used her managers at appropriate points in order to seek advice and escalate her concerns.

Bruising in toddlers and pre-school children will usually be on particular parts of the body which take the knocks in everyday falls. An unusual pattern or site of bruising should provoke curiosity about how and why the bruising is occurring, and how well the child is being kept safe and supervised. (DFE RR226)

5.2 A practitioner, who visited a family frequently, did their best to provide support and advice to the family and communicated well with other agencies. They discussed their concerns with their manager and successfully challenged the decision by managers not to hold a Child Protection Conference. This was achieved despite their lack of qualification for the role and lack of experience.

Questioning the meaning of the child for the parent helps social workers, and other professionals, to make sense of children's development and to understand the child in the context of their caregiving environment. (DFE RR226)

5.3 A practitioner quickly communicated with an agency when they realised that the meaning of 'supervision' in their agency was different from the meaning of the term used in another agency. This difference in what the term meant could have led to a family member being expected to supervise and ensure the safety of a baby when they were not capable of doing so.

5.4 A practitioner recognised that the "floppy and lifeless" behaviour in a baby required immediate medical attention whilst this was being minimised by the parent.

What has changed in Derby?

- **Escalation of concerns about a difference of professional opinion leading to appropriate services.**

5.5 The Derby Safeguarding Children Board implemented an Escalation Policy following the review and this has recently been updated as a joint policy with the Derbyshire Safeguarding Children Board. The Derby Safeguarding Children Board monitors the numbers of repeat referrals as a way to monitor the application of thresholds. The indicators that the resolution of a difference of a professional opinion is successful are linked in so much as a reduction of repeat referrals may indicate that appropriate services are being identified at an earlier stage.

5.6 Ofsted reported (2012) that agencies have "a good shared understanding of thresholds and they are consistently applied. The early help offer is good, easily accessible and provides effective early identification of children and young people of all ages who may need additional or targeted support."

- **Thresholds – Are we becoming more consistent in our judgement about the seriousness of a situation?**

5.7 A key priority of the Derby Safeguarding Children Board is to seek evidence of the effectiveness of the decision making around thresholds of concern from early help to safeguarding including child protection. Threshold guidance was published in 2012 and updated in 2013.

5.8 Practitioners and managers were asked to indicate how they perceived thresholds are applied and how they seek to resolve professional disagreements about needs and risks. They were also asked about their awareness of Derby Safeguarding Children Board procedures that are now online and their ability to seek further guidance about their concerns.

5.9 Questionnaires were completed anonymously at multi-agency briefing sessions throughout March and April 2014 that were publicising the implementation of the Early Help Assessment (to replace the Common Assessment) and the Single Social Care Assessment. A total of 526 questionnaires were completed.

5.10 The results gave an overall positive picture of how safeguarding and decision making are perceived by the workforce, whilst highlighting areas for attention and exploration. The audit revealed that the 87% of the workforce was aware that Derby Safeguarding Children Board procedures are now online and 99% know who, within their agency, they could take advice from if they were worried about a child. (It is essential that all staff can obtain advice and guidance if they are in any way worried about a child)

5.11 Similarly encouraging responses were evident for the qualitative questions, particularly the numbers regularly finding agreement around early help and risk of harm and of those being able to voice their opinions when in disagreement.

5.12 When all professionals are in agreement of risk and need, better decisions and integrated planning will be better placed to deliver improved outcomes for young people. It is clear that further work is needed to achieve consistently high levels of agreement on levels of need across agencies.

- **Support for Pregnant Women - Pre Birth Protocol**

5.13 New guidance for practitioners was provided to improve multi-agency early help for pregnant women to improve outcomes for the children before and following birth. A multi-agency case file audit was carried out (October 2013) to establish a baseline assessment of existing practice and then carry out a follow up audit in August 2014 to see what progress had been made as a result of the changes.

5.14 The second audit found a generally positive picture of multi-agency working delivering positive interventions for families and protection planning for the unborn and newly born children. It could be seen that a consensus of concerns, circumstances and knowledge of families' past histories was shared across agencies in most cases. It was felt that the protocol had improved the timeliness of identifying and referring of vulnerabilities, with appropriate referrals being made to agencies for support. There remains work to be done to continue to improve practice and support for pregnant women but there has been an encouraging start to seeing the changes implemented in Derby.

- **Support for new parents**

5.15 The majority of cot deaths now involve a parent who smokes co-sleeping with their baby. The Derby Safeguarding Children Board has actively supported a local Safe Sleeping Campaign and published guidance on safe sleeping in 2014. Advice to new parents emphasises this area and includes additional information that babies are not to be left to sleep in their car seats for a long period of time. The progress is being monitored via the Safe Sleeping Group. 80 staff have been assessed as competent on completing the *"Safe Sleep"* E-learning package.

5.16 Support for parents to cope with the challenges of a new baby is very important and the Derby Safeguarding Children Board has worked with partner agencies to promote the DVD *'Don't Shake your Baby'.* The DVD was updated for multi-agency use in Derby/Derbyshire. 350 copies were then circulated for use with staff and parents alongside advice leaflets on responding to a crying baby and safe sleep advice. The DVD is available on the Derby Safeguarding Children Board website and all mothers giving birth at the Royal Derby Hospital are now shown the DVD before they are discharged. Multi-agency guidance has been produced to help prevent non accidental head injuries alongside family safety advice that is included in the new guidance supporting Early Help Assessments.

Engagement with male carers

The Derby Safeguarding Children Board has audited the way in which agencies capture information about male family members who are involved in the care of the children. Agencies are promoting active engagement with male carers so that their

role within their household is understood and the right support can be put in place for them alongside other family members.

- **Emergency Protection Orders – more effective use of emergency powers**

5. In light of the learning from a review there is now careful reflection when Emergency Protection Orders are sought when there is no safe alternative and to ensure that there is sufficient evidence to support the application.

5. Her Majesty's Courts and Tribunal Service have issued specific advice to all legal advisors on the management of any application for an emergency protection order; all such applications are now referred to the senior family lawyer on site to ensure appropriate supervision. The outcome of emergency protection order proceedings are now reviewed to check that lawyers act in accordance with High Court guidance and in all such future applications Magistrates will, wherever possible, be advised by a member of a local specialist team of family lawyers.

5. Her Majesty's Courts and Tribunal Service confirmed that procedures at all courts (nationally) dealing with emergency applications of this type are fully compliant with the current rules. The creation of a Single Family Court will also mean that in future such applications can then be considered by judges as well as by Magistrates.

6 Working with school age children and young people

Whilst overall rates of violent deaths in infants and children have fallen over the past 30 years, rates in adolescents have not fallen. The highest risks remain in infancy, although a second peak is seen in adolescence. (DFE RR226)

a) Early childhood experiences have a critical impact on later development, and need to be thoroughly assessed and understood, both at the time, and in retrospect if intervention begins at a later date. The potential for poor outcomes increases significantly when properly informed intervention does not take place at an early stage to address early signs of concern.

Neglect was a feature in at least 60% of the serious case reviews. Past neglect was a factor in eleven out of fourteen reviews relating to the suicide of a young person. (DFE RR226)

b) A parent's own history and lifestyle has a significant impact on parenting abilities, and this needs to be assessed and understood.

SCR carried out on children in between 5 and 10 years old indicated many are affected by parental separation. This may be a context within which children are at risk of significant harm. This may be particularly so where the separation is coupled with ongoing domestic violence or controlling behaviour; where there are conflicts around contact arrangements; or where children are caught in the midst of acrimonious separations. (DFE RR226)

c) There are links between young people who go missing, poor school attendance, parental separation or significant loss/bereavement and early childhood experiences of trauma and vulnerability to CSE. Use the online CSE toolkit to make sure that possible concerns about CSE have been rigorously explored and informed decisions are made about how serious the situation is and whether safeguarding action is needed.

d) Young people considered to be at risk of CSE must be treated as 'children at risk' and statutory safeguarding procedures used to assess this risk and determine levels of intervention.

e) Assessments of the risk of CSE must include consideration of issues of 'capacity' and 'consent', within the context of their life experiences and circumstances, and taking account of the grooming process and the impact of coercion.

f) Criminal behaviour can be another indicator of abuse, and this needs to be taken into account when assessments, plans and sentencing options are being considered.

g) Covert policing techniques to obtain evidence must be fully understood by all practitioners and managers involved in an operation so that there is confidence in the arrangements to assess the actual level of risk, share information and safeguard children. How the balance of risk between 'protection' and 'prosecution' has been assessed must be explicitly recorded.

h) Patience, empathy and perseverance are needed by staff to establish successful engagement with young people.

Getting a sense of older children's developmental state needs professionals to understand their developmental pathway over time. When practitioners did not know or make a relationship with the young person they tended to pay insufficient attention to the impact of maltreatment on the young person's development. (DFE RR226)

i) Multi-Agency Risk Assessment Conferences (MARACS) must consider not just the victim, but all children who possibly remain at risk from the perpetrator.

j) When returning home after a period in care, build on the knowledge of a child's needs and ensure that their return home is risk assessed and support provided to avoid further breakdown and damage to their relationship with their family.

k) Attend Derby Safeguarding Children Board multi agency training to improve skills and knowledge to be able to act on concerns about *Child Sexual Exploitation* and/or *Working with suicide and self-harming behaviours*.

l) Victims of sexual abuse are unlikely to admit that they are being subject to sexual abuse due to feelings of fear, guilt and confusion until they feel safe

and free from the perpetrator. Multi-agency strategy meetings are key to ensuring that responses to allegations of sexual abuse are coordinated and consider how best to protect the child.

m) Effective management oversight and supervision is essential in all multiagency practice to ensure robust arrangements for allowing staff time to reflect and discuss challenging individual cases. This helps staff to "think the unthinkable" and to test out any reasonable hypothesis before disregarding the suspicion or concern about abuse.

n) Action must be taken by practitioners, from all agencies, to ensure that families moving across boundaries receive the necessary support from the new area to keep the children safe. Unresolved requests for services must be escalated to senior managers for resolution.

o) Action must be taken by practitioners, from all agencies, who find a family living in conditions that fall short of acceptable living standards for any child, including those who are "Travellers" and / or "Homeless". This would include a lack of access to sanitation, running water, heating and electricity.

p) Managers from different agencies and/or areas must resolve differences of professional opinion or local arrangements that is causing delay to the transfer of cases and make sure that children are kept safe during any transition.

q) Practitioners from all agencies must take action to escalate concerns about children and young people who are not in school or college to the local Education Welfare Service.

r) Use the Derby and Derbyshire Safeguarding Children Boards' *Threshold Document* to clarify levels of concern about the welfare of children. The *Threshold Document* is applicable to all children, including those from new and emerging communities.

s) Gaining a picture of family life can sometimes be difficult – where there are language barriers a professional interpreter service should be used – not family members and particularly not children.

t) Families may have different beliefs and views about the Police and Social Care that at times can lead to fear, anxiety and suspicion towards these agencies. Practitioners need to explain the reason for Police and Social Care involvement and support their role to facilitate working relationships.

u) Families may not always cooperate, engage or actively work in partnership with practitioners. Parents and carers may be poor historians or they may not want to fully disclose their circumstances. Practitioners should retain their professional curiosity and ask questions, use of an interpreter when necessary. Always check out any doubts and never use family members as interpreters.

v) Routinely ask to see proof of identity - checking the detail of identity documents can help practitioners ensure correct spelling of names, determine whether passports are in date (and can be used), confirm dates of birth and be referred to at a later date to verify the identity of children and young people who are subject to concern.

w) Practitioners should take proactive steps to ensure that children are registered with a local GP. There is a National Data Base of GP registration that can be checked through the Designated Nurse for Safeguarding Children. This can help tell practitioners whether the child was registered with a GP and their last known address. GPs often hold key information about children who have lived in different areas of the country and can provide important links to other agencies.

x) When closing a case where there have been safeguarding concerns always inform other practitioners involved with the family so that they are aware of the change in circumstance.

y) Practitioners who work with children should engage with adult services before young people reach 18 to share important safeguarding information in planning meetings and if needed, participate in meetings once the young person is 18. Vulnerable Adult Risk Meetings (VARM) can be held for adults (these arrangements may be updated following the implementation of the Care Act) and more information is available on the Derby Safeguarding Adults Board website – http://www.derbysab.org.uk/

Good Practice

6.1 A large sibling group were well known to their school teachers who described them as happy, well adjusted, caring children who had good relationships with each other and with children from other families. They did not appear cowed, malnourished or uncared for and attended school regularly. Teachers were vigilant and able to qualify their observations about how well the children were cared for in unusual circumstances.

6.2 A social worker diligently worked with a young person and provided a great deal of individual child centred support despite their challenging and at times unpleasant behaviour and attitude. The social worker, residential social workers, community police officers and Runaways workers managed to overcome the young person's reluctance to engage with them and secured a positive relationship through, child centred, flexible, practice.

6.3 A Police Officer recognised a family group in a local supermarket and took steps to follow them to see where they were living and was tenacious in seeking to establish whether the living conditions were appropriate and verify the identity of those present.

6.4 The Multiagency Worker who provided practical and emotional support to both mother and young person under very difficult circumstances including conflict

between them. She was praised by them both for her commitment and demonstrated perseverance in her attempts to get partner agencies to understand the complex history of concerns.

6.5 The foresight of the workers in the Housing Department who tried to engage a young person in having a pregnancy test to determine concerns about her vulnerability alongside meeting her needs for the accommodation required.

6.6 Good practice between Police, Social Care and Health Staff at the hospital following the birth of a baby in determining DNA that led to the prosecution on an individual for sex offences.

6.7 Good practice from staff at a hospital, a hospice and YMCA to understand the complex history and presenting trauma of a young person and respond to them in a non-judgmental way that focused on their needs in very difficult circumstances.

What has changed in Derby?

- **Therapeutic support for CYP who have suffered trauma and abuse (and reference to post traumatic stress disorder)**

6.8 Post-Traumatic Stress Disorder (PTSD) develops following a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. In Derby City CAMHS there are now 4 Workers trained in psychological therapies for children and young people and 2 workers who will offer trauma focused therapy to young people with symptoms severe enough to affect their everyday lives and requiring specialist intervention.

- **Risky self-harming behaviour - comprehensive multi-agency risk assessment or management plan in terms of para suicide or risk taking**

6.9 As a result of service transformation and the serious case review a dedicated Child and Mental Health Liaison Service (CAMHL) was created in 2011. The CAMHL team are skilled in assessing young people who self-harm and will offer short term follow up (up to 6 sessions). For those young people requiring longer term work the team work with staff from tier 3 CAMHS to ensure transfer of young people to this service and try to minimise drop out from services. These changes have improved consistency for young people, improve therapeutic alliance, enabled access to evidence based interventions to develop coping skills and anecdotally CAMHL have received a number of positive service feedback stories. This is currently a 5 day a week service and has limited access out of hours. Commissioners and Providers are currently reviewing this positive practice and the feasibility to expand availability.

- **Support for children who go missing**

6.10 Arrangements are now in place so that children who frequently go missing from home, care and school have plans put in place to help them. Children who go missing receive a return interview by an independent person so that their individual circumstances are understood and action taken to help reduce the likelihood of

further missing incidents. The Runaway and Missing Children Protocol has been revised and implemented to ensure that practitioners and police officers are clear about what action should be taken when a child is reported missing.

- **Compliance with Placement with Parents Regulations.**

6.11 When returning home after a period in care, the child's needs and circumstances are thoroughly assessed to ensure that their return home is properly supported to avoid further breakdown and damage to their relationship. Since April 2012, Placements with Parents have been included in the annual case file audit schedule to check whether the arrangements are helping children. The audit in October 2012 sampled 9 cases. A further audit of seven sample cases was carried out in December 2013. The quality of work in these cases was judged very good overall and significantly better than the audit from the previous year. Some auditors commented on the "exceptional" work and good outcomes for the children.

- **Children who are electively home educated.**

6.12 Children and young people educated at home are seen to be potentially vulnerable and a more robust process has been established since the review. Those children and young people, who have been educated at home for more than 1 academic year, receive a yearly offer of a home visit. The Service is managed by Additional Educational Needs Consultant and the contact to families is carried out with the support of an Elective Home Education Officer. The post was created in 2010 to reflect the need for increased monitoring of this group.

- **Child Sexual Exploitation - Awareness raising in schools**

6.13 Young people in Derby have received specific sessions in schools to help them become aware of the risks of CSE both online and offline. Primary school pupils have received general safeguarding awareness sessions delivered by the NSPCC.

6.14 Research was carried out in three Derby schools with pupils to gather an understanding of the online behaviour of children and young people and how they are able to keep themselves safe online. This research is helping local schools to understand what they can do to help children and young people keep themselves safe online.

6.15 A theatre production called "Chelsea's Choice" was delivered in all secondary schools with support from the CSE champions and police. The interactive play raised awareness of CSE and of online grooming to approximately **5090** YP in 18 schools in Derby (Yr 8, 9 and 6th Form pupils) raising awareness of both CSE and E Safety. (130 sessions)

- **Child Sexual Exploitation – Reducing the risk to young people**

6.16 The child sexual exploitation (CSE) work in Derby is driven by a multi-agency partnership and action plan coordinated through the Derby Safeguarding Children Board. Derby has a well-developed strategy on CSE and works with young people and families who are at risk of or have experienced sexual exploitation. The virtual team model operated in Derby has achieved national recognition through OFSTED and the Office of Children's Commissioner for our proactive and 'excellent joined up approach' (Ofsted 2012, OCC 2013). There are local CSE procedures in place and a robust toolkit that helps practitioners identify and respond to concerns.

6.17 Following the changes brought about by the review it is important to reflect that the vast majority of Derby cases are at risk of CSE, very few show evidence of actual exploitation. A higher number of cases were closed during 2013 - 2014 (42 cases in comparison to 35 last year). This year 40% of cases were closed due to the risk being removed or reduced to low level compared to 28% last year. Cases are thoroughly reviewed under the multi-agency strategy and are only closed where there is a sustainable reduction in risk to the child. Only 7% were escalated to child protection in comparison to 36% last year.

6.18 The analysis of the levels of risk to young people as a result of engagement to the strategy shows that there is a significant reduction of risk for the majority of young people. The levels of risk and additional vulnerability factors are measured at every meeting including network meetings. The “official” risk rating is recorded at the CSE strategy meeting. Of the young people assessed as high risk at their initial meeting 85.7% had the CSE risk removed or reduced within 3 months (54% in 2012-13, 45% in 2011-12). This is a significant improvement on previous years and demonstrates increasing effective interventions with these young people.

6.19 Evaluation forms for young people indicate that they find CSE meetings very positive. Of the young people who attended meetings (2013 - 2014), 100% felt listened to, 100% found the meetings supportive (92% previous year), 100% have a better understanding of CSE issues and 87% (previous year 96%) agreed with the CSE plan agreed at the meeting. Often the reason to disagree with the plan is related to actions taken to disrupt or prosecute the person who is deemed to pose a risk to the young person.

6.20 Witness care programmes are in place to help reduce the impact of Court processes and investigations of sexual exploitation to promote the best outcomes for the young person.

- **Domestic Violence - Improving how the impact on children is understood**

6.21 Following evaluation of themes arising from local and regional learning about the response to domestic violence and abuse, the Derby Safeguarding Children Board implemented the use of the Domestic Violence Risk Identification Matrix (DVRIM). The use of this tool by all agencies will improve consistent assessment and analysis of the risk to individual families and inform judgement about next steps to be taken to safeguard them. 325 practitioners attended multi-agency briefings on the use of the new model (developed by Barnardo’s) and its impact on practice will

be audited as part of the Workforce Group scrutiny of effectiveness in the coming year (2014 – 2015). Social workers in Derby are now using the extended Domestic Violence Risk Assessment Matrix (DVRAM) to assess and analyse complex cases that require child protection plans or legal action.

6.22 Early indications are that where it has been used, better informed analysis and evidence is being presented to Child Protection Conferences and practice is improving. One participant reflected on the impact of using the DVRIM and reported that “In the past I haven’t wanted to call it domestic abuse because I didn’t want to damage my relationship with the mother, but now I will talk to her about why I am calling it domestic abuse”

- **Domestic Violence – Making sure all children and young people are assessed**

6.23 At Multi Agency Risk Assessment Conferences the circumstances and risks to victims of very serious domestic violence are assessed. Audit work has confirmed that the assessments now include consideration of the risks to all children who remain in contact with the alleged perpetrator. This makes sure that the safety of all children is considered. All high risk cases of domestic abuse in a household where children live are assessed urgently by Children’s Social Care.

- **Fire Safety**

6.24 National Fire Safety messages were publicised to promote having fitted, working and tested smoke alarms on each level of a domestic property. The national media passed on the message that families should practice their escape plan and this should be familiar to anyone in the property (family, friends and visitors). Additionally smoke detectors should be located in bedrooms and that smoke detectors should be easily heard throughout the property.

Learning Review completed in 2014

6.25 The impact of changes arising from the learning review completed in 2014 will be illustrated in the Derby Safeguarding Children Board Annual Report that will be published in 2015.

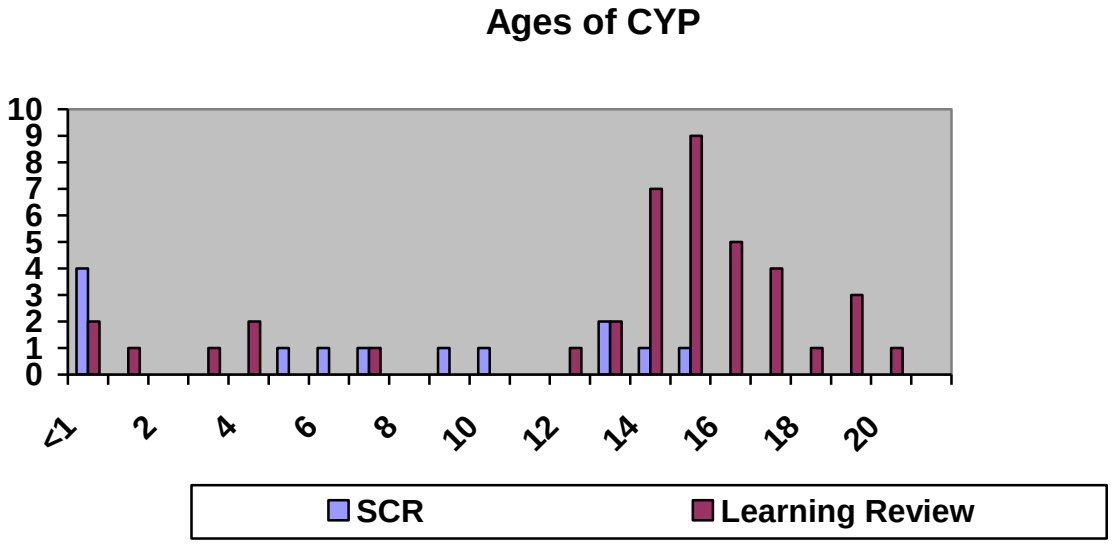
Appendix 1: Demographic features of local reviews carried out in Derby

A.1 Serious case reviews were carried out in respect of **four babies** (two who lived in another authority area) and of **9 school aged children** (of these six were siblings).

A.2 Learning reviews have been carried out on:

- One baby and two children under four in one family
- One baby
- A four year old and a seven year old in one family
- Two school aged children in one family
- A group of seven unrelated teenagers
- A group of twenty five unrelated teenagers and young adults

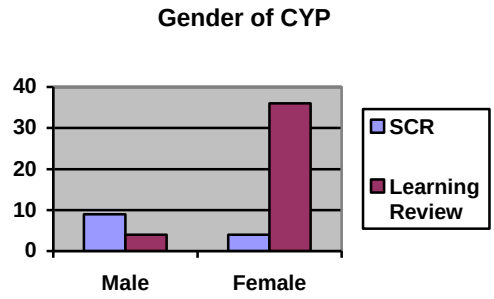
A.3 The ages of children subject of review are set out in the table below.



A.4 The national analysis of serious case reviews identifies that 36% of all serious case reviews concerned a baby under one year of age. Whilst the numbers of cases are low, 30% of local reviews were held in respect of babies.

Gender

A.5 Of the children subject of serious case reviews, nine were male and three were female. This figure includes six siblings from one family who all died in a fire. Two learning reviews have considered a total of 32 female victims of child sexual abuse. Four female and four male children were subject of the other learning reviews.



Ethnicity

A.6 The following table illustrates the ethnicity of children subject of serious case reviews and learning reviews against census figures in 2011. Currently the figures are too small to provide meaningful analysis. However it is noted that the 34 reviews (both SCR and LR) carried out of young people subject of child sexual exploitation identified victims from white and other minority ethnic groups in derby.

Ethnic Group	Derby Population 2011 Census	Serious Case Reviews	Learning Reviews	Of the 34 total CSE victims
Asian or Asian British	12.5%	0	2	2
Black or Black British	2.9%	1	2	3
Dual Heritage	2.9%	3	6	7
Not recorded	Nil	0	0	0
Other	1%	0	0	0
White British	75.3%	9	28	22
White Other	4.9%	0	2	0
Total	100%	13	40	34

Categories of Abuse

A.7 The small number of cases considered for serious case review (6) and learning review (6) mean that it is not beneficial to compare with national trends for cases considered or in respect of individual children.

A.8 In light of this, it is noted that the categories of abuse considered were as follows:

Serious Case Reviews

Physical Abuse:	3 cases	(4 children)
Sexual Abuse:	1 case	(2 children)
Neglect:	1 case	(6 children)

Other:	1 case *	(1 child)

(* initial concern about self-harm was revised following Coroner's decision that the death was accidental)

Serious case reviews were carried out in respect of **four babies** (two who lived in another authority area). Three babies experienced physical abuse and one baby died as a result of physical abuse. **9 school aged children**, of these six died in a fire (neglect), two were subject of sexual exploitation and one died accidentally.

Learning Reviews

Sexual Abuse:	3 cases	(33 children)
Physical Abuse:	2 cases	(4 children)
Neglect:	1 case	(2 children)