What did we learn.... What have we done?

Child Sexual Exploitation (CSE) has been a key feature of Warwickshire’s learning activity over recent months, the new face to face sessions have been rolling out since January 2015 and recent figures show that across Warwickshire in excess of 1000 professionals have received some form of CSE training either through the e-learning programme, face to face multi-agency sessions or through single agency briefing sessions.

The data profile of CSE held by the police provides some encouraging detail in relation to CSE activity. The most recent figures show an increase in the amount of activity being detected and investigated. In 2012 there were just 3 recorded incidents of which CSE was considered to be an element, in 2015 (Jan – June) there have been a total of 434 incidents recorded across the policing alliance (Warwickshire and West Mercia) and this year alone 10 arrests have been made and 7 abduction notices issued. A high proportion of CSE victims in Warwickshire have high instances of missing, Warwickshire have a fairly unique service in response to this having located the missing service with the CSE multi-agency team in Leamington Justice Centre.

Child Sexual Exploitation has been a recent focus of a local case review in Warwickshire. The review highlighted a number of considerations for Warwickshire’s LSCB partnerships, specifically concerning the appropriate placement of young people from ‘distant authorities’ in Warwickshire. It notably
highlighted some inconsistencies in information sharing and communication between police services in the region and identified similar difficulties with CCG’s (Clinical Commissioning Groups) in responsible authorities and Warwickshire as the host authority.

WSCB continue to drive the CSE strategy forward and have commissioned Alter Ego Creative Solutions to deliver the performance of Chelsea’s Choice to all Yr8 pupils across 33 high schools in Warwickshire. “‘Chelsea's Choice’ is a hard-hitting Applied Theatre Production that has proven highly successful in raising awareness of the issues surrounding Child Sexual Exploitation. The play, which has now been seen by hundreds of professionals and over 300,000 young people throughout the UK, is followed by a Q&A/plenary session exploring the issues raised.

The play tells the story of a group of three students who discover the diary of a girl called Chelsea. Chelsea was a young girl who, having fallen out with her friends and family, was approached by a man called Gary. Gary was older, owned a car, had a flat and treated her like an adult. Unfortunately Gary was not what he seemed to be! Chelsea's story is played out and examined by the three students who, along with their teacher, attempt to understand what happened to Chelsea and how it could have been prevented” (http://www.alteregocreativesolutions.co.uk/chelseas-choice/).

On October 13th 2015 Warwickshire published a serious case review following the death of ‘John’ a ten-week old baby in September 2013. Johns’ mother and some extended family members of John have contributed to the review process and despite their deeply saddening circumstances have given support to the review being published so the learning can be shared widely amongst multi-agencies. John, a premature infant, died unexpectedly on the first night his family were staying with extended family after being evicted from their social housing tenancy. John died after he was brought downstairs for a feed and then slept on the sofa with a parent. When the parent woke John had died. The coroner recorded an open verdict on the death. Although John did not die as a result of maltreatment, WSCB carried out a review because his circumstances and contact with agencies as a ‘child in need’ met the criteria for a Serious Case Review.

A number of agencies were in contact with the family and, although child protection issues were not a causable factor in John’s death, WSCB felt that there was important learning for all agencies from this case. Independent reviewers Joanna Nicolas and Deborah Jeremiah were commissioned for the review, and identified five key findings with subsequent actions for both single and multi-agencies. The headline
feedback from the reviewers noted that multi-agencies working with the family had not fully understood the issues at the heart of the case and could have done more to mitigate the impact of the family’s’ eviction.

Sadly, the learning from this review echo similar findings of a recent serious case review of Child A (part one), where there is evidence to support professional curiosity and respectful uncertainty are not embedded within multi-agency practice.

WSCB have responded to the learning and have begun implementing change within single and multi-agency practices. These include:

1. The housing association now holds an internal case conference including all officers involved with a family before eviction to ensure all information is considered and if eviction is progressed that a referral is made to children’s services.
2. Training has been developed to ensure professionals making referrals and duty social workers share a better understanding and jointly make decisions so that people receive the right level of help for their needs
3. The Safeguarding Board will clarify the role of the lead professional during an assessment
4. Additional police officers have been trained in responding to unexpected child deaths
5. The multi-agency safeguarding hub (MASH), which is being developed, will support comprehensive information sharing at the point of referral and will go live on 1st May 2016.
6. New paediatricians appointed in Warwickshire are now contracted to be trained to respond to unexpected child deaths

Child Death Overview Panels (CDOP) were introduced by the government in April 2008 to review the deaths of all children aged 0-17 years, irrespective of how they died, in order to identify any learning or wider public health issues which may prevent future child deaths. The responsibility lies with Warwickshire Safeguarding Children Board (WSCB) and Warwickshire CDOP is one of the sub-committees of WSCB. Warwickshire CDOP works closely with Coventry and Solihull CDOPs by aggregating data to identify trends and themes and to share learning arising from all three CDOPS.

The following are examples of learning arising from reviews:

**Deaths due to Sudden Infant death Syndrome (SIDS)** (also referred to as cot death) – Warwickshire CDOP has reviewed 17 deaths to date attributed to SIDS. Modifiable and contributable risk factors were identified in 15 of the deaths such as placing baby in an unsafe sleeping position, i.e. on their side or front instead of on their backs, or baby sleeping in an unsafe sleeping environment, i.e. co-sleeping with an adult in an adult bed or sofa with a parent or parents who are smokers, or have consumed alcohol or taken drugs. This figure was also replicated in Coventry with the same risk factors identified. What is important to note is that in several of the cases reviewed the parent did not intend to co-sleep with the baby but fell asleep with the baby whilst giving a night feed.

In order to promote safer sleeping advice, Warwickshire conducted a ‘Sleep Safe!’ campaign in 2010 where all parents of new-born babies in Warwickshire were given a ‘goody bag’ containing merchandise displaying
safe sleeping advice. The campaign lasted for over a year and Health Visitors continue to give parents a room thermometer with safe sleeping advice, which was part of the original goody bag.

In later reviews CDOP found that parents acknowledged receiving safe sleeping advice and the goody bag but chose not to follow the advice. In view of this a SIDS Risk Assessment Tool has been developed for Community Midwives and Health Visitors to use when conducting their first home visit. If any risks are identified a plan is agreed with parent(s) to minimise the risks. It also asks the health professional to conduct a physical check of where baby is sleeping as previous reviews have identified that where parents say baby is sleeping is not always the case. The assessment will be part of the child’s ‘red book’ so other agencies who have contact with parent(s) e.g. Children’s Services, Children Centre staff, will be aware of any risks identified and can reinforce safe sleeping messages. The assessment will be in the red book by early 2015.

**Accidental asphyxiation from objects suspended from bunk type beds** -
There have been 4 deaths reviewed across the sub-region (2 in Warwickshire) where children aged between 15 months and 13 years have become entangled with objects suspended from a bunk bed. In one case this was alerted to the manufacturers who changed the design of the bed. This information was shared with Early Years practitioners and with schools to warn parents and carers of the dangers.

**Support provided by schools** -
Information is routinely requested from schools in relation to the child that has died and also on the welfare of school age siblings. It is evident from the information received that schools are in an excellent position to provide support to parents and siblings following a bereavement. There have been a couple of occasions when schools have not been aware that a sibling of a pupil has died and would have benefitted in knowing to ensure support for the sibling. Although it is acknowledged that it is parental choice to share information, it has been suggested to paediatricians caring for chronically ill children or children with life limiting conditions to have a discussion with parents about informing schools.

**Neonatal deaths** -
The highest category of deaths reviewed is neonatal deaths, i.e. those less than 28 days old, very often born prematurely and never leave hospital. In recent years modifiable and contributable factors identified have related to maternal lifestyle factors, i.e. maternal smoking during pregnancy, a raised BMI (body mass index), alcohol or drug misuse during pregnancy where there is evidence based research to link these lifestyle factors with mothers going into premature labour. CDOPs will ensure that expectant mothers have been referred to appropriate support groups such as smoking cessation and healthy eating programmes as part of their antenatal care and is aware of ongoing Public Health campaigns but the messages and indeed the risks need to be reinforced to expectant mothers at every opportunity.