Safeguarding Children Joint Strategic Needs Assessment 2014-15

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1. Foreword

Welcome to the refreshed Joint Strategic Needs Assessment for Devon. This is an important document as it provides information that will guide the work of the Safeguarding Children Board and its constituent agencies in terms of really understanding need in our local communities.

The role of the Board is to look how agencies can work more effectively together to prevent harm to children and young people. This document brings together a whole range of information that will support closer working and a better understanding of the interdependence of the different agencies working with families in Devon.

As we develop our approach to tackling particular issues, notably neglect and child sexual exploitation, this will shape our response and enable us to create a more holistic strategy to achieve better outcomes for children and young people.

I am particularly grateful to colleagues in Public Health for leading this piece of work and individuals in particular agencies who have contributed to the different sections.

David Taylor
Independent Chair
Devon Safeguarding Children Board

2. Executive Summary

A Joint Strategic Needs Assessment (JSNA) looks at the current and future needs of local populations to inform and guide the planning and commissioning of services within a local authority area.

The Safeguarding Children JSNA covers a field where cross-agency arrangements require strong leadership, shared intelligence and appropriate joint commissioning arrangements to be effective.

It is intended that this report will be used as the evidence base to inform the work of the DSCB and organisational commissioning plans.

THE YOUNG POPULATION IN DEVON

The **population** of 0-19 year olds in Devon stood at **159,800 in 2013** (ONS Mid-Year Population Estimate) and is set to rise by around 11,400 to around 171,200 by 2037 (ONS Sub-National Population Projections).

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.

Factors affecting the **life chances** of children occur **before a child is even born** and continue **throughout childhood**.

Whilst outcomes for children and young people in Devon generally compare favourably to the England rate, there is considerable variation within the county, with a **strong inequalities gradient** between outcomes for those living in the most deprived and least deprived areas.

ENSURING A SAFE ENVIRONMENT

Accidental and deliberate harm affect many young people across Devon as evidenced by accident and emergency attendances, hospital admissions, road traffic accidents, missed health appointments and referrals to local authority designated officers (LADOs).

The **risk of harm** is influenced by **a number of factors**, including **socio-economic deprivation**, **age** and **sex**.

There have been an **unprecedented number of serious case reviews** within Devon over 2013 and 2014, and this has thrown **considerable strain on the system** to deliver these.

There were **36 deaths of persons aged 17 and under in 2013** of which the majority were infants under the age of one (24 deaths, 66.7% of those aged 0 to 17).

The Child Death Overview Panel (CDOP) suggested **areas for action** include those **aged less than one**, the prevention of **sudden unexplained deaths in infancy** and **unintentional injury prevention**.

CDOP concluded that action to address this will need to **sit within wider public health and population approaches to prevention and early intervention** that ensure the best start to life through the promotion of health and wellbeing and the delivery of the healthy child programme, tackling child poverty and reducing unintentional injury.

PROTECTION FROM IMPAIRMENT TO HEALTH AND/OR DEVELOPMENT

The **personal circumstances** of children and young people can have a **major impact on their development and wellbeing**.

Children and young people who are **absent from school**, **missing from education**, or **educated outside of the school system**, may be at **particular risk of impairment**, along with those aged 16 and over who are not in education, employment or training.

Bullying can have a **major impact** on the **health and wellbeing** of children, and tackling bullying is identified as an important aspect of safeguarding.

In terms of particular **risks to health**, there are issues for children and young people in relation to **sexual health**, **mental health** and **emotional wellbeing**, **smoking**, and **substance misuse**.

Sexual exploitation is a **significant risk**, particularly for children and young people who are already **vulnerable.**

PROTECTION FROM MALTREATMENT

Risk of maltreatment is **influenced by parental and familial factors** including **mental health**, **substance misuse**, **learning disability**, **domestic violence** and **sexual abuse**. Whilst the presence of certain factors does not necessarily indicate maltreatment, awareness of these risk factors amongst professionals is important.

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.

ENSURING SAFE AND EFFECTIVE CARE

Ensuring safe and effective care is provided by local authorities and other services to children in their care or referred to the services is **essential.**

The **MASH received 14,664 enquiries** relating to **11,734 children** during 2013/14.

There were **8,717 Children in Need referrals** to social services in 2013/14, with **684 Children in Care**, and **600 children were the subject of a Child Protection Plan.**

Important priorities include ensuring that **privately fostered children and children placed out of county are adequately protected**, **children experiencing homelessness receive support** and **monitoring the use of restraint** in all settings where Devon children are accommodated.

3. Introduction

A Joint Strategic Needs Assessment (JSNA) looks at the current and future needs of local populations to inform and guide the planning and commissioning of services within a local authority area.

The Safeguarding Children JSNA covers a field where cross-agency arrangements require strong leadership, shared intelligence and appropriate joint commissioning arrangements to be effective.

It is intended that this report will be used as the evidence base to inform the work of the Devon Safeguarding Childrens Board (DSCB) and organisational commissioning plans.

What is safeguarding

Safeguarding children - the action we take to promote the welfare of children and protect them from harm - is everyone's responsibility. Everyone who comes into contact with children and families has a role to play.
Safeguarding and promoting the welfare of children means:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes.

(Working Together to Safeguard Children 2013, https://www.gov.uk/government/publications/working-together-to-safeguard-children)

The Safeguarding Children JSNA looks at the wider definition of safeguarding children including risks to health and wellbeing, in order to identify whole system demands and how these demands have changed over time.

The 'needs of the population' section begins with a section on the young population in Devon, followed by the four DSCB themes; ensuring a safe environment, protection from impairment to health and/or development, protection from maltreatment and ensuring safe and effective care. This concludes with a section on complex and multiple needs.

The voice of the child has been included in some sections to include the views of children and young people on the issue of safeguarding.

4. The needs of the population

4.1 The young population in Devon

Population

The population of 0-19 year olds in Devon stood at 159,800 in 2013 (Office for National Statistics (ONS) Mid-Year Population Estimate) and is set to rise by around 11,400 to around 171,200 by 2037 (ONS Sub-National Population Projections). The proportion of residents aged less than 20 years of age in Devon (21.08%) remains below the national average of 23.82%, with all Devon districts below the national rate. A breakdown of the population by ethnic group is included in appendix 1.

Figure 1, Population aged 0 to 19 by Local Authority District, 2013

LA, Devon, South West, England

East Devon 19.76%
Exeter 21.88%
Mid Devon 23.36%
North Devon 21.82%
South Hams 20.36%
Teignbridge 20.65%
Torridge 20.88%
West Devon 20.35%

0% 5% 10% 15% 20% 25% 30%

Source: Office for National Statistics Mid-Year Population Estimates, 2014

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.

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.

Life Chances

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.

16,760 children (13.6%) in Devon live in households dependent on benefits or tax credits, compared with 16.2% in the South West and 20.6% nationally. Child poverty rates in Devon fell between 1999 and 2008 and have dropped further from the South West average over time. Rates increased in 2009 and 2010 before falling slightly in 2011. Rates at a district level range from 10.6% in East Devon to 16.8% in Torridge. Rates in the most deprived areas are five times those in the least.

Considerable variation exists across Devon communities. Rates of child poverty are higher in younger families due to higher benefit claimant rates and lower incomes in persons in their 20s and 30s. Single parent households, particularly where headed by a female, are also more likely to experience economic poverty, as are children of disabled parents. There are no significant variations by ethnic group in Devon.

Figure 2, Children in Poverty by National Deprivation Group, Devon, 2011

Source: HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics), 2013

Inequalities in outcomes for children and young people relating to social and economic conditions are evident locally and nationally. Figure 3 lists outcome measures from the Devon Health and Wellbeing Outcomes Report, and the Public Health Devon Outcomes Report and shows the difference between the most and least deprived communities in Devon. The 'inequalities gradient chart' within figure 3

is a bar chart showing the range in outcomes for a particular measure from the most deprived areas of the county on the left to the least deprived areas of the county on the right. The slope from left to right across these bars is known as the 'inequalities gradient' and steeper slopes highlight greater inequalities between areas and a stronger association between the outcome measure and social and economic conditions. The 'ratio' column is calculated by dividing the figure for the most deprived communities by the figure for the least deprived communities. A ratio of 1 would suggest no differences in outcomes, whereas a ratio of 3 would suggest that rates were three times higher in the most deprived communities compared with the least deprived. Together these measures are useful in establishing the extent of inequalities.

This highlights that whilst outcomes in Devon generally compare favourably to the England rate, there is considerable variation within the county. The greatest variations are seen in the proportion of children living in income deprived households, and the proportion of mothers smoking at time of delivery, which are both almost five times higher in the most deprived areas compared with the least. Very strong inequalities gradients are also seen in relation to rates of teenage conception, and hospital admissions for self-harm. Accident and Emergency (A&E) attendance rates in the most deprived areas are almost double those in the least deprived areas. Weaker but still significant differences are seen for early years foundation score, and levels of excess weight recorded through the National Child Measurement Programme. Finally, there is no clear relationship between area deprivation and uptake of child immunisation in Devon.

Figure 3, Outcome Measures for Children and Young People in Devon and the Inequalities Gradient

Outcome Measure	England Rate	Devon Rate	National Quintile on Index of Multiple Deprivation: Most Deprived	Above Average	Average	Below Average	Least Deprived	Inequalities Gradient Chart	Ratio*
Children Living in Income Deprived Households (%)	20.60%	13.60%	29.76%	20.20%	12.94%	8.91%	6.10%		4.88
Smoking at Time of Delivery (%)	12.69%	9.90%	25.74%	14.86%	9.59%	7.10%	5.38%		4.78
Vaccination: Uptake of MMR (% not immunised)	11.63%	9.93%	8.45%	9.92%	12.61%	8.23%	9.20%		0.92
Early Years Foundation Score (% not achieving good level of development)	48.00%	36.28%	43.84%	40.49%	36.82%	32.71%	29.29%		1.50
Excess Weight in Four/Five Year Olds (%)	22.23%	24.91%	28.85%	29.06%	23.66%	22.95%	23.11%		1.25
Excess Weight in 10/11 Year Olds (%)	33.32%	29.73%	32.39%	32.32%	29.25%	29.61%	25.83%		1.25
A&E Attendances, aged 0 to 19 (Rate per 100,000)	-	41189.6	63503.2	47986.2	38770.4	38026.9	33109.8		1.92
Teenage Conception Rate per 1,000 #	26.5	25.6	42.8	34.4	24.5	17.1	11.5		3.73
Hospital Admissions for Self-Harm aged 10-24 (DASR per 100,000)	346.3	419.5	1035.7	541.1	366.0	353.4	307.6		3.37

Source: Devon Health and Wellbeing Outcomes Report and Public Health Devon Outcomes Report, August 2014
* Most Deprived to Least Deprived Ratio
# Inequality breakdown uses national rather than Devon data

Life expectancy at birth varies considerably across the county, with a 12.1 year difference between the wards with the longest (Three Moors in Torridge at 87.6) and shortest (Ilfracombe Central at 75.5) life expectancies in the period 2007 to 2011. This great variation in life expectancy in relatively small geographic areas reveals the impact deprivation has in terms of inequalities in health throughout life.

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. Mental health issues can also come to the fore soon after birth with around one in eight mothers suffering postnatal depression affecting over 900 mothers per annum in Devon.

In 2012-13, 718 mothers were smoking at time of delivery in Devon. This represents 9.9% of all mothers in Devon, compared with 13.3% in the South West, and 12.7% in England. Devon has one of the lowest smoking at time of delivery rate in the South West and the local authority comparator group. Within Devon the lowest rates were in East Devon (6.3%), and the highest in Torridge (13.2%). Rates have fallen over recent years. Whilst overall rates in Devon are the lowest in the South West, there is a strong inequalities gradient. As illustrated above in figure 3, rates in the most deprived areas (25.7%) are almost five times higher than those in the least deprived areas (5.4%). Smoking at time of delivery varies by age with younger mothers in their teens and twenties much more likely to smoke than mothers in their thirties and forties.

In 2013, 51.1% 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 41.0% in the most deprived areas to 56.6% in the least deprived areas, meaning that the nutritional and health benefits associated with breastfeeding are not equally shared across the county.

Childhood immunisation uptake rates vary considerably across the county. For example, Measles, Mumps and Rubella (MMR) vaccination uptake rates are highest in East Devon and Torridge, and lowest in parts of Southern Devon (Totnes, Ashburton, Buckfastleigh, Tavistock). Low immunisation rates are associated with a greatly increased likelihood of outbreaks of infectious diseases. As illustrated above in figure 3, there is no direct relationship between immunisation rates and deprivation, with a 2012-13 MMR uptake rate at Wonford Green in Exeter of 95.0%, which covers one of the most deprived areas in the county, in line with the World Health Organisation gold standard of 95%, and above the Devon rate of 88%.

Poor oral health can affect children and young people’s ability to sleep, eat, speak, play and socialise with other children. Poor oral health also causes pain, infections, and impaired nutrition and growth. Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. While

children's oral health has improved over the past 20 years, almost a third (27.9%) of five-year olds in England still had tooth decay in 2012[1].

Nationally, tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2012-13. Dental treatment under general anaesthesia (GA), presents a small but real risk of life-threatening complications for children. Tooth extractions under GA are not only potentially avoidable for most children but also costly. Extracting multiple teeth in children in hospitals in 2011-2012 cost £673 per child with a total NHS cost of nearly £23 million[2].

Local authorities are statutorily required to provide or commission oral health promotion programmes to improve the health of the local population, to an extent that they consider appropriate in their areas[3].

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 2012 there were 347 under 18 conceptions in Devon, of which 53% ended in abortion. Over this period the rate per 1000 females aged 15-17 was 27.4 for Devon as a whole, varying from 18.0 in East Devon to 35.4 in Teignbridge.

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).

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[1] Public Health England. National Dental Epidemiology Programme for England: Oral Health Survey of Five-Year-Old Children 2012. A report on the Prevalence and Severity of Dental Decay. 2013

[2] Department of Health. National Schedule of Reference Costs 2011-12 for NHS Trusts and NHS Foundation Trusts. 2012.

[3] Public Health England (2013) Local authorities improving oral health: commissioning better oral health for children and young people https://www.gov.uk/government/publications/improving-oral-health-an-evidence-informed-toolkit-for-local-authorities

4.2 Ensuring a safe environment

Accident and emergency attendances

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 1 shows overall numbers by gender and category for Devon, highlight that there were over 65,000 attendances for persons aged 0 to 19 in 2013-14. 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.

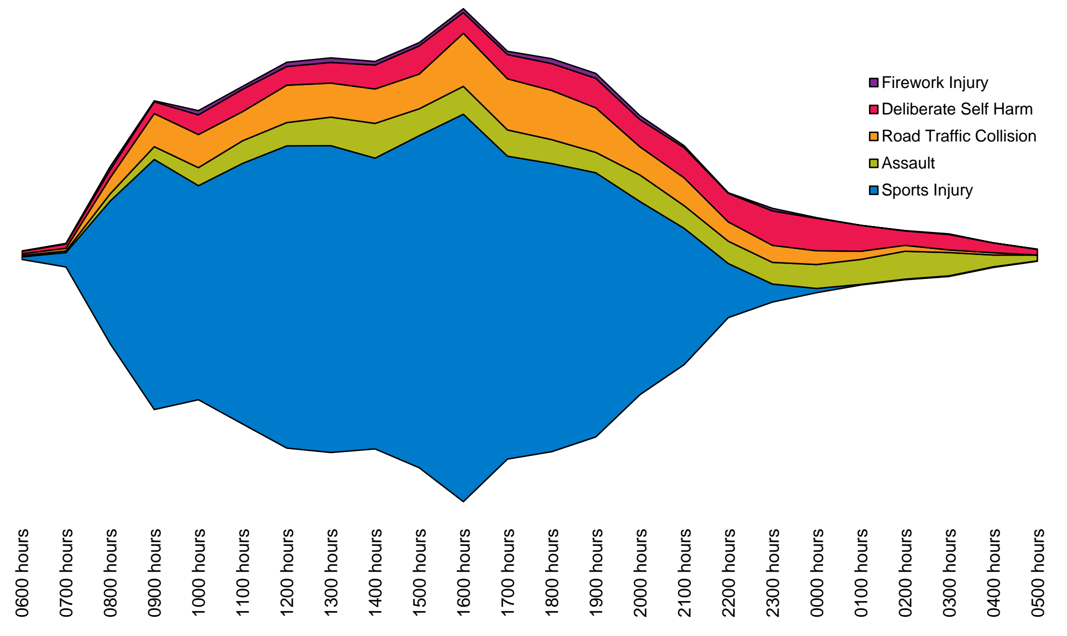
Table 1, Accident and Emergency Attendances in Devon by gender and category, persons aged 0 to 19, Devon, 2013-14

Patient Group	Males	Females	Total
Road Traffic Collision	276	207	483
Assault	274	111	385
Deliberate Self-Harm	139	409	548
Sports Injury	2,769	963	3,732
Firework Injury	28	14	42
Other Accident	18,121	14,866	32,987
Other	10,628	10,452	21,080
Unknown	3,449	2,958	6,407
Grand Total	35,684	29,980	65,664

Source: Secondary Uses Service, Accident and Emergency Commissioning Dataset, 2014

Figure 4 displays the pattern by time of attendances by time of day for selected patient groups for 2011-12 to 2013-14. This highlights that attendances due to sports injury are highest during the daytime peaking at 4pm. Road traffic collision attendances peak in the late afternoon. Attendance rates for deliberate self-harm increase through the day and peak between 11pm and 1am. Attendance rates for assault are highest from 12 noon to 4pm and peak again in the early hours.

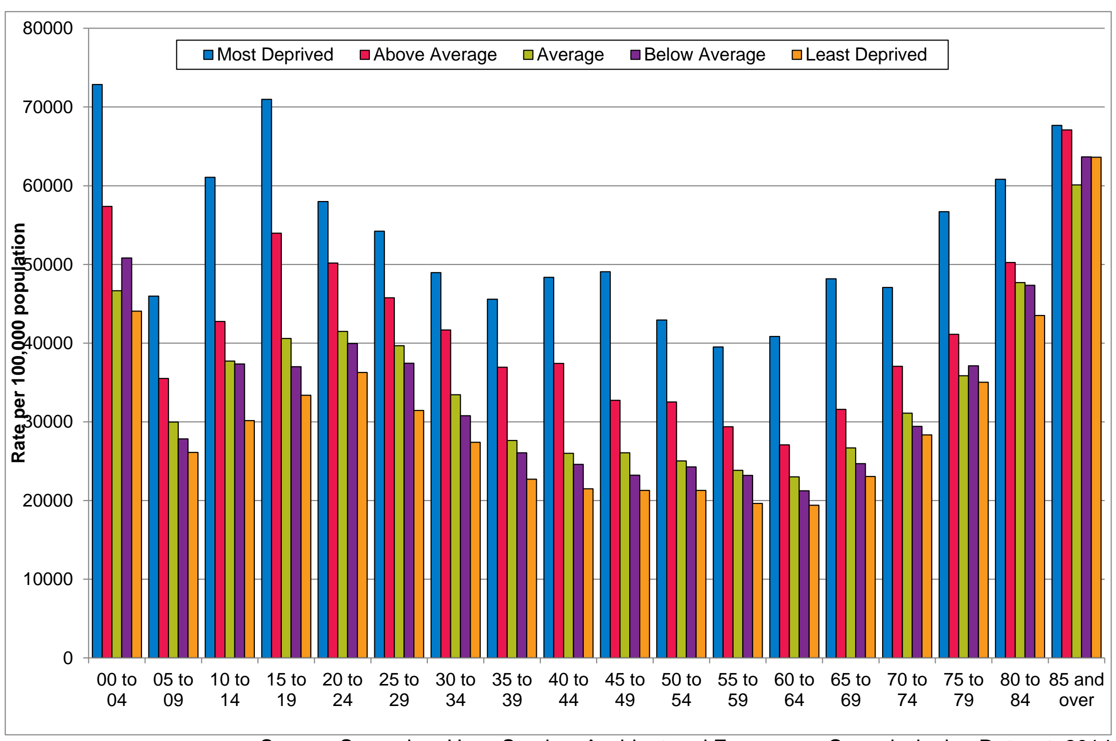
Figure 4, Accident and Emergency / Minor Injury Unit Attendances in Devon for Selected Patient Groups and Hour, 2011-12 to 2013-14



Source: Secondary Uses Service, Accident and Emergency Commissioning Dataset, 2014

The figure below shows age-specific attendance rates for Devon by deprivation, highlighting that attendances are particularly frequent for children, with the peak ages being 0 to 4, and 15 to 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 5, Accident and Emergency Attendances per 100,000 population by Age and Deprivation, Devon, 2013-14



Source: Secondary Uses Service, Accident and Emergency Commissioning Dataset, 2014

Unintentional injuries affecting children

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/).

More up-to-date figures on emergency admissions from accidental causes for under-fives are included below. This highlights that falls, exposure to inanimate objects and accidental poisoning are the leading causes of accidental injury.

Figure 6, Emergency Hospital Admissions from accidental causes in under-fives, Devon, 2008 to 2012

	Falls	Exposure to inanimate mechanical forces*	Accidental poisoning	Contact with heat and hot substances	Exposure to animate mechanical forces (e.g. animal bites)	Transport Accidents	Threats to breathing / drowning	Other accidents	Total
Persons	1034	380	232	122	85	83	40	148	2124
Female	475	160	119	49	49	45	12	49	958
Male	559	220	113	73	36	38	28	99	1166

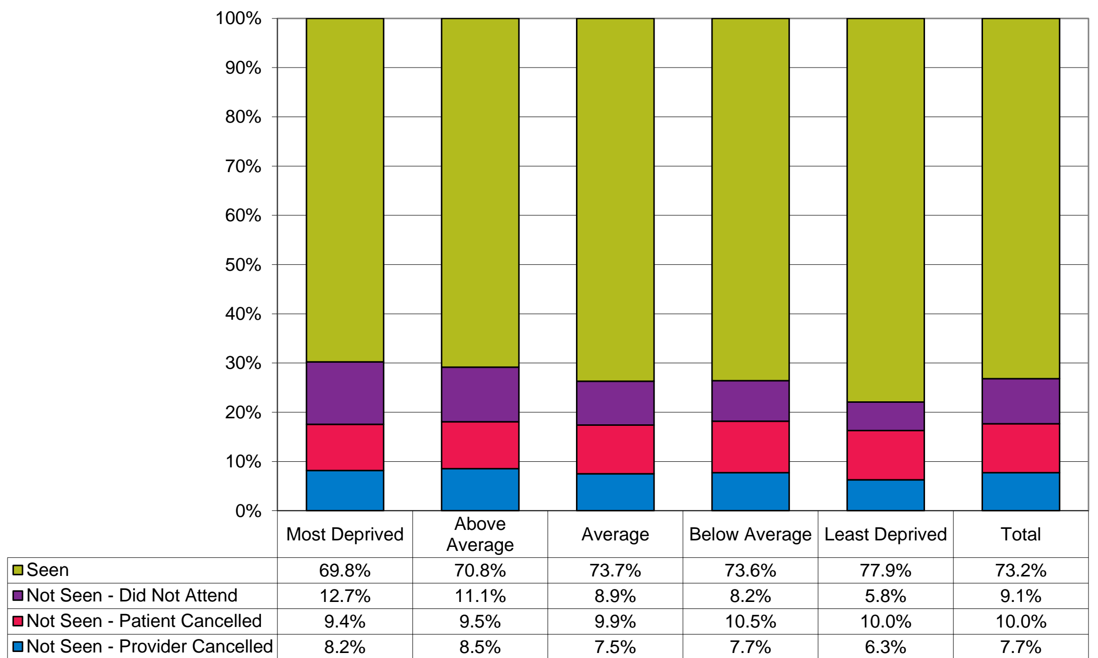
* includes accidentally being struck by objects, crushing, contact with tools / machinery, glass or sharp objects, explosions, and exposure to noise

Source: Secondary Uses Service, Inpatient Commissioning Dataset, 2014

Missed Health Appointments

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 2013-14, of the 49,337 first outpatient appointments for 0 to 15 year olds, 4,550 did not attend (9.1%), 4,910 were cancelled on behalf of the patient (10.0%), and 3,803 were cancelled by the provider (7.7%). The pattern varies by age, with the highest level of 'did not attends' in the 0 to 4 age group (2,391 or 10.9% of all appointments), with lower levels for older ages (8.99% for 5 to 11 year olds and 5.75% for 12 to 15 year olds). The pattern varies by deprivation as well, as illustrated in the figure below, which highlights that the highest 'did not attend' levels were in the most deprived areas (12.7%), and the lowest in the least deprived areas (5.8%).

Figure 7, First Outpatient Appointments by Attendance and Deprivation, persons aged 0 to 15, Devon, 2013-14



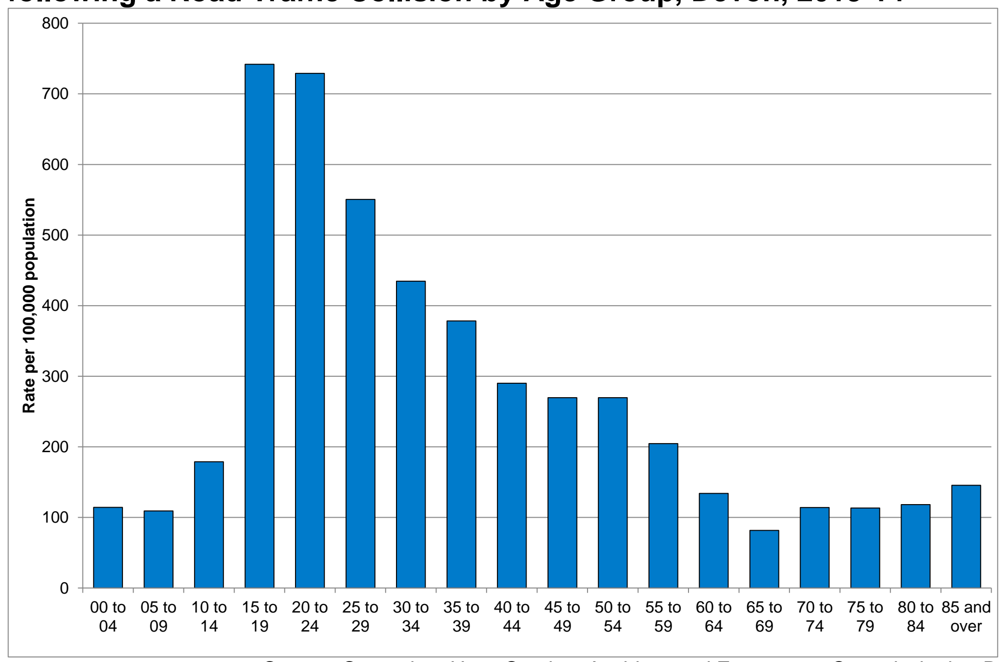
	Most Deprived	Above Average	Average	Below Average	Least Deprived	Total
Seen	69.8%	70.8%	73.7%	73.6%	77.9%	73.2%
Not Seen - Did Not Attend	12.7%	11.1%	8.9%	8.2%	5.8%	9.1%
Not Seen - Patient Cancelled	9.4%	9.5%	9.9%	10.5%	10.0%	10.0%
Not Seen - Provider Cancelled	8.2%	8.5%	7.5%	7.7%	6.3%	7.7%

Source: Secondary Uses Service, Outpatient Commissioning Dataset, 2014

Road Traffic Accidents

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 2013-14 there were 483 accident and emergency department attendances for persons aged 19 or under following a road traffic accident. The following figure illustrates the pattern of by age group, highlighting that the highest risk was in the 15 to 19 age group.

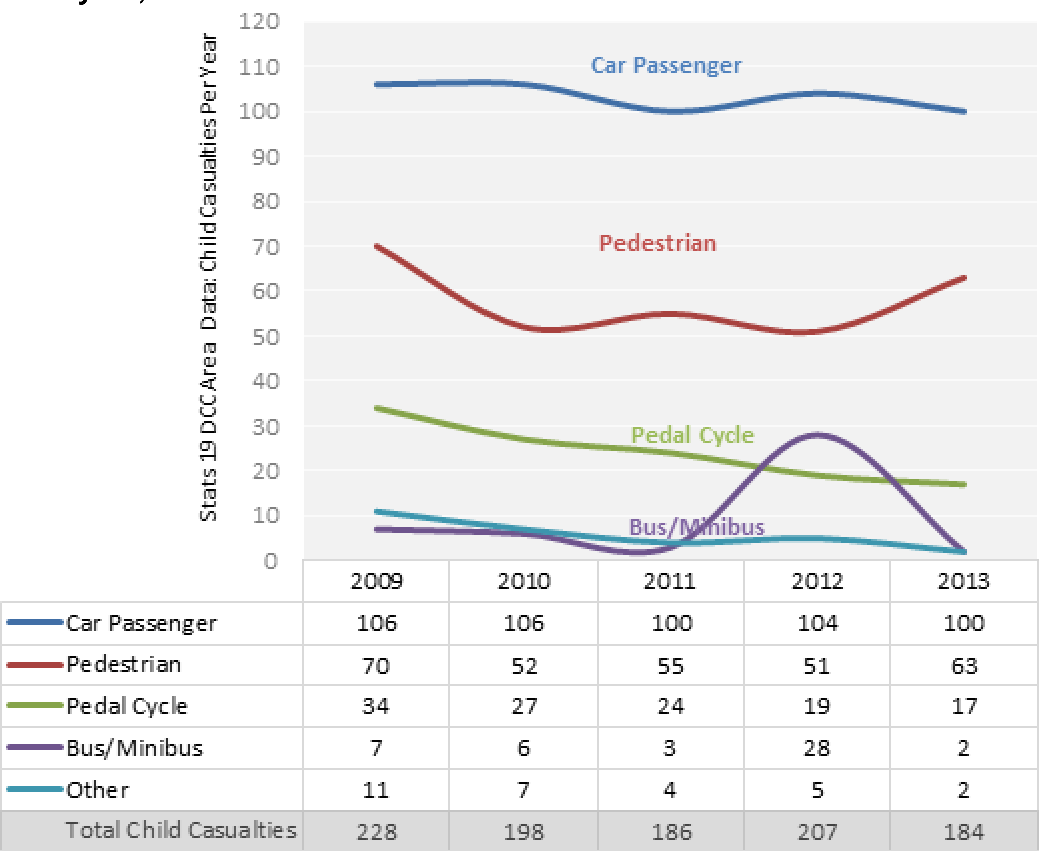
Figure 8, Accident and Emergency and Minor Injury Unit Attendance Rates following a Road Traffic Collision by Age Group, Devon, 2013-14



Source: Secondary Uses Service, Accident and Emergency Commissioning Dataset, 2014

In 2013-14 238 persons aged 0 to 19 were admitted to a hospital bed following a transport accident, including 139 aged 0 to 15 and 99 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 184 casualties recorded in 2013, of which 100 (54.3%) were car passengers, 63 (34.2%) were pedestrians, 17 (9.2%) were cyclists, and 4 (2.2%) were using other modes of transport. Cyclist accidents have fallen in recent years, which may relate to the increased use of school travel plans and cycle training schemes such as Bikeability.

Figure 9, number of children aged 0 to 15 injured on Devon roads by mode of transport and year, 2009 to 2013



	2009	2010	2011	2012	2013
Car Passenger	106	106	100	104	100
Pedestrian	70	52	55	51	63
Pedal Cycle	34	27	24	19	17
Bus/Minibus	7	6	3	28	2
Other	11	7	4	5	2
Total Child Casualties	228	198	186	207	184

Source: Stats 19 Data for Devon County Council Area, Department for Transport, 2014

In Devon there were 55 transport accident deaths in persons aged 0 to 19 in the decade between 2004 and 2013. Nine were under the age of 16, and 46 aged between 16 and 19, with car (34) and motorcycle (12) accidents the most frequent cause. Death rates following road traffic accidents have fallen considerably over recent years, principally reflecting improvements in car design. 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.

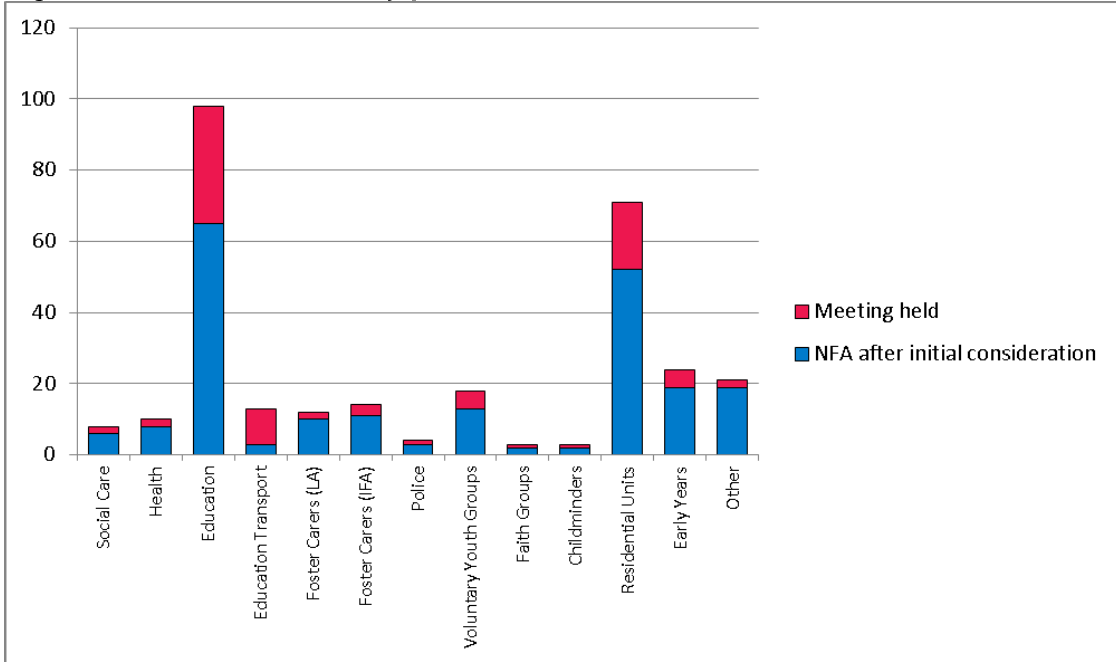
Local Authority Designated Officer (LADO) referrals

Referrals are made to the Local Authority Designated Officer (LADO) in cases where employees are accused or suspected of abuse or inappropriate behaviour.

In Devon there were 299 such referrals in 2013-14, of which 86 required further meetings and action, and 213 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 10 highlights the pattern of referrals in 2013-14, 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 11 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.

Please note, due to administrative staffing issues, not all information was captured during 2013-14 and therefore the information presented here is based on available information.

Figure 10, LADO referrals by profession and action, 2013-14



Source: Devon County Council LADO Team, 2014

Figure 11, LADO referrals requiring meetings and further action by outcome, 2013-14

Outcome	Count
Dismissal	8
Section 47	8
Criminal	3
Referral to ISA/DBS	3
Resignation	3
Further training	2
Cessation of Use	1
Caution	1
Unfounded	1
Unsubstantiated	4
NFA	13

Source: Devon County Council LADO Team, 2014

Serious Case Reviews

Serious case reviews (SCRs) are undertaken by local safeguarding children boards (LSCBs) for every case where abuse or neglect is known - or suspected - and either the child dies or is seriously harmed. Serious and fatal maltreatment represents the tip of an iceberg; while overall numbers of children dying as a direct consequence of maltreatment may be small; many more children and young people suffer from lower levels of abuse or neglect. Every serious case review can provide a potential window on the system[4]. There have been an unprecedented number of serious case reviews within Devon over 2013 and 2014, and this has thrown considerable strain on the system to deliver these.

Findings from the two most recently published SCR's in Devon (CN08 and CN10) found that the including: arrangements for parents with mental health issues disproportionately favouring adult's rights over children's; insufficient professional understanding of other's roles and responsibilities leading to assumptions over levels of knowledge and inhibiting professionals' confidence to challenge other agencies/professionals; systemic concerns over assessment processes and inconsistent application of thresholds within the Multi-Agency Safeguarding Hub (MASH); and lack of robust assessment of risk to children at Multi-Agency Risk Assessment Conferences (MARACs) (CN08). For the other: A misplaced assumption of mother as a protective factor; over-reliance on the children making a direct disclosure; and insufficient knowledge and understanding of sex offending, offender profiles and risk (CN10)[5].

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[4] Brandon, M. et al (2012) New learning from serious case reviews: a two year report for 2009-2011 (PDF). London: Department for Education.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184053/DFE-RR226_Report.pdf

[5] http://www.devonsafeguardingchildren.org/documents/2014/06/serious-case-review-cn10-report.pdf

Child Deaths

There were 36 deaths of persons aged 17 and under in 2013 of which the majority were infants under the age of one (24 deaths, 66.7% of those aged 0 to 17). Whilst the number for 2013 is the lowest on record, numbers do vary year-on-year and the differences observed over the last 10 years are not statistically significant.

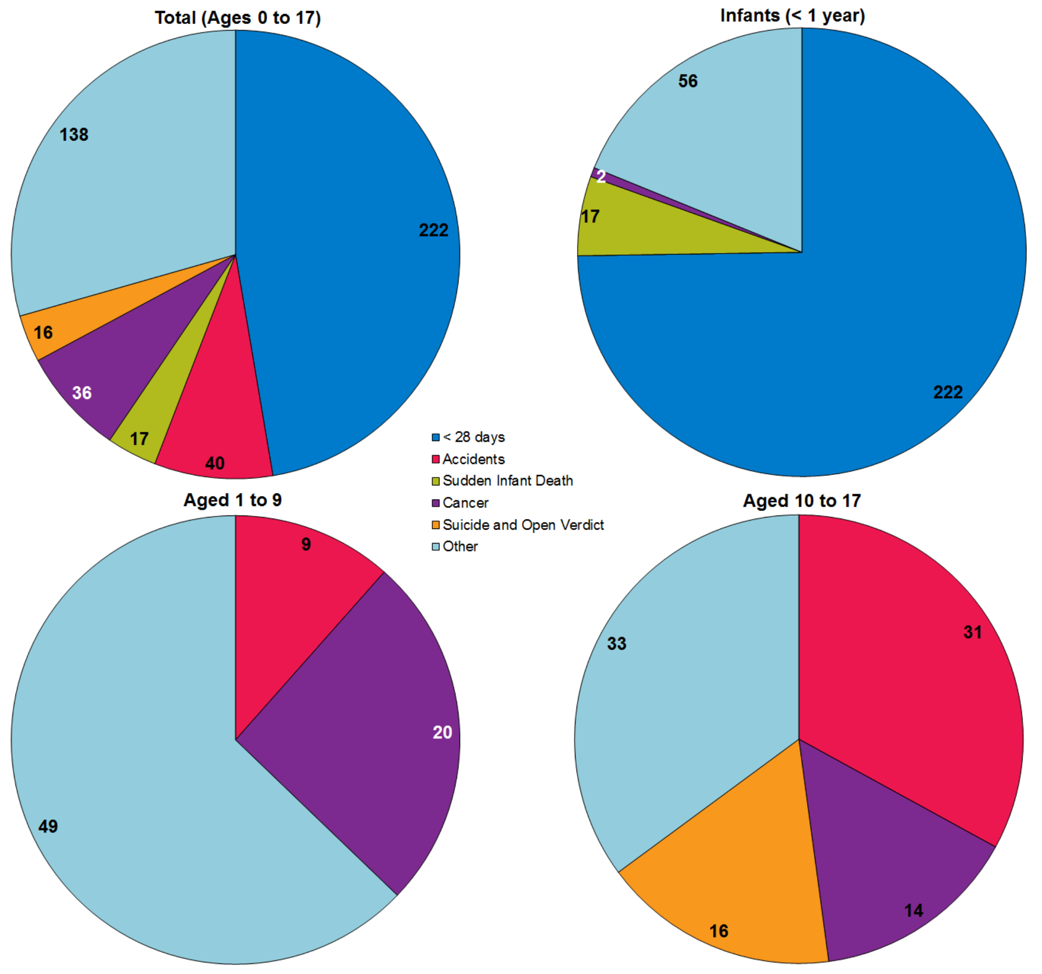
Table 2, Child Deaths by Age and Year, Devon, 2004 to 2013

Age	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
0 to 27 days	26	25	21	21	19	17	23	25	28	17
28 to 364 days	8	8	7	10	5	6	9	9	6	7
1 to 9 years	9	5	6	9	5	16	10	5	7	6
10 to 17 years	14	14	9	9	9	11	5	6	11	6
Total	57	52	43	49	38	50	47	45	52	36

Source: Primary Care Mortality Dataset, 2014

The following figure describes the cause of child deaths by age group. The top five groupings are deaths before 28 days, accidents, sudden infant death, cancer, and suicide / open verdicts, which together account for almost three quarters of all deaths. The share varies by age group, with the risk from accidents increasing with age, and suicide and open verdicts being the second largest cause of death in the 10 to 17 age group.

Figure 12, Child Deaths by Age and Cause, 2004 to 2013



Source: Primary Care Mortality Dataset, 2014

Child Death Overview Panel (CDOP)

In the South West Peninsula local safeguarding childrens boards collaborate to form one Child Death Overview Panel serving Cornwall & Isles of Scilly, Devon, Plymouth and Torbay. The South West Peninsula is a wide geographical area with many challenges including long distance travel, cross-boundary working, and a transient tourist population. Nationally the South West Peninsula Child Death Overview Panel (CDOP) is one of the largest in activity and this report marks its fifth year of operation. Arrangements include a multi-agency 'rapid response' to investigate unexpected child deaths consisting of police, health and social care representatives and a multi-agency expert CDOP review of all child deaths.

The South West Peninsula CDOP annual report for 2012-13 highlighted an overall decline in infant and child mortality rates over time. The work of the child death review process continues to support and inform how further child deaths can be prevented. Local analysis shows that overall the local picture is not different in nature to the national picture. Although local case review has been able to identify issues and themes, this would be enhanced by capture of this at national level, as it would help to build numbers faster and reduce the potential of small numbers effects to skew findings.

This report highlighted that the greatest burden of deaths falls on those aged under one and that attention to this group remains an area of priority, highlighting the need for continued scrutiny.

In terms of modifiable deaths the report identified that the greatest burden in absolute numbers for this falls on the very young (under ones) and young people (aged 15-17 years). In terms of causation categories local and national analysis suggests that deaths related to *trauma and external factors* and those related to *sudden, unexpected and unexplained deaths* particularly in infancy have higher risks of having modifiable factors. Review of deaths from trauma and external factors within the home have identified themes associated with hazardous environments either due to accident risk or sleeping environment and family vulnerabilities.

As a result of this, suggested areas for action have focussed on the need to ensure that under ones mortality, the prevention of sudden unexplained deaths in infancy and unintentional injury prevention are areas for focus and that attention is paid within these to families with additional vulnerability and hazardous environments in the home.

The report concluded that action to address this will need to sit within wider public health and population approaches to prevention and early intervention that ensure the best start to life through the promotion of health and wellbeing and the delivery of the healthy child programme, tackling child poverty and reducing unintentional injury.

4.3 Protection from impairment to health and/or development

School Attendance and Exclusions

Absence from school can severely interrupt a young person's education and life chances. There is evidence linking exclusion from school with academic underachievement, offending behaviour, exploitation, risk taking behaviours, limited ambition, homelessness and mental ill health[6].

Overall attendance across Devon's schools during the Autumn Term was 95.9%. The combined Autumn and Spring Term school census data for 2013/14 shows Primary absence at 3.83% and Secondary at 4.98%[7] (not including all academies). Both of these figures are an improvement of just over 1% point on the same data source for the same period in the previous year. Pupils in Devon eligible for free school meals and those with special educational needs were more likely to have poor attendance in 2013-14. Nationally those with a Statement of special educational needs are more than four times more likely to be persistently absent from school than those without special educational needs.

There is a strong correlation between exclusion, poverty (as indicated by free school meals entitlement) and educational disadvantage. Certain groups of pupils continue to be disproportionately excluded – those with Special Educational Needs, particular minority ethnic groups and those from lower socio-economic groups. The Devon Safeguarding Children's board is currently exploring exclusions, managed moves and the use of reduced timetables within Devon schools.

Nationally pupils with special educational needs (with or without statements) are more than eight times more likely to be permanently excluded than pupils with no special educational needs and account for 74 per cent of permanent exclusions; they are also more likely to be fixed-term excluded than pupils with no special educational needs. Black Caribbean pupils are nearly four times more likely to be permanently excluded, and are more likely to be fixed-term excluded than the school population as a whole. Children who are eligible for free school meals are approximately four times more likely to be permanently excluded and three times more likely to be fixed-term excluded than children who are not eligible for free school meals[8].

Bullying

Bullying can have a great impact on the health and wellbeing of children, and tackling bullying is identified as an important aspect of safeguarding.

In 2013/14, bullying was cited as the reason for 9% of Elective Home Education referrals in Devon[9]. Devon schools all have access to the DCC 'Bullying and Prejudice Related Incidents' (BPRI) guidelines and incident form and are actively encouraged to report incidents of bullying centrally via Babcock LDP. During

[6] New Philanthropy Capital, Misspent Youth; The costs of truancy and exclusion, London: New Philanthropy Capital, 2007
[7] Babcock LDP Education Welfare Service Q2 14-15
[8] Department for Education Permanent and Fixed Period Exclusions from Schools in England,
[9] Elective Home Education, Babcock LDP, 2013/14

2013/14, 115 bullying incidents were reported in 67 schools, this is an increase in reports received in the previous year. Advice and guidance has been provided to schools on all aspects of reducing bullying including policy, curriculum programme and incident management. The 'Happiness and Well-being Award' launched in 2011, a natural development of the 'Healthy Schools Programme', is available to all schools across the UK. A whole school approach to reducing bullying is a major aspect of the award. The 'Reducing Bullying Quality Mark' was developed in 2012 and is available to all schools and settings. The quality mark outlines the specific policies, procedures and strategies that are required in a school to prevent all forms of bullying.[10]

Bullying can affect any young people in schools but it can be disproportionately targeted at those from certain groups such as those from minority ethnic groups (including Gypsy Roma Travellers), young people who identify as LGBT and young people with disabilities.

From September 2014, pupils in all four key stages will be taught about e-safety as part of the new curriculum. For the first time, schools will be legally required to teach e-safety to pupils in infant and junior schools. This will empower all young people to tackle cyberbullying through responsible, respectful and secure use of technology.[11]

Devon Transport Team have a 'Code of Conduct' in place on school transport and by accepting transport provision all pupils and parents are agreeing to abide by it. This was introduced 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. There were 66 recorded bullying incidents in 2013/14 which represents 21% of all reported behaviour incidents on school transport.

When a group of young people who had worked with the REACH team during 2014 were interviewed there was an emerging theme of peer group and bullying. Participants identified their contemporaries as playing a significant role in their likelihood to engage in risk taking behaviour and missing episodes; frequently stating that friends had introduced them to drugs, alcohol, older males and/or had encouraged them to go missing.[12]

"I think it was to do with people I was hanging around with. They would say things like, 'come out, come out'… they kind of led me into it."
16 year old female working with REACH team in Devon, 2014

Sexual orientation and gender identity

Sexual orientation and gender identity are discussed here under one heading, since there is often an overlap in the experiences of discrimination and isolation experienced by these groups, and studies often consider these groups under one umbrella. However, sexual orientation and gender identity are distinct protected characteristics, and a diverse cross-section of society are represented under these terms. Belonging to multiple minority groups/protected characteristics may have a

[10] Reducing Bullying in Devon Schools – Summary for April 2013 – March 2014. Report produced by: Dr. Annette Lyons, Babcock LDP, March 2014
[11] Hansard written answers 14 July 2014 : Column 579W Pupils: Bullying
[12] REACH Team – Reflective Conversations with Young People. Summary Report for Children's Social Work & Child Protection SMT, July 2014. Sophie Ellis – Senior Involvement Officer

compounding effect on experiences of disadvantage, isolation and discrimination (Varney 2013). Local data on the experiences of lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth in Devon is limited. The Devon Schools Survey (results due autumn 2014) will provide some baseline indicators.

The boundaries of homophobic and transphobic bullying are often blurred, since it is often based on *perception* of sexual orientation or gender identity, regardless of whether a young person is actually out or not. Boys who behave 'like girls', girls who behave 'like boys', young people with gay parents, friends or family members, and young people merely perceived to be gay can all be victims of homophobic bullying.

Stonewall[13] undertook a survey of 1,600 British pupils in 2012. Levels of homophobic bullying had fallen by 10% since their previous survey, but remain high, with 55% of pupils saying they had experienced this. 99% of pupils hear the term 'gay' used derogatorily or hear other homophobic language. 44% of respondents skipped school because of homophobic bullying, and 32% of those who were bullied had changed their plans for future education as a result of it. There is little evidence on the experience of young trans people at school, but one survey found that 64% of young trans men and 44% of young trans women had experienced harassment or bullying at school, from teachers as well as pupils[14]. The Metro Youth Chances survey[15] (7,000 LGBTQ aged 16-15) found that overall nearly half of respondents (49%) reported that their time at school was affected by discrimination or fear of discrimination. Experiences of abuse are not limited to the school environment. The table below shows the proportion of LGBTQ youth who have experienced abuse or hate crime. Over half of all types of crime had happened in the last year.

Table 3, Abuse experienced by LGBTQ respondents (Metro Youth Chances 2014)

Type of abuse	Proportion of respondents experiencing abuse
Name-calling	74%
Harassment	45%
Threat	45%
Physical assault	23%

Source: 'Youth Chances Summary of First Findings: the experiences of LGBTQ young people in England' London, METRO 2014.

Sexual and gender identity can have an impact on wider wellbeing. METRO Youth Chances (2014) found that 8% of respondents had had to leave home for reasons relating to their sexual orientation or gender identity. Homeless young people have often left home as a result of rejection and intolerance from family or friends, and then may face ongoing difficulties while rough sleeping or in temporary accommodation. Substance misuse and mental health problems are far higher amongst those who identify as LGBT in comparison with the general population. US and UK research has found significantly higher levels of depression, anxiety, self-harm, suicide attempts, and substance abuse in LGBTQ young people[16]. The strongest risk factors for substance misuse were victimisation, lack of supportive environments, psychological stress, internalizing/externalizing problem behaviour, negative disclosure reactions, and housing status.

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[13] Guasp, A. 'The School Report', Stonewall, London, 2012.

[14] Whittle et al. 'Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination' Press for Change 2007.

[15] METRO Youth Chances '*Youth Chances Summary of First Findings: the experiences of LGBTQ young people in England' London,* METRO 2014.

[16] Marshal, M.P. et al, 'Sexual orientation and adolescent substance use: a meta-analysis and methodological review', *Addiction* 2008 April; 103(4): 546-556.

Special Educational Needs

Devon has a higher proportion of children and young people with a statement of SEN (at both primary and secondary), than our statistical neighbours or the national average. For 2013, 2.4% of primary and 2.8% of secondary pupils had a statement of SEN in Devon, compared with 1.6% and 2.2% for our statistical neighbours and 1.4% and 1.9% nationally[17].

In January 2014 there were 3,400 children and young people with SEN Statements attending Devon schools, which is a 2% increase from the previous year (3,333) (includes all Maintained Schools, Special Schools and Devon Personalised Learning Service (DPLS) establishments)[18]. The most common primary need for SEN statements was behaviour, emotional and social difficulty (23% of the statemented population), followed by Autism Spectrum Disorder and speech, language and communication needs (19% and 18% of the statemented population respectively).

As previously stated, there is a strong correlation between poverty (as indicated by free school meals entitlement) and educational disadvantage. With 8.8% of Devon pupils in receipt of free school meals in January 2014 having an SEN statement, compared to 2.9% of those who don't receive free school meals.

In addition to those with a statement, in January 2014 there were 5,757 children and young people with School Action Plus (SAP) or Early Years Action Plus in Devon, a 1% decrease from January 2013 (5,828). Behaviour, emotional and social difficulty was also the most common primary need among pupils at SAP in Devon (30% of the population at SAP), followed by speech, language and communication needs (25% of the population at SAP).

Children with Disabilities and Additional Needs

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.

The 2011 Census reported that 4% of children aged 0 to 15 (4,568 children) in Devon have a long term health problem or disability where day-to-day activities are limited in some way. 4,090 of these children were in receipt of Disability Living Allowance as at February 2013[19].

A further 3,963 young people aged 16 to 24 (or 5% of the 16-24 population) in Devon were reported to have a long term health problem or disability where day-to-day activities are limited in some way, of whom 2,650 were in receipt of Disability Living Allowance as at February 2013.

[17] DfE Local Area Interactive Tool (LAIT), 8th August 2014
[18] DfE School Census 16th January 2014
[19] Department for Work and Pensions (DWP), snapshot of benefit claimants - February 2013

The proportion of children aged 0 to 15 and young people aged 16 to 24 in Devon that have a long term health problem or disability where day-to-day activities are limited in some way is in line with the national average[20].

As at end of March 2014, 1,720 children and young people with disabilities and additional needs were receiving support via integrated working (multi-agency). These children will have more than one service working with them e.g. Learning Disability, Occupational Therapy and Health Visitor[21].

Table 4, Children and young people with disabilities and additional needs receiving support via single agency services as at end of March 2014

Single Agency Service	Number receiving service end March 2014
Speech and Language Therapy	2,125*
Occupational Therapy	543*
Palliative Care	85#
Portage Home Visiting	144
Rehabilitation Officers for Visually Impaired Children	95
Learning Disability Nursing	212
Autistic Spectrum Condition Service	155*
Community Nursing	84*

Source: Children with disabilities and additional needs receiving single agency services March 2014, Virgin Care Ltd
Please note: there could be some duplication with children receiving multi-agency services
* Based on referrals to the service in 2013/14
# Average of open cases throughout the year

Children missing from Education

All children of compulsory school age (5-16 years) who are not on a school roll, being educated otherwise (e.g. at home, privately, or in alternative provision) and who have been out of educational provision for a substantial period of time (usually agreed as four weeks or more) are regarded as Children Missing from Education.

The Government has placed a duty on Local Authorities to make arrangements to establish (as far as it is possible) the identities of children in their area who are of compulsory school age and not receiving a suitable education (i.e. children missing education). Children not receiving a suitable education are at increased risk of a range of negative outcomes that could have long term damaging consequences for their life chances.

Children may be missing from education for a variety of reasons including

- not starting school at the appropriate time and so they do not enter the educational system
- removal by their parents due to problems at school, disinterest or poor attendance
- children cease to attend due to exclusion, illness or bullying
- failure to find a suitable school place after moving to a new area (particularly a problem if the family move home regularly)
- problems at home

[20] Long term health problem or disability by health by sex by age - Census 2011
[21] Children with disabilities and additional needs receiving multi-agency services March 2014, Virgin Care Ltd

571 children and young people were referred to the children missing education team at Babcock in 2013/14 a slight increase from 468 in 2012/13[22]. 25% of those had been missing from education for more than 80 days[23].

Home Education

Although the majority of parents choose to send their children to school, a small number of families choose to educate their children at home. This is a challenging undertaking and requires a serious commitment of time, money, patience and energy. The 1996 Education Act states that 'it is the duty of parents to secure an appropriate full time education for their children of compulsory school age', placing the burden on the family to provide a broad and balanced curriculum if they educate out of school (though they do not need to follow the national curriculum).

There are a wide variety of reasons for parents choosing to home educate, including (but not limited to)

- deeply held religious, cultural and/or ethical beliefs which lead parents to provide a particular style of education which is not available locally
- a belief in the benefits of one-to-one learning
- feeling that their child's particular personality or special educational needs makes them unsuitable for the school environment
- a crisis of confidence in school resulting from bullying or school phobia
- the pupil did not get into their choice of school or that the nearest school is too great a distance from the home
- a short-term intervention for a particular reason as a result of an exclusion

Parents do not need permission to home education but they decide to remove their child from school then they must register with the local authority (number registered are in the table below). If the children are known to social care services then they will be more vulnerable. If children have never attended mainstream education there is no obligation to register, these children will be largely absent from the recording.

In 2012/13 521 pupils were open to Devon's Elective home education team. 187 new pupils entered the service (similar to 2013/14) and 167 young people returned to school (a greater return rate than 2013/14).

Table 5, Registered elective home education in Devon (2012-13 and 2013-14)

Elective Home Education	2012/13 Summary	2013/14 Term 1	2013/14 Term 2	2013/14 Term 3
Open cases at the start of term	521	463	514	**544**
New registrations	187	102	51	**34**
Number returned to school	167	50	7	**6**
Moved out of County	7	2	5	**0**
School Attendence / Education Supervision orders issued	2	2	2	**1**
% Elective Home Education young people who become NEET	17.10%	-	-	-

Source: EHE commissioned LDP service Q1 14-15 report

[22] LDP DCC Report Card Q4 update
[23] Commissioning Framework 2013/14: Workstream Report 1312: Deliver Statutory Responsibilities Related to Children Missing Education Q4 2013/14

The numbers of students in years 10 and 11 coming off role is cause for concern. Finding a suitable place may be difficult, it is especially challenging in Devon to find school places for year 11's post-Christmas. On a positive note, due to funding changes, there are now more 14-16 year old elective home education students accessing part time college courses.

Not in Education, Employment or Training (NEET)

The overall trend of young people aged 16-18 not in education, employment or training (NEET) in Devon decreased between 2011 and 2013 from 5.8% to 5.5%, although the 2013 figure does represent a slight increase from 2012 (5.3%). However, the proportion of young people whose destination is 'not known' is one of the lowest in the Country. Both the South West and National figures have also declined and are below Devon at 5.2% for 2013[24].

Local and national research has shown that those most likely to be persistently not in education, employment and training (NEET) include:

- children in care
- care leavers
- children with additional needs
- young people with poor social skills or poor school attendance records
- young offenders
- young carers
- teenage parents
- young people who are excluded from school
- young people brought up in workless households
- young people with troubled home backgrounds

Young Carers

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 2011 Census there were around 111,400 young carers in England aged 0-15, including 1,650 in the Devon County Council area[25]. It is likely the actual number of young carers 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). As at 31st March 2014 Devon Carers were in touch with 2,836 young carers aged 0-18[26]. Devon Carers has a specialist team who work with young carers, addressing the needs of young people providing care and support to other family members. Young carers can be put in a position of great responsibility at a very young age; dealing with situations that many adults would find a challenge.

[24] DfE Local Area Interactive Tool (LAIT), 8th August 2014
[25] LC3304EW - Provision of unpaid care by age, Census 2011
[26] Devon Carers Report Q4 2013/14, Matthew Byrne, May 2014

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. 10,110 persons aged under 16 in England were identified in the 2011 census as providing care for over 50 hours per week, including 98 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 the only person having physical contact with that adult.

Sexual Health

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 13 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 13, Percentage of sexually transmitted infections diagnosed among young people (16-24), England, 2013

Percentage	Chlamydia	Gonorrhoea	Herpes	Syphilis	Warts
Males	58.2%	29.7%	29.9%	11.8%	45.6%
Females	76.4%	67.0%	47.4%	30.1%	61.6%

Source: Public Health England GUMCAD Returns, STI Diagnoses and Rates, 2013

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.

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.

Mental Health and Emotional Wellbeing

Mental Health and Emotional Well-being describes how we think, feel and relate to ourselves and others and how we interpret the world around us. Having good Mental Health affects our capacity to manage, communicate, and form and sustain relationships. It also affects our ability to cope with change and major life events.

Most people will come into contact with mental health issues during their lifetime, and one in four will have personal experience of a mental health problem. The invisibility of mental illness means that many do not receive the support and treatment that could help them.

The Mental Health Foundation have highlighted some of the common mental health problems in childhood:

- **Depression** affects more children and young people today than in the last few decades, but it is still more common in adults. Teenagers are more likely to experience depression than young children.
- **Self-harm** is a very common problem among young people. Some people find it helps them manage intense emotional pain if they harm themselves, through cutting or burning, for example. They may not wish to take their own life.
- Children and young people with **generalised anxiety disorder** (GAD) become extremely worried. Very young children or children starting or moving school may have separation anxiety.
- **Post-traumatic stress disorder** can follow physical or sexual abuse, witnessing something extremely frightening of traumatising, being the victim of violence or severe bullying or surviving a disaster.
- Children who are consistently **overactive** ('hyperactive'), behave impulsively and have difficulty paying attention may have Attention Deficit Hyperactivity Disorder (ADHD) Many more boys than girls are affected, but the cause of ADHD isn't fully understood.
- **Eating disorders** usually start in the teenage years and are more common in girls than boys. The number of young people who develop an eating disorder is small, but eating disorders such as anorexia nervosa and bulimia nervosa can have serious consequences for their physical health and development.

Nationally there has been an increased prevalence of mental ill health in children and young people, with only a small proportion with mental health problems in contact with mental health services. Around one in 10 children in Devon have a mental health disorder.

The table below show the number of school-age children estimated to have a mental health condition by local authority district.

Table 6, Estimated number of school-age children (aged 5 to 16) with a mental health disorder, 2013

Local Authority	Total
East Devon	1,538
Exeter	1,398
Mid Devon	1,041
North Devon	1,185
South Hams	1,006
Teignbridge	1,521
Torridge	772
West Devon	672
Devon Total	9,133

Source: Association for Young People's Health: Key Data on Adolescence 2013

Tier four specialist inpatient and day-patient care are for children who are suffering from severe and/or complex mental health conditions that cannot be adequately treated by community mental health services. Between 15 and 25 young people from Devon will be in inpatient care at any one time[27].

[27] CAMHS Annual Report to Devon Safeguarding Board 2013

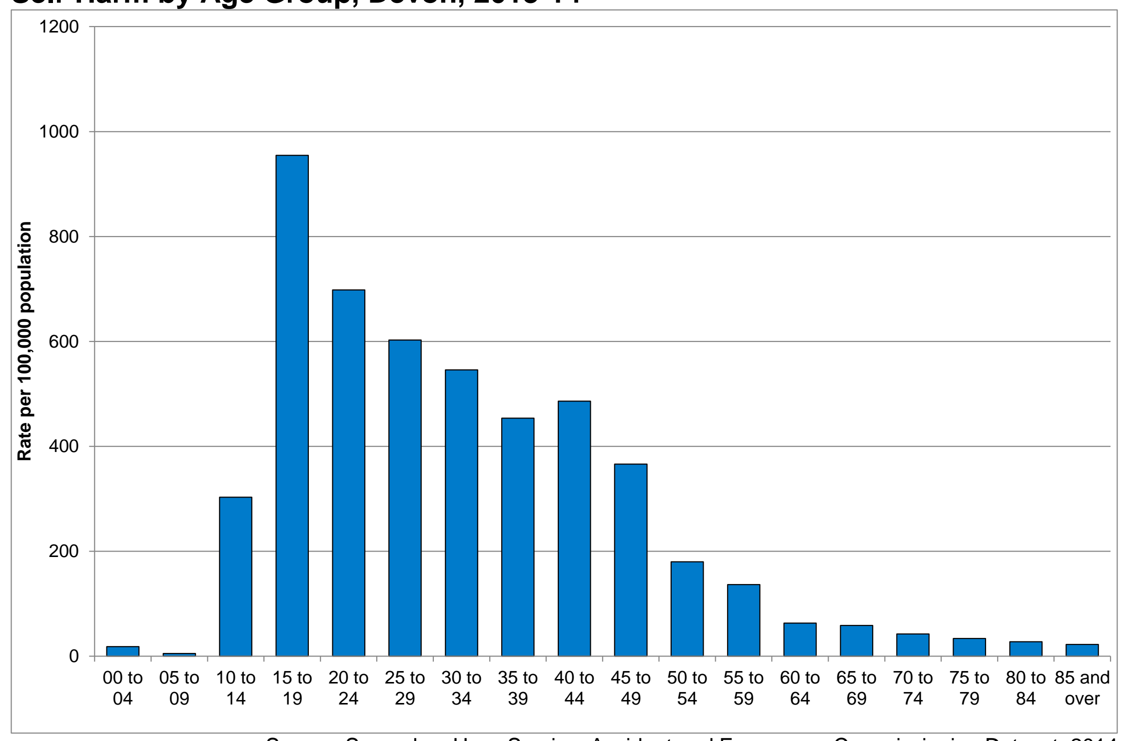
The range and nature of risk behaviour from young people at tier four is broad and can include self-harm, suicide, physical consequences of low weight, absconding, aggression, sexualised behaviour, fire-setting, safeguarding concerns. All of these can represent a risk to the young person and may represent a risk to other patients. These risks and behaviours are harder to manage if the young person is placed on a paediatric ward instead of in a specialist Children and Adolescent Mental Health Services (CAMHS) bed.

There has been an increase within Devon of young people admitted to paediatric wards and to tier four units. Devon does not have specialist mental health beds in county (the nearest being in Plymouth, though the young people may be placed at a much greater distance if a more local bed is not available) meaning the majority of South West admissions have been to paediatric a ward on which staff may not have the specialist skills to support a mental health crisis. This means that young people in crisis are being placed at great distances from their family and support networks and that family member are unable to participate in supportive therapy.

Self-Harm

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, 139 males and 409 females aged 0 to 19 attending accident and emergency departments as a consequence of self-harm in 2013/14. Attendance rates peak in the 15 to 19 age group as illustrated in the chart below.

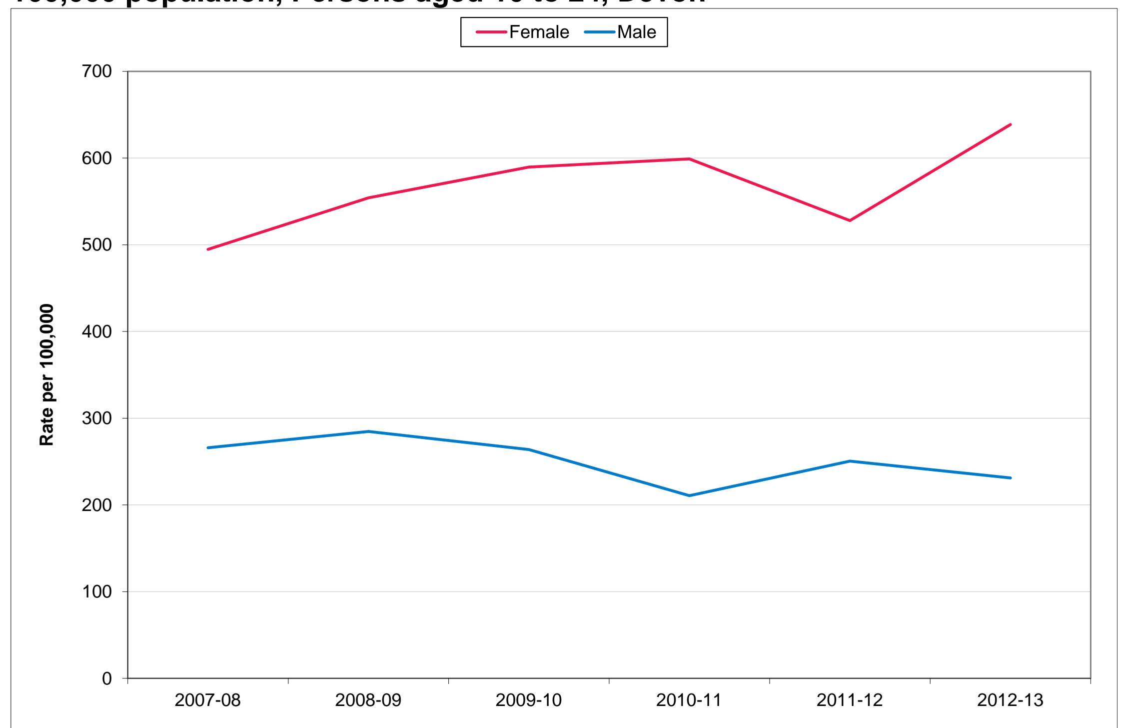
Figure 14, Accident and Emergency and Minor Injury Unit Attendance Rates for Self-Harm by Age Group, Devon, 2013-14



Source: Secondary Uses Service, Accident and Emergency Commissioning Dataset, 2014

The Child Health and Maternity Service (CHIMAT) monitor self-harm admissions in the 10 to 24 age group. There were 548 hospital admissions for self-harm in persons aged 10 to 24 in Devon in 2012-13. The rate per 100,000 in Devon was 419.5, which is below the South West rate (442.5), but above the local authority comparator group (388.8) and England (346.3) rates. Admission rates increased from 376.6 in 2007-08 to 419.5 in 2012-13. Within the 10 to 24 age group admission rates were highest in those aged 15 to 19 (625.4). Admission rates also are higher in more deprived areas, with a rate of 1034.0 in the most deprived areas compared with 308.6 in the least deprived areas in 2012-13. Within Devon rates were highest in North Devon, and lowest in the South Hams and Torridge. Rates of hospital admission for self-harm are three times higher in females than males and the gap has widened in recent years as illustrated in the chart below.

Figure 15, Hospital Admissions for Self-Harm by Year and Sex, Rate per 100,000 population, Persons aged 10 to 24, Devon



Source: Secondary Uses Service, Inpatient Commissioning Dataset, 2014

Eating Disorders

Eating disorders usually start in the teenage years and are more common in girls than boys. The number of young people who develop an eating disorder is small, but eating disorders such as Anorexia Nervosa and Bulimia Nervosa can have serious consequences for their physical health and development. Table 7 highlights that around 122 persons aged between 11 and 15 are have an eating disorder. Around 15 new cases of Anorexia Nervosa and 17 new cases of Bulimia Nervosa are expected in Devon each year.

Table 7, Estimated Incidence and Prevalence of Eating Disorders in Devon, 2013

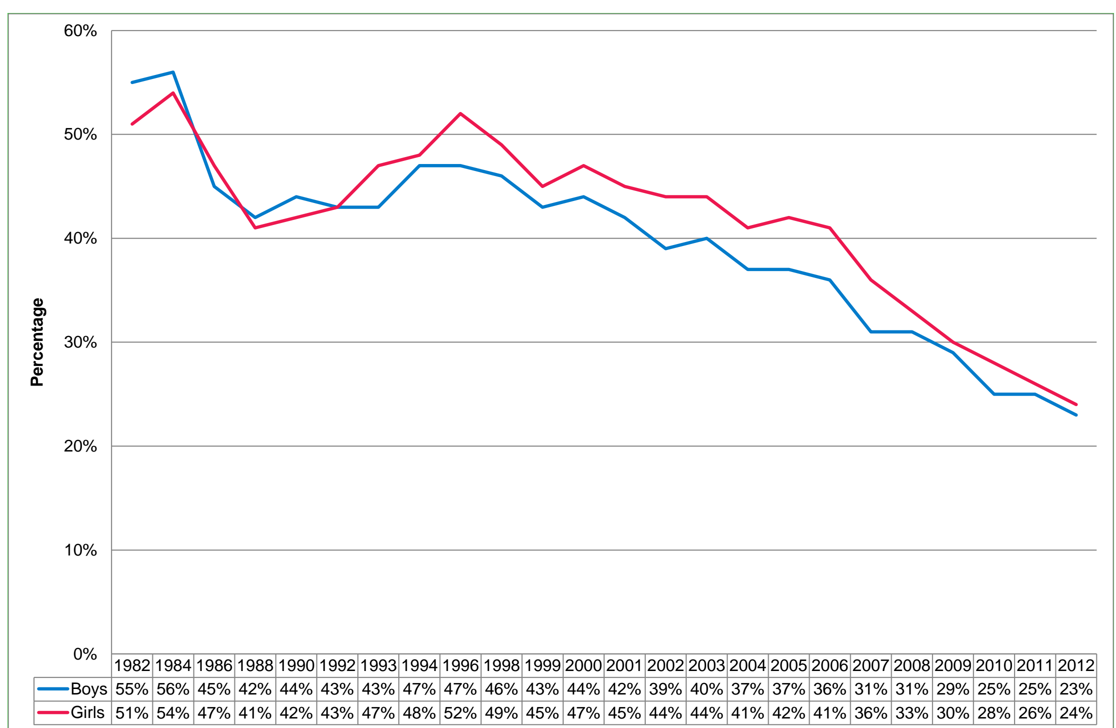
Condition	Rate	Numbers Affected in Devon
New cases of Anorexia Nervosa per year, aged 10 to 19	17.5 per 100,000	15
New cases of Bulimia Nervosa per year, aged 10 to 19	20.5 per 100,000	17
Persons with any eating disorders, aged 11 to 15	300 per 100,000	122

Source: Early Onset Eating Disorders, BPSU 2007 and LHO Mental Health of Adolescents 2000

Smoking

The proportion of children who smoke has fallen consistently over time and particular sharply in recent years. This is illustrated in figure 16, which highlights that the proportion who have ever smoked has halved since 1996 in those aged 15 years.

Figure 16, Young people aged 15 who have ever smoked, by sex, 1982 to 2012



Source: Smoking, Drinking and Drug Use among young people in England in 2012, HSCIC

Smoking, like other health-related behaviours, occurs in a social context, with family, community and peer group factors having a strong influence on the behaviour and attitudes of young people. This is illustrated in figure 17, which highlights the smoking status of those aged 15 according to the number of smokers they live with. Only 2% of 15-year olds who did not live with smokers were regular smokers, compared with 16% of 15-year olds who lived with three or more smokers.

Figure 17, Smoking status at age 15, by number of smoking pupil live with, England, 2012

Number of smokers pupil lives with	None	One	Two	Three or more
% Non-smokers	95%	89%	85%	75%
% Occasional smokers	3%	5%	7%	8%
% Regular smokers	2%	5%	9%	16%

Source: Smoking, Drinking and Drug Use among young people in England in 2012, HSCIC

Substance Misuse in Young People

The majority of young people do not use drugs, and most of those that do are not dependent. Drug or alcohol misuse can have a major impact on children and young people's education, their health, their families and their long-term chances in life. Reducing substance misuse will lead to improved outcomes for individual young people, reduce anti-social behaviour, and improve community wellbeing.

Y-Smart supported 649 new young people in 2014 and their existing clients across drug treatment and prevention including 142 referrals for tier 3 substance misuse support. Whilst the gender of young people in Devon is 51 per cent; of those receiving treatment interventions the split is 89% male to 53% female (based on 142 young people receiving an intervention in 2013-14) [28]. 5% of clients in 2014 were aged 13 or under but most (74%) were aged 15-17.

The main referring agencies into treatment for 2013-14 were universal education (32%) and youth offending (14%). 17% 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 26 clients in services are children in care it would appear that other agencies are referring or they are self-referring.

The vast majority of young people sought support for cannabis or alcohol usage some young people reported using a wider range of drugs including MDMA, Ketamine, cocaine, solvents, amphetamines, NPS (novel psychoactive substances) and nitrous oxide. 75% of young people were using more than one type of substance regularly; the figures do not capture experimental use.

[28] Y-Smart Annual Report 2013-14, Devon County Council

Perpetrators of Crime/Offenders

Positively the level of offending by children and young people is relatively low in Devon, 411 young people offended in 2013/14 committing a total of 719 offences. The total number of young people aged 10-17 years who offended in Devon has fallen by 56% between 2010 and 2013 and the overall number of offences committed has fallen by 60% within the same period. The highest number of offences committed in 2013 was violence against the person (24%), theft & handling (20%), criminal damage (12%) and drugs offences (12%)[29].

Children and young people in contact with the youth justice system have more – and more severe – unmet health and well-being needs than other children of their age. They have often missed out on early attention to health needs. They frequently face a range of other, often entrenched, difficulties, including school exclusion, fragmented family relationships, bereavement, unstable living conditions, and poor or harmful parenting that might be linked to parental poverty, substance misuse and mental health problems[30][31]. The overwhelming majority of children and young people in contact with the Youth Justice Service remain in the community throughout that contact, but a small number are remanded or sentenced to custody. The health and well-being needs of children and young people in custody tend to be particularly severe.

For the purposes of the Safeguarding it is 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 8, Looked after status of youth offenders (2013/14)

Looked after child status	Accommodated by Voluntary Agreement	Subject to Care Order	On the Child Protection register
Currently	35	18	5
Previously	19	5	31
Never	105	136	123
Total	159	159	159

Source: Devon Youth Offending Team, ASSETS completed 2013-14

Over half of the children and young people assessed by the Youth Offending Team (YOT) in 2013-14 had experienced intensive social care input into their families. This is likely to indicate high levels of need within that population.

The vulnerability level reflects the risk of harm-to-self relating to that young person. It is clear from the data that a significant minority of YOT clients are quite vulnerable and will need support to stay safe.

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[29] Devon Youth Offending Team reporting 2014
[30] Healthy children, safer communities, DH, 2009 http://dera.ioe.ac.uk/11034/
[31] Evidence of needs paper, Ryan M and Tunnard J, 2011 http://www.chimat.org.uk/resource/view.aspx?RID=111768

Table 9, Vulnerability of youth offenders (2013/14)

Vulnerability Level	Number of Young People	%
None	5	3%
Low	90	57%
Medium	47	30%
High	17	11%
Total	159	100%

Source: Devon Youth Offending Team, ASSETS completed 2013-14

Young people as victims of crime

According to the Crime Survey for England and Wales, children and young people are more likely to be victims of crime than any other age group and only 13% of young victims report incidents to the police.

Children and young people can be victims in relation to any offence. For example, as victims they may be abused sexually or physically by adults or, much more commonly, they may be assaulted by other children or have their possessions damaged or stolen. They may also be witnesses in cases involving other children or adults for offences from common assault to homicide. In the domestic setting they may witness violence against a close family member.

Children can be affected by crime even if they are not themselves victims or witnesses. A child may be seriously affected by, for example, domestic violence, even if not present in the same room where the offence is committed.

Both serious and low-level persistent crime can have devastating effects on children and young people.

Research shows that this can lead to:

- Self-harm or suicide attempts
- Unemployment or truancy
- Low attainment
- Social isolation

These effects often last into adulthood with a corresponding emotional and financial cost to children, families, communities and the wider society.

The more traumatic the offence for the child (being a victim of or a witness to violence or sexual abuse are the most obvious examples), the more likely it is that criminal proceedings may re-traumatise and cause further emotional damage to the child. Yet the most serious cases are usually the ones that will, on the facts, require a prosecution in the public interest, both to secure justice but also to provide protection for the child and the public at large.

In 2013-2014 over 1,824 children aged under 18 were victims of crime in Devon[32] (this does not represent all child victims as it only covers the first victim in any crime, many crimes have multiple victims). The most common crimes for males to experience where 'violence with injury' followed by 'violence without injury' and 'other

[32] Devon Strategy Policy & Organisational Change Report based on Devon and Cornwall Police Reporting

theft' where as females were most likely to experience 'violence without injury' followed by 'violence with injury', the third most common crime was 'other sexual offences'. Young people in Devon are far more likely to be victims of contact crime and far less likely to be victims of property crime than older age groups. As a proportion of reported crime females under 18 are the most likely to experience rape and other sexual offences than other age groups.

Missing Persons/Runaways

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. Young people who go missing, particularly those who go missing repeatedly or for longer periods of time, are vulnerable to harm, including sexual exploitation, drug and alcohol misuse, crime, and educational disengagement.

Table 10a, Devon missing person reports (<18's) to Devon and Cornwall Police 2014.

	Q1	Q2	Q3	Q4	Total (year to date)
Looked After Child	68	84	99		251
Child/Youth	401	529	342		1272
Total	469	613	441		1523

Source: National Crime Agency quarterly reports 2014

Table 10b, Devon missing person reports (<18's) to REACH team.

Month	Total no. of missing episodes	Total no. of YP reported missing	Total no. allocated to REACH
Jan	n/a	n/a	44
Feb	129	94	51
March	196	121	63
April	193	118	55
May	202	137	64
June	234	139	70
TOTAL	**954**	**609**	**347**

Source: Devon REACH Team, July 2014

Note **: REACH team formed in January, more cases allocated and recorded as the team developed**

Return home interviews are carried out with higher risk young people to determine the reasons for going missing and any support that is needed to prevent further episodes. The REACH team in Devon conducted 229 of these interviews in the first 6 months of 2014.

"I have no idea what made me run away from it all because it has all got on top of me and I feel like I'm losing the will to live."
Young male in care, December 2013

Common reasons for young people to go missing identified in these interviews include problems at school, domestic violence at home, problems with friends, 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 majority of persons under 18 reported missing were found within 24 hours (over 80% within two to four hours). Around a third of missing reports are repeats.

Young people may run away or go missing from home (or from care) following grooming by adults who seek to exploit them. Evidence from Barnardos[33] suggests the vast majority of those going missing regularly are subject to sexual exploitation. If a young person goes missing on a regular basis for short periods of time then this is unlikely to attract much attention, in fact this case could be a high exploitation risk.

Child Sexual Exploitation and Trafficking

Sexual exploitation of children and young people under eighteen involves exploitative relationships, violence, coercion and intimidation being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability. Perpetrators of child sexual exploitation are found in all parts of the country and across ethnic groups.

Models of child sexual exploitation include[34]:

- 'inappropriate relationships' involving a sole perpetrator who has inappropriate power or control over a child and uses this to sexually exploit them. This is where the majority of exploitation occurs.
- the 'boyfriend' model in which the victim believes themselves to be in a loving relationship, but the exploiter forces them to have sex with associates
- 'peer exploitation', where a child is forced by peers into sexual activity with a number of other children
- 'organised sexual exploitation' in which networks of men pass children around for forced sexual activity with multiple rapists.

Reliable estimates of the prevalence of child sexual exploitation are also difficult to find. It is rarely identified and victims do not disclose for various reasons including fear of the perpetrator, shame and fear that they will not be believed. Some young people are not even aware they are experiencing abuse as the perpetrator has manipulated them into believing they are in a loving relationship. The majority of child victims of sexual exploitation are girls and the average age of victims, of any gender, is 15.

The REACH team in Devon is tasked with working with children who are being sexually exploited (except those in care, who are supported by their existing social worker but the REACH team offer input). The team supported 96 young people in Devon in the first 6 months of 2014 who had been victims of child sexual exploitation (6 of whom were subject to child protection plans).

When a group of young people who had worked with the REACH team during 2014 were interviewed, participants expressed a lack of knowledge and understanding amongst their peers with regard to child sexual exploitation, on-line grooming and, to

[33] Barnardo's (2011) Puppet on a string: The urgent need to cut children free from sexual exploitation. http://www.barnardos.org.uk/ctf_puppetonastring_report_final.pdf
[34] Department of Health (2014) Child sexual exploitation: health working group report https://www.gov.uk/government/publications/health-working-group-report-on-child-sexual-exploitation

a lesser extent, internet safety. Young people reflected that had they been more knowledgeable they may not have put themselves at risk in the way that they did.[35]

> *"I just think that not many people know what it [Child Sexual Exploitation] is. I thought I knew what it was but when you do this work you realise a lot more."*
> *17 year old female working with REACH team in Devon, 2014*
>
> *"It would definitely be helpful [for other young people] to know more about it [Child Sexual Exploitation]."*
> *16 year old female working with REACH team in Devon, 2014*

Some of the young people participating discussed the subsequent impact of realising what had happened to them once they had completed the work with their REACH worker.

> *"I was at my Nan's house when I read the paper and I just cried my eyes out and I was thinking, how the hell did I go there? I didn't have a clue what he was like. I just think that it is so much risk I was in but I don't know, I didn't even see it… and I didn't think anything of it until now."*
> *17 year old female working with REACH team in Devon, 2014*

On the 7th Jan 2014 Devon had 448 children in care aged 10 and over, 62 (13.84%) of these children were recorded by the police as victims of child sexual exploitation[36]. There is a strong link between young people going missing, 54 of the 62 (87%) young people in care linked to child sexual exploitation have missing episodes recorded by the police.

Sexually exploited young people have a range of vulnerabilities which may be associated with physical and mental health problems. Some vulnerabilities contribute to the exploitation, others arise from it. These include mental health problems, self-harm and suicide attempts, injuries from physical violence, sexual health problems, pregnancy, terminations and drug and alcohol misuse. In particular, children who go missing frequently, are not attending school, and those who live in care are over represented among sexual exploitation victims.

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[35] REACH Team – Reflective Conversations with Young People. Summary Report for Children's Social Work & Child Protection SMT, July 2014. Sophie Ellis – Senior Involvement Officer

[36] Devon & Cornwall Police. Ad Hoc report sent 08/04/14

4.4 Protection from maltreatment

Parental Learning Disability

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). Parents with learning disabilities access parenting courses ran in Children's Centres across Devon[37].

In Devon in 2014 there are an estimated 10,500 adults aged between 18 and 64 with a learning disability of which around 2,350 have a moderate or severe learning disability (Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI), 2012). 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.

An estimated 7% of adults with a learning disability are parents, but most have a mild to borderline impairment, which may make it difficult to identify them as they will not have a formal diagnosis. There are around 3,100 adults with learning disabilities on GP practice learning disability registers in Devon and around 2% of these are parents[38]. 3.6% of families covered by the survey have a parent with identified learning disabilities.

Around 40% of parents with a diagnosed learning disability do not live with their children. The children of parents with a diagnosed learning disability are more likely than any other group of children to be removed from their parents' care. Parents with a learning disability are often affected by poverty, social isolation, stress, mental health problems, low literacy and communication difficulties.

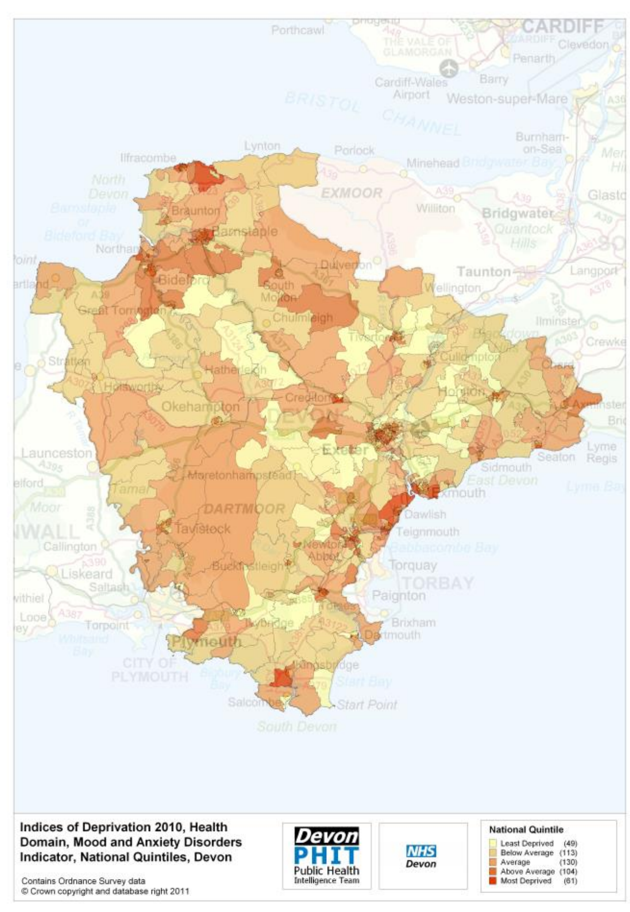
A survey of families supported by a health visitor in Devon (in November 2012) found that 4% of families (157 families) and 318 children and young people (4% of children in the survey), contained one or more parent with a learning difficulty. In 22 of the families both parents in the household had learning difficulties, 53 single parent families were headed by a parent with learning difficulties. This represents learning difficulties rather than disability as it is reported as the professional opinion of the health visitor as a "recognised learning difficulties that required or still require additional educational support" and may not have a formal diagnosis as a learning disability, and/or meet the threshold for support from adult learning disability services.

[37] Early Years and Childcare, Devon County Council
[38] Devon PCT Learning Disability Audit 2009

Parental Mental Health

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, 33,700 persons were registered with depression at their GP practice, and 5,800 persons were registered with a serious mental illness (Quality and Outcomes Framework, 2013). The anxiety and mood disorders indicator from the Indices of Deprivation 2010 shown in figure 18 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 18, Indices of Deprivation 2010, Mood and Anxiety Disorders Indicator, Devon areas in national context



Source: Indices of Deprivation, 2010

Parental Substance Misuse

All child safeguarding enquiries in Devon are referred to the Devon Multi-Agency Safeguarding Hub. Between November 2011 and August 2012, 8,488 enquiries were investigated relating to 6,828 children and 3,936 adults. The number of enquiries revealing, and children affected by, parental substance misuse is shown in the table below, along with the number of parents this involved.

Table 11, Devon Multi-Agency Safeguarding Hub Enquiries relating to Parental Substance Misuse in Devon between November 2011 and August 2012

Risk Factor	When used	Substance	Per Enquiry Form (8488 forms)	Individual Children (6828 children)	Individual Households (3936 households)
Parent	Historical	Drug use	330	267	161
	Historical	Alcohol use	423	343	193
	Current	Drug use	624	510	288
	Current	Alcohol use	793	629	347
Child	Historical	Drug use	31	23	17
	Historical	Alcohol use	32	25	17
	Current	Drug use	97	80	48
	Current	Alcohol use	105	83	51

Source: Devon Substance Misuse Needs Assessment, 2012

Children of parents that misuse substances are more likely to experience a range of negative outcomes and potentially face serious harm at every stage of their life from conception through to adulthood. Children of parents or carers who misuse drugs or alcohol are more likely to develop misuse and / or mental health problems themselves.

The Devon family health needs profile conducted in 2012 required health visitors to record if there were substance misuse issues amongst the parents of the families visited. This would have been either, reported by the parent or shared with the Health Visitor on a ‘need to know’ basis. The survey reached 4,700 households containing 8,238 children (including 48 unborn children). This represents just under 10% of the number of children aged under 5 living in Devon. A total of 341 families (containing 659 children) had 1 or more parents that were recorded as abusing drugs and/or alcohol.

Table 12, Families with using smoking or with problematic drug or alcohol use (Devon Family Needs Survey, 2012)

Need	Number of Families	% of Families	Number of Children	% of Children
Parent(s) abuse* alcohol	215	4.57%	439	5.34%
Parent(s) smoke	982	20.89%	1,949	23.69%
Parent(s) abuse drugs	205	4.36%	367	4.46%

*either binge drinking (6+/8+ unites a day) or increasing and higher risk drinking (35+/50+ units per week)

Source: Devon Family Needs Survey, 2012

Domestic Violence and Abuse

Exposure to domestic violence represents a serious risk. The Children and Adoption Act 2002 broadened the definition of significant harm to include 'any impairment of the child's health or development as a result of witnessing the ill-treatment of another person such as domestic violence'. National research has found that nearly a quarter young people witnessed at least one type of domestic violence during childhood[39]. The research found that

- 12 per cent of under 11s, 17.5 per cent of 11–17s and 23.7 per cent of 18–24s had been exposed to domestic violence between adults in their homes during childhood.
- 3.2 per cent of the under 11s and 2.5 per cent of the 11–17s reported exposure to domestic violence in the past year.

National figures indicate that nearly three quarters of children with a child protection plan live in households where domestic abuse occurs.[40] 624 Devon children and young people were subject to a child protection plan in March 2014 (up from 446 in March 2013). In 2013-14 domestic violence was the most common risk factor identified during social care initial assessments. In sample of 101 plans in March 2010 65% of children with a child protection plan either were at the time, or had previously lived in a household, experiencing domestic violence.

The Police record data on the number of children and young people who were present at reported domestic abuse incidents. Children were at around 40% of domestic abuse incidents although there is variation over time and across the districts. The majority of incidents will not be recorded here as they have not been reported to the police.

Table 13, Number of reported domestic violence and abuse incidents (last 5 years)

Devon	09/10	10/11	11/12	12/13	13/14
Domestic Violence Incidents	9,151	8,798	8,957	9,236	10,334
Domestic Violence Crimes	2,352	2,415	2,728	2,994	3,457
Number of incidents with Children and Young People Present	4,259	3,418	3,649	3,584	3,737
% incidents with Children and Young People present	47%	39%	41%	39%	36%

Source: Devon and Cornwall Police 'Crimed' Domestic Violence Incidents Data record on CIS with Mo Code DV1

Devon specialist domestic violence services supported 226 children and young people in 2012-13 a large increase from 165 clients in 2011-12. 154 children and young people spent time living in a refuge in 2012-13. 73% of the children in the refuge were under the age of 7. Their reporting shows that 96% of children had been exposed to domestic abuse with 54% having been direct victims of abuse themselves[41]. Between April and October 2014 the parents of 807 children and

[39] Radford L, Corral S, Bradley C, Fisher H, Bassett C and Howat N (2010) The Maltreatment and Victimisation of Children in the UK: NSPCC Report on a national survey of young peoples', young adults and caregivers' experiences http://www.nspcc.org.uk/inform/research/findings/child_abuse_neglect_research_PDF_wdf84181.pdf

[40] Confidential Enquiry into Maternal and Child Health (2007)

[41] CAADA Insights outcome measurement: Devon Specialist domestic violence services (2012-13)

young people from 389 families received support from Devon domestic violence and abuse support services (SPLITZ)[42].

In 2013 805 cases, assessed to be at very high risk, were taken to Multi Agency Risk Assessment Conferences (MARACs) in Devon compared to 621 in 2012. 27% of these were repeat attendances. There were 1,009 children and young people associated with these cases in 2013[43].

As of April 2013 the assessment process for children's social care referrals was revised to include risk factors relevant to the assessment, such as domestic violence or parental substance misuse[44]. Analysis is underway to examine the risk factors identified in the initial assessments undertaken in Devon in the first quarter of 2012-13.

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[45]. On both a national[46] and local level (four out of the last seven serious case reviews in Devon found domestic violence as a contributory factor) there is evidence that serious injury or death can occur as a consequence of domestic violence. 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 posttraumatic stress disorder, for example have nightmares and flashbacks, and be easily startled.

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[47].

Sexual Violence and Abuse

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

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[42] CAADA Insights Data reports for SPLITZ for all service types Q1 and Q2 2014-15
[43] CAADA (2014) MARAC Performance Data January 2013 – December 2013
[44] Additional Guidance on the Factors Identified at the End of Assessment Children in Need Census 2013-14
[45] Safeguarding Children Abused through Domestic Violence – Draft for Consultation, August 2009, Devon County Council
[46] Reder P and Duncan S (1999), Lost innocents. A follow-up study of fatal child abuse. London, Routledge.
[47] Devon Domestic and Sexual Violence JSNA, 2011 http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2011/07/JSNA-DVA-and-SV-FINAL-Feb2011.pdf

encouraging them to behave in sexually inappropriate ways. National estimates suggest that 16% of children aged under 16 experience sexual abuse during childhood which would equate to roughly 20,000 children in Devon. Of those children in care in Devon at 31 March 2014 6.1% were recorded under the abuse category of sexual abuse[48]. It is likely that a proportion of those in the other need categories have an element of sexual abuse.

National evidence from Rape Crisis suggests that only 10% of rape and serious sexual assault cases are reported to the police. Whilst this figure reflects reporting in adults it is reasonable to assume that sexual offences against young people are under reported to the police to a large degree.

Reported sexual violence has been increasing over the last 5 years in both adults and children. In 2013/14 there were 332 reported incidents of sexual violence against young people aged under 18 compared to 285 in 2012/13. Young women are far more likely to report being victims of sexual violence than young men.

Table 14, Sexual Offences reported to the police with a recorded age of 17 or under (2009/10 to 2013/14)

		Gender		
		Female	Male	Total by Financial Year
Financial Year Entered	2009/10	229	31	260
	2010/11	250	28	278
	2011/12	259	51	310
	2012/13	241	44	285
	2013/14	278	54	332
	Total by Gender	1,257	208	1,465

Source: Devon and Cornwall Police Forces Crime Information System (CIS) as at 7 April 2014

[48] Devon child protection and private fostering management information report 2011-12Q4

Figure 19, Sexual Offences reported to the police with a recorded age of 17 or under (2009/10 to 2013/14)

Source: Devon and Cornwall Police Forces Crime Information System (CIS) as at 7 April 2014

The Devon and Torbay Sexual Assault Referral Centre (SARC) is now established and is providing clinical and emotional support for adult and child victims of rape and sexual assault. 411 clients were supported by the SARC in Exeter in 2012-13, of these 176 clients (43%) were children.

There is reliable evidence that being a victim of sexual violence or abuse leads to mental health problems including depression, post-traumatic stress disorder (PTSD) or other mental health conditions.

Female Genital Mutilation (FGM)

Female Genital Mutilation/Cutting involves partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It is a grave violation of the human rights of girls and women to life and their right to health. This is a crime in the UK[49] even if the person is taken overseas for the mutilation. It is also sometimes known as female circumcision or 'sunna'.

The procedure is traditionally carried out by an older woman with no medical training. The procedure can have significant long and short term health implications (including immediate fatal haemorrhaging, severe pain and shock, urine retention, infections, sexual dysfunction and complications in pregnancy and child birth). In addition to these health consequences, there are considerable psycho-sexual, psychological and social consequences of FGM.

[49] The UK Government has signed a number of international human rights laws against FGM, including the Convention on the Rights of the Child. The law relating to female genital mutilation was amended by the introduction of the Female Genital Mutilation Act 2003, which came into effect in March 2004. This repealed and replaced the Prohibition of Female Circumcision Act 1985.

The number of women and girls in Devon who are victims of, or at risk of, female genital mutilation is unknown. The health and social care information centre has introduced reporting for FGM from acute hospital providers from September 2014. The first monthly report identified 1,746 women and girls in England who had been victims of FGM and had used acute hospital services during that month (for any medical condition not limited conditions relating to FGM).

Neglect

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.

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 Black and Minority Ethnic (BME) communities where a lack of cultural understanding may be a barrier to identification.

Both nationally and in Devon neglect is the most common reason for children to be taken into Local Authority Care. Of the 497 children starting care in Devon in 2013/14 58% of those cases were for abuse or neglect. Of the 600 children subject to a child protection plan at 31st March 2014 36% of children were recorded under the abuse category of "neglect", with a further 43% recorded under "emotional" abuse.

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.

Neglect is a background factor in the majority of serious case reviews nationally (60%), and for children of all ages not just the younger children. Although neglect is uncommon as a primary cause of death in children, it is a notable feature in the majority of deaths related to but not directly caused by maltreatment, including sudden unexpected death in infancy (SUDI) and suicide, and in over a quarter of homicides and fatal physical assaults. Neglect was the primary reason for undertaking a serious case review in 11% of the non-fatal cases, but also featured in 58% of other non-fatal cases, including physical abuse and sexual abuse[50].

[50] Brandon, M. et al (2012) New learning from serious case reviews: a two year report for 2009-2011 (PDF). London: Department for Education.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184053/DFE-RR226_Report.pdf

4.5 Ensuring safe and effective care

Multi-Agency Safeguarding Hub (MASH)

The MASH is the single point of contact for enquiries regarding children where there are safeguarding concerns in Devon which may require a multi-agency response or social care services. The aim of the MASH is to share partnership information at the earliest point of a concern being identified. The MASH has representation from children's Social Care, Devon and Cornwall Constabulary, local Health services, Education services, Devon and Cornwall Probation Trust, Devon Youth Offending Service, Domestic Violence Services, Early Years and Families' services and Children and Family Court Advisory and Support Service (CAFCASS).

A total of 14,664 enquiries relating to 11,734 children[51] were made to the MASH during 2013/14. Over 50% of all enquires came from schools, Police and family members / carers or relatives. For MASH enquiries received during March 2014 the most frequently identified risk factors were adult historical / current domestic violence (identified in 17% of MASH enquiries)[52].

Children Referred to Social Services - Children in Need

During 2013/14 there were 8,717 Children In Need referrals, of which 162 (2%) resulted in no further action[53]. This represents a 54% increase in referrals from 2012/13 (5,648 referrals).

As at 31st March 2014 there were 5,741 Children in Need in Devon[54], an increase of 23.5% from the previous year (4,648 children)[55], this number includes Children in Care and Children with a Child Protection Plan. Provisional reporting for the 2014/15 financial year indicates this trend has stabilised and the number of children in need is starting to fall.

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[51] MASH Enquiries, 2013/14 - *Subject to final validation*
[52] MASH Enquiries, March 2014
[53] DfE Children In Need Census 2013/14 - *Subject to final validation*
[54] DfE Children In Need Census 2013/14 - *Subject to final validation*
[55] DfE Children In Need Census 2012/13

Figure 20, Children In Need - rate per 10,000 children aged under 18

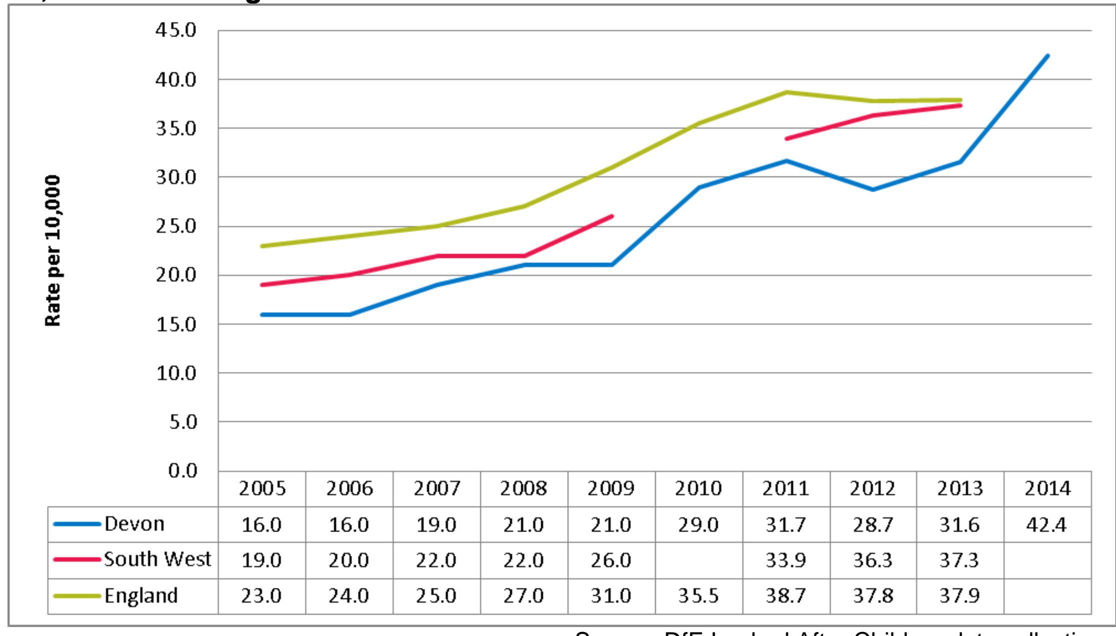
	2010	2011	2012	2013	2014
Devon	300.5	302.3	316.7	329.2	405.6
South West		320.0	313.0	327.2	
England	341.3	346.2	325.7	332.2	

Source: DfE Children in Need data collections

Children subject to a Child Protection Plan

As at 31st March 2014 there were 600 Children with a Child Protection Plan in Devon[56], a significant increase (34.5%) from 446 children the previous year, which was in turn an increase from 404 children at 31st March 2012. Child Protection Plan numbers have therefore risen by 48.5% over two years. Provisional reporting for the 2014/15 financial year indicates this trend has stabilised and the number of children subject to a child protection plan is starting to fall.

Figure 21, Children who are the subject of a Child Protection Plan - rate per 10,000 children aged under 18



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Devon	16.0	16.0	19.0	21.0	21.0	29.0	31.7	28.7	31.6	42.4
South West	19.0	20.0	22.0	22.0	26.0		33.9	36.3	37.3	
England	23.0	24.0	25.0	27.0	31.0	35.5	38.7	37.8	37.9	

Source: DfE Looked After Children data collections

56 DfE Children In Need Census 2013/14 - *Subject to final validation*

Of the 600 children subject to a child protection plan at 31st March 2014 36% of children were recorded under the abuse category of "neglect", with a further 43% recorded under "emotional" abuse. These were also the top two abuse categories nationally for 2012/13 but in reverse order with 42% recorded under “neglect” and 34% under “emotional” abuse.

Privately fostered children

A private fostering arrangement is essentially one that is made privately (without the involvement of a local authority) for the care of a child under the age of 16 (under 18 if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more.

The reasons for children being in private fostering arrangements are varied and include:

- Local children and young people under the age of 16 (18 if disabled) living apart from their families due to family breakdown
- Children studying at language schools or sports colleges
- Children with parents overseas
- Children on holiday exchanges

There is a legal requirement for parents and private foster carers to notify the local authority about a proposed private fostering arrangement six weeks before the arrangement is made. Local authorities must ensure that the welfare of children who are, or will be, privately fostered in their area is being, or will be, satisfactorily safeguarded and promoted and it is the local authority in whose area the privately fostered child resides that has legal duties in respect of the child not their home authority.

Despite the requirement to register, 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. It is estimated that between 10,000 and 20,000 children nationally may be living in private fostering arrangement (Philpot, 2001, A Very Private Practice - an investigation into private fostering).

Devon has the highest level of private fostering in the country (with the exception of Torbay), this is largely due to the high levels of summer schools and language schools for non-Devon residents. In Devon there were 186 notifications of new private fostering arrangements received in 2013/14[57], a slight decrease of 6% from 197 in 2012-13. Still more young people are in informal unregistered private fostering arrangements in Devon, the number of which is unknown. The number of young people in unregistered informal private fostering, which represents a much higher level of safeguarding risk, such as sofa surfing or staying with relatives, is much less visible to the authority.

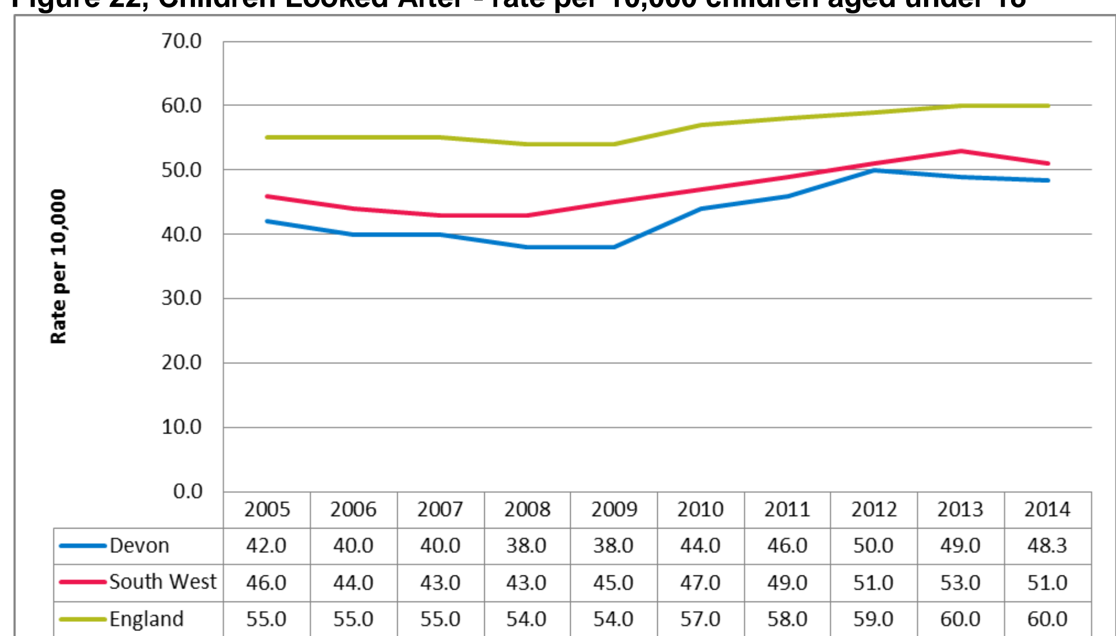
[57] Children’s Social Care Scorecard 2013-14 Q4 - *Provisional*

Children in Care

Children in care are amongst the most vulnerable in our society. They have often experienced abuse, neglect or trauma. They often require support from a range of agencies.

684 children were in the care of Devon County Council at 31st March 2014, the 2013-14 reporting year-end[58]. This is a slight decrease (1.3%) from 693 children a year previously, which was in turn a decline from 711 children at 31 March 2012. Numbers of children in care have therefore fallen by 3.8% over two years. Boys are more likely to be in care than girls. 58% of young people in care are male compared to 51% of the general population.

Figure 22, Children Looked After - rate per 10,000 children aged under 18



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Devon	42.0	40.0	40.0	38.0	38.0	44.0	46.0	50.0	49.0	48.3
South West	46.0	44.0	43.0	43.0	45.0	47.0	49.0	51.0	53.0	51.0
England	55.0	55.0	55.0	54.0	54.0	57.0	58.0	59.0	60.0	60.0

Source: DfE Looked After Children data collections

Although there has been a decrease in the number of children in care in Devon in 2014, it still represents a 27% increase in numbers since 2009. Nationally the numbers of children in care have also risen, but only by 12% (2009-2013). Despite this rise the rate of children in care in Devon for 2014 is 48.3 per 10,000 children aged under 18, significantly lower than the England average rate of 60 per 10,000 for 2014, and below the South West rate of 51 per 10,000 for 2014.

Devon continues to have a population of children in care that is older than the national average, as at 31st March 2014 64.8% of children in care were aged 10-17 in Devon compared to 56.1% nationally (31st March 2013). Following the Southwark Judgement, which states that where appropriate local authorities have a responsibility to accommodate homeless young people assessed to be in need or who choose to become accommodated, Devon saw a doubling of the number of 16-17 year olds in care; there were 220 16-17 year olds in care in 2012, up from 112 in 2008. By contrast England only saw an increase of 12% in the 16-17 year old age group. The figures demonstrate that the Southwark Judgement has had a far greater

[58] DfE Looked After Children Return 2013/14 - *Subject to final validation*

impact on children in care numbers locally than for England as a whole. This may however be as a result of Devon's strict interpretation of the Southwark Judgement in comparison to other local authorities.

A lack of continuity of care and placement stability can have a detrimental impact on the health and wellbeing of young people. 13.7% of children in care had three or more separate placements during the year to 31st March 2014. Older children are less likely to have stable placements. Amongst children in care aged 16-17 at 31st March 2014, 20.8% had three or more placements, compared with 10.8% of children aged 0-15.

"I want to stay here… [my foster carer] is my Mummy… I don't want a new Mummy and Daddy 'cos I want to stay here."
5 year old female, Placement Order granted

To maintain links with their family and community most children are placed near to their home address. The average placement distance at 31st March 2014 was 22.9 miles from the home address on entry to care. 36% of children were placed less than five miles' distant and 51% overall placed less than 10 miles' distant.

"When mum is OK I would like to see her more."
10 year old female, Full Care Order

"I would like to see Nanny and Grandad more."
11 year old female, Full Care Order

Of the 497 children who started to be looked after during the year ending 31st March 2014 58% came under the category of need of abuse or neglect, this is in line with the overall England rate of 56% for the 2012/13 reporting year.

Out of County Placements

Out of County placements are children and young people who are in the care of Devon County Council but who are placed away from Devon. These children are amongst the most vulnerable, and may be at additional risk to those who are living close to home.

As at 31st March 2014 15.4% of children in care with Devon were placed out of county (105 children)[59]. This is a slight increase on the previous year when 13.7% of children were placed out of county (31st March 2013), but is below the South West average of 25.5% of children placed out of county (31st March 2013).

There are a number of risks and challenges to placing out of county including:

- Children placed out of county are no longer part of their network and home environment. They will be separated from their parents, siblings, friends, school, extended family and the place they have grown up. They may feel isolated and lose a sense of belonging.

[59] DfE Looked After Children Return 2013/14 - *Subject to final validation*

- Control with social workers and other staff will be more limited as ad-hoc or unplanned visits cannot be managed in line with local placements. It is not as easy to monitor the quality of placements when they are at some distance.
- Social workers will be unfamiliar with local resources. This is particularly risking for the provision of specialist services such as mental health or child sexual exploitation; and for the provision of care leavers support such as housing.
- If there are safeguarding concerns it may not be as easy to get full information about the concerns and to visit quickly to ensure a child is safe.

Some of the outcomes for children in out of county placements are very positive. For some children it is not possible to replicate the same specialist packages in Devon such as inpatient mental health or special placement for severe learning disabilities. Kinship placements are sometimes out of the county boundary but it is accepted that these placements are better for children and are often more successful in the long term. Young people often stay on longer with their friends and family placements beyond 18.

Young people may actually be safer placed away from their local area. This could be for reasons of sexual exploitation or involvement in drug and crime related activity; it maybe that their families are uncooperative and represent a risk to the young person.

Children from other authorities

There are looked after children who are placed in Devon but are under the responsibility of another local authority, 521 as of March 2014 (an increase from 202 as 31st March 2012). However, DCC is not always notified of placements by other local authorities and therefore the numbers may be much higher. Far less information is available in relation to the needs of these young people as all care records are held by the placing authority.

Homelessness

Table 15, Youth homelessness presentations to District Councils during 2013-14

	Youth Homelessness Presentations 2013-14				
District	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
East Devon	5	13	7	7	32
Exeter	15	18	26	30	89
Mid Devon	7	11	3	8	29
North Devon	29	26	29	28	112
South Hams	1	3	1	2	7
Teignbridge	23	17	9	16	65
Torridge	17	16	15	17	65
West Devon	0	9	3	4	16
Devon	97	113	93	112	415

Source: District Council Youth Homelessness Presentations

People who are homeless may be sleeping rough but it is more likely they are living where they may not have any right to stay, or their home may be unsuitable to live in. Children and young people may experience homelessness as individuals or along with their family.

Although the reasons for becoming homeless differ between each person, there are common factors such as family breakdown, domestic violence, mental and physical health problems, substance misuse and poverty.

4.6 Complex and Multiple Needs

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.

A survey of 4,136 families under the care of health visiting teams in Devon with children under the age of 5 identified that 30% (1,275) of families had more than four needs and of these 514 had more than 8 needs (12% of the total), meaning that these families were living with a wide variety of complex and varied needs that would impact negatively on their ability to parent successfully.

National policy recognises that multiple needs within families can compound and exacerbate their difficulties and subsequent cost to services. The Troubled Families Programme (TFS) is a major focus in the government's approach to social justice and to reducing public sector costs. Phase 1 of the programme, now in its third and final year, aims to turn around the lives of 120,000 'Troubled Families', which equates to a cohort of 1,370 in Devon, who have multi risk factors. It focuses on those families where:

- no adult in the family is working
- children are not in school
- family members are involved in crime and anti-social behaviour
- there is 'high cost' to the system

Within Devon there is a long tradition of seasonal or under employment. This contributes to the cycle of deprivation or poverty in disadvantaged communities but is often not reflected in National policy as that tends to focus on those completely out of work. Attributing the national criteria to the need profile in Devon has been challenging as a result. Negotiations with the Department of Communities and Local Government who are charged with overseeing the programme has led to the following criteria for risk categories in Devon being developed:

1. Youth Crime and Anti-social Behaviour (mandated)
Under 18 in the household that has offended in the last 12 months OR A member of the household has received a second letter from a Community Safety Partnership in last 12 months regarding anti-social behaviour (ASB) (or equivalent status as assessed by a Provider of social housing). There are 3,032 individuals in the County that meet this individual criteria. There are 1,666 individuals in 1,194 families cumulatively identified that meet this and at least one other TFS mandatory criteria and are therefore part of our TFS Cohort (June 2014).

2. Education (mandated)
Child in household has been subject or permanent or 3 year fixed term exclusions in last school year OR at any point in the last school year child in household has been in receipt of Personalised Learning Service service after previous exclusion OR child

missing education in household that is currently subject to education welfare officer referral OR under 17 in household had an unauthorised absence rate of >15% in last school year. There are 3,334 individuals in the County that meet this individual criteria. There are 1,449 individuals in 1,177 families cumulatively identified that meet this and at least one other TFS mandatory criteria and are therefore part of our TFS cohort (June 2014).

3. An adult in the household is currently in receipt of ‘out of work’ benefits
There are 1,611 individuals in 1,239 families cumulatively identified that meet this and at least one other TFS mandatory criteria and are therefore part of our TFS cohort (June 2014).

4. Child at Risk (local discretion)
Local authorities and partners have flexibility in including families who have two out of three of the criteria of a ‘Troubled Family’ and other more locally identified needs where they would benefit from a different service response. For Devon these include a child in the household with a social care classification of ‘in need’, offenders on probation, mental health issues (adult, child or young person), substance misuse, where a Common Assessment Framework or Devon Assessment Framework has been opened in the last 12 months, families with unstable housing, persistent absence at school, and failure to take up early years educational entitlements amongst others.

5. Conclusion

It is intended that this report will be used as the evidence base to inform the work of the DSCB and organisational commissioning plans.

Appendix 1. Devon's Younger Population by Ethnic Group

Ethnic Group	All Ages	Age 0 to 19	Age 0 to 4	Age 5 to 7	Age 8 to 9	Age 10 to 14	Age 15	Age 16 to 17	Age 18 to 19
All categories: Ethnic group	746,399	159,737	37,479	22,022	14,310	40,518	8,845	17,586	18,977
White: Total	728,073	153,428	35,789	21,196	13,826	39,242	8,587	16,992	17,796
White: English/Welsh/Scottish/Northern Irish/British	708,590	150,311	34,843	20,787	13,564	38,635	8,446	16,722	17,314
White: Irish	3,130	252	33	25	33	62	17	28	54
White: Gypsy or Irish Traveller	554	150	37	19	10	39	9	16	20
White: Other White	15,799	2,715	876	365	219	506	115	226	408
Mixed/multiple ethnic group: Total	6,520	3,246	985	492	274	756	144	257	338
Mixed/multiple ethnic group: White and Black Caribbean	1,750	834	207	116	75	213	45	84	94
Mixed/multiple ethnic group: White and Black African	787	479	178	95	35	87	21	35	28
Mixed/multiple ethnic group: White and Asian	2,429	1,253	381	187	119	286	53	93	134
Mixed/multiple ethnic group: Other Mixed	1,554	680	219	94	45	170	25	45	82
Asian/Asian British: Total	8,710	2,400	528	252	153	396	92	268	711
Asian/Asian British: Indian	1,873	542	203	78	39	71	12	19	120
Asian/Asian British: Pakistani	280	58	15	10	2	7	0	3	21
Asian/Asian British: Bangladeshi	570	198	57	27	24	48	6	17	19
Asian/Asian British: Chinese	3,195	896	63	50	32	120	50	161	420
Asian/Asian British: Other Asian	2,792	706	190	87	56	150	24	68	131
Black/African/Caribbean/Black British: Total	1,413	292	59	27	16	64	17	38	71
Black/African/Caribbean/Black British: African	845	223	48	23	11	45	11	28	57
Black/African/Caribbean/Black British: Caribbean	421	41	1	3	3	15	4	5	10
Black/African/Caribbean/Black British: Other Black	147	28	10	1	2	4	2	5	4
Other ethnic group: Total	1,683	371	118	55	41	60	5	31	61
Other ethnic group: Arab	913	230	73	38	30	27	3	15	44
Other ethnic group: Any other ethnic group	770	141	45	17	11	33	2	16	17

Source: 2011 Census, Table DC2101EW - Ethnic group by sex by age (www.nomisweb.co.uk). In order to protect against disclosure of personal information, records have been swapped between different geographic areas. Some counts will be affected, particularly small counts at the lowest geographies.