CUMBRIA LSCB
CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD


# Learning from Serious Case Reviews – Child AC

This short briefing summarises the findings and lessons from a Serious Case Review (SCR) into the death of Child AC in Cumbria in 2015 – the SCR focusses specifically on how agencies worked together and individually from the middle of 2014 to the middle of 2015.

A Serious Case Review takes place "where abuse of a child is known or suspected; and either - (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child".

If you work with children and families in Cumbria, there may be additional specific actions and recommendations for your agency and your role. Please ask your manager, or contact your representative on the Cumbria Local Safeguarding Children Board, to find out more. You can read the full report at www.cumbriaLSCB.com

**Child AC's story**

Child AC was killed by 3 other youths in June 2015 aged 14 years. Child AC was permanently excluded from school in July 2014 and attended the Pupil Referral Unit (PRU) where his attendance was poor. Child AC had a history of offending, first coming to the attention of the Criminal Justice System in August 2011. He attended a secure centre in November 2014 where he served two months. Upon release he was made subject to a Detention and Training Order on a licence with supervision.

Following allegations against an elder sibling, Child AC and his siblings, were made subject to a Child Protection Plan in January 2015. In April 2015, the younger two siblings were stepped down to a Child in Need Plan and Child AC remained on a CP Plan. His behaviour further deteriorated and there remained problems with attendance at the PRU and he was engaging in low-level criminal behaviour with episodes of him going missing overnight and a refusal to engage with professionals. The perpetrators of his murder, were tried, found guilty and are currently serving their sentences.

## THEME 1: Working with Children and Young People in secure settings

**Finding 1**

In the case of Child AC the planning at the start of custodial sentence and for discharge did not involve agencies who had been involved with Child AC and his family; therefore they could not contribute to the planning for his resettlement when he came home.

**Lesson to be learned**

Professionals, who are involved with a child or young person who is detained in a secure unit, should ensure their continued participation in planning, especially as the child or young person approaches resettlement.

### Do you ensure that planning for resettlement is multi-agency and results in effective transition for the Young Person?

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**THEME 2: Working with young people and their families who do not engage**

**Finding 2**
In this case of Child AC there was an increase in Child AC's risk taking behaviour and this was not robustly challenged as there was professional optimism about the family's capacity to change without further intervention.

**Lesson to be learned**
Professionals need to remain focussed on the needs of the children - when working with families who appear to engage with support, or engage well, but there is little evidence of progress and, with other agencies may need to consider an escalation in intervention.

**Are you familiar with the LSCB Working With Uncooperative Families – Disguised Compliance Procedure?**

**THEME 3: Working with Children and Young People who misuse substances**

**Finding 3**
In the case of Child AC there was intelligence to say that Child AC was using Cannabis, however there is no evidence that the risks associated with this, alongside other vulnerabilities were considered holistically in the assessments for Child AC.

**Lesson to be learned**
Professionals, who work with children and young people, where there is suspicion of substance misuse, must use this information when considering risk.

**As a practitioner do you take into consideration suspicions of substance misuse when undertaking a risk assessment?**

**As a practitioner do you escalate appropriately any concerns you have regarding a young persons suspected substance misuse?**

**Sharing learning from serious case reviews in order to improve safeguarding practice is vital. We use the recommendations from case reviews to improve safeguarding of children & young people.**

If you would like to discuss this briefing or any of its contents then please speak to your line manager, your representative on the LSCB or contact the LSCB Office. 1st Floor - Lower Gaol Yard, The Courts, Carlisle, Cumbria, CA3 8NA Email LSCB@cumbria.gov.uk

The LSCB will conduct a number of workshops and a conference to raise the profile of the lessons in this and the other SCR being published

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**The report identified the following additional lessons:**

A. Agencies with a responsibility for working with children who are placed in another area need to consider how they communicate and share information with organisations outside of their usual local partnerships or networks.

B. Agencies that hold a rich mix of information on children should consider how they can store that information in a format that can be shared effectively when there is an appropriate requirement.

C. Where a child is subject of more than one statutory plan, it is important that the managers of each plan ensure there is effective coordination between each other and that the identified risks are being managed effectively.

D. Professionals working with children who display non-compliance or passive avoidance should consider what incentive measures they may need in place to secure more effective engagement.

E. Where children are placed in residential or secure centres a large distance from their homes consideration should be given to using communication technology to maximise agency engagement at meetings.

F. Agencies working with children who demonstrate risk-taking behaviour should challenge themselves to consider the possible longer term consequences in respect of the risk-taking behaviour that is being displayed and how that behaviour may be managed.

G. Agencies engaging with families should give consideration to the local context in which the family is operating and the wider span of influences that may be impacting on the children.

**Single agencies will respond to these lessons and the LSCB will receive assurances that these are being implemented.**