CUMBRIA LSCB

CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

Child R

Serious Case Review

Into the Death of Child R

18 July 2016

NB To be read alongside the Cumbria LSCB

Response Document

Independent Author and Lead Reviewer

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1. Introduction

1.1 The subject of this Serious Case Review (hereafter referred to as a SCR) is Child R who died at home, aged thirteen, in October 2014, whilst in the care of his father, FR.

1.2 Child R's school reported that he could sometimes be anxious and timid but was also a humorous and popular student who had a supportive circle of friends.

1.3 The cause of Child R's tragic and untimely death was morphine poisoning, after being given a morphine tablet by his father who mistakenly believed it to be a suitable painkiller for his son's headache.

1.4 FR was arrested by the Cumbria Police and subsequently charged with the manslaughter of his son. He stood trial in 2015 when he pleaded guilty to the charge and received a four year custodial sentence.

1.5 Child R's parents, FR and his mother, MR, separated after only a few months, following their son's birth in 2001. Child R stayed with his mother until the age of three when he went to live with his father who eventually obtained a residence order in 2009. Child R remained in contact with his mother with whom, initially, he had court defined, supervised contact; which was subsequently varied to unsupervised contact three times a week.

1.6 Following Child R's death the Chair of the Cumbria Safeguarding Children Board decided in November 2014 to hold a SCR. It was determined that the grounds for holding a SCR as set out in Government guidance in 'Working Together to Safeguard Children'(2013)[1] were met, namely that:

> "Abuse or neglect of a child is known or suspected; and ……the child has died" (page 68, from Regulation 5 of the Local Safeguarding Children Boards' Regulation, 2006)

[1] Since superseded in March 2015 by the current edition of 'Working Together'

2. Purpose of the SCR

2.1 The overall purpose of a SCR is to undertake a rigorous, objective analysis that will:

- "Look at what happened in a case, and why, and what action will be taken to learn from the review findings
- Action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm
- There is transparency about the issues arising from individual cases and actions which organisations are taking in response to them
- Including sharing the final reports of Serious Case Reviews (SCRs) with the public".

(Working Together to Safeguard Children (2013), Chapter 4, paragraphs 1 and 4, page 65)

3. Terms of Reference (ToR)

3.1 The SCR and Overview Report have been undertaken in relation to the following agreed ToR.

A. To consider transition arrangements for Child R from Junior School to Secondary School. Were effective plans/arrangements in place?

B. To consider the effectiveness, or otherwise, of Child R's attendance plan implemented by his Secondary School (SS1).

C. To review the health needs of Child R – including non-attendance at appointments, asthma management, behaviours and whether neglect/emotional issues were considered.

D. To consider the voice of the child – was the case mainly adult led? How visible was Child R?

E. To consider the social needs of Child R, including family environment.

F. To consider domestic violence and substance misuse issues and review whether mental health needs were taken into account and whether the impact of these issues in the family were considered to have had an impact on Child R's needs.

G. To identify any learning or development opportunities within the chronology timeframe and from contextual information within the family. The timeframe for the SCR is the September 2011 – October 2014: namely from the beginning of Child R's last year at his Primary School (PS1) to his death.

4. Methodology

4.1 The SCR was conducted by:

- Identifying a set of seven Terms of Reference.
- Collating a composite chronology of agencies' involvement with Child R and his family.
- Identifying a set of Key Practice Episodes[23] from the composite chronology that was analysed at the 'Learning event'.
- Holding a 'Learning event',[4] on the 03.06.15 that aimed to further explore and analyse the Terms of Reference and Key Practice Episodes with the relevant practitioners[5] in order to understand why decisions were made and actions taken from the perspective of the practitioners at the time.
- The Learning event included the lead reviewer, the SCR Panel Chair and the Senior Manager of the Cumbria Safeguarding Children Board.

4.2 The Learning Event was facilitated by the Lead Reviewer using the, '5 Whys' and the Cause and Effect/ Fishbone', analytical techniques in an attempt to understand from a systems perspective why and how decisions and actions were made within the context of prevailing organisational and agency practices and expectations of the time. The Expert Panel and Lead Reviewer were mindful of hindsight and outcome bias in conducting the analysis.

5. Independence

5.1 The Lead Reviewer was Mr Paul Sharkey (MPA)6 who has wide experience of both writing and chairing Serious Case Reviews since 2002. He is presently an independent safeguarding consultant with over thirty years background in both statutory and third sector child protection agencies. He completed the Department of Education/ NSPCC/ Action for Children/ 'Improving Serious Case Reviews' course in July 2013 and is on the Department for Education (DfE) and Association of Independent Chairs

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[2] Key Practice Episodes (KPE) are episodes from the case that require further analysis and are thought to be significant to understanding the way the case developed and was handled. They are not restricted to specific actions or inactions but can extend over longer periods. See SCIE, ' Learning Together to Safeguard Children, Developing a Multi-agency Systems Approach for Case Reviews' (2008)

[3] See Appendix 1 for the KPEs

[4] See Appendix 1

[5] These included personnel from the secondary and primary schools, the school nurse service, the educational welfare service, the Clinical Commissioning group, Cumbria Police, the local hospital and adult mental health services.

[6] Master's in Public Administration (2007) from Warwick University Business School

of LSCBs lists for independent SCR Chairs and Lead Reviewers. He has had no previous involvement with the Cumbria Safeguarding Children Board or any of its partner agencies prior to this SCR.

6. Expert Lead Panel

6.1 The Review was led by Paul Sharkey and assisted by an Expert Lead Panel of senior managers from agencies providing services to children and families in Cumbria.

Title	Organisation
Panel Chair	LSCB Member
Senior Manager - LSCB	LSCB
Designated Nurse	Clinical Commissioning Group (CCG)
Lead General Practitioner (GP) for Safeguarding Children	CCG – Primary Care (Also representing CHOC)
Detective Superintendent	Cumbria Constabulary
Senior Manager	Children's Services
General Advisor, Learning & Improvement Service	Children's Services
Safeguarding Lead	GMW Mental Health NHS Salford (Unity)
Head of Clinical Safety	NWAS
Clinical Services Manager (CAMHS)	CPFT
Minutes	LSCB

7. Confidentiality

7.1 Although Child R's tragic death and the subsequent criminal investigation were reported by the media, this SCR has nonetheless sought to respect the privacy of Child R and his family. Thus, no names have been used.

8. Family Involvement

8.1 Child R's mother and father and other family members were notified of the SCR. Tragically, prior to the publication of the report, Child R's mother died. Child R's father (FR) met with the lead reviewer and the panel chair in June 2016 to discuss his views on the services he received.

8.2 Regarding services, FR made reference to the school (SS1) and the GP for his own health needs. He stated that he was a ‘soft touch’ and guilty of spoiling his son with whom he had had a great friendship. He had not given enough weight to the importance of education but said that his son, ‘Hated school’, in reference to the secondary school, SS1.

8.3 FR acknowledged the support given to his son in the transition from primary to secondary school. He made reference to some bullying experienced by Child R and felt that the school, perhaps, took ‘too long’ to respond to it. It could have been dealt with more speedily. He resorted to keeping his son away from school until it was addressed, which it was. Overall, apart from the bullying issue, he was not critical of the school (SS1).

8.4 FR acknowledged that he was at fault for being ‘too soft’ with his son and would let him stay off school at the slightest hint or tear, which he reflected was not a good thing. He said that his son had ‘no health problems’ despite having asthma, and he did play football. He recalled having meetings with school staff about the attendance plan and said that, on occasions, he could be aggressive when he spoke to them which may have put them off contacting him more. He recalled speaking with the Head of Year about his son. FR did not think that, apart from his son’s dislike of PE, there were any other issues around his learning, although he did believe that Child R may have had some autistic or OCD traits. He said that his son ‘did not like change at all’.

8.5 FR recounted a time when he went to his GP because he was depressed and was a single parent with an addiction to painkillers. He recalled that the GP was dismissive. However, he did not describe this incident in a ‘blaming’ or complaining way.

8.6 In concluding the meeting, FR was invited by the lead reviewer and panel chair to offer a view on whether anything else might have been done to offer help to himself and his son. He was unable to identify anything other than the school possibly being more focused in their initial response about the bullying.

8.7 FR was extremely clear that he was responsible for his son’s death and that he was not let down by anyone.

9. Parallel Enquiries

9.1 Child R's death was investigated by Cumbria Police. His father pleaded guilty to manslaughter in 2015 and was sentenced to a period of custody.

10. Dissemination of Learning

10.1 The learning from the SCR will be used to develop and review relevant Policies and Procedures. In addition, training and other learning opportunities will be updated to reflect the learning. A newsletter/leaflet will be produced and the lessons will be included on the LSCB website pages to ensure all agencies and their staff are able to locate and learn as appropriate.

11. Race, Religion, Language and Culture

11.1 Child R and his family are of White British heritage whose language is English. The family's religion, if any, is not known.

12. Summary of Significant Events from September 2011 - October 2014

2011

12.1 Child R started in Year six at his primary school, PS1 in early September 2011. His attendance in the previous year had been recorded at 49%, some nineteen full weeks out of a total of thirty nine.

12.2 He was seen by a GP at the surgery (Surg1) in mid-November for an upper respiratory infection.

12.3 Throughout 2011(and also before this time) Child R's mother had been in receipt of adult mental health services.

2012

12.4 Child R suffered from Stage 2, mild persistent asthma, which was managed through the use of an inhaler and steroid medication, visits to his General Practitioner at Surg1 when necessary; and oversight by the surgery asthma clinic. A nurse led asthma review held in March 2012 at Surg1 indicated that he was doing well and concluded that he should continue on step 2 of the asthma pathway.

12.5 MR continued to receive mental health intervention throughout 2012.

12.6 Child R was due to move up from his primary school to his secondary school (SS1) in September 2012. In the light of his poor attendance record at his primary school, due to school authorised illness absences, enhanced transitional arrangements were begun in May by the education welfare officer (EWO1) at SS1.

12.7 For the avoidance of any confusion, it should be understood that pupil illness absences are authorised by the school and not any medical authority or practitioner such as a GP. 'Authorised absence', means that the school has either given approval in advance for a pupil of compulsory school age to be away, or has accepted an explanation offered afterwards as justification for absence. In the case of the school, SS1, its ' Attendance for Learning Policy' (17.01.2014) defined an authorised absence as follows:

> *' These are a day or half day away from school for a good reason like illness, medical or dental appointments which unavoidably fall in (school) time, or other emergencies with unavoidable cause'*

12.8 Child R was absent from the primary school for most of June. His father had sent a note saying that Child R's absence was because he (FR) was ill and that Child R was autistic and was unable to walk to school. In fact, Child R had never been given a diagnosis of autism and had never experienced it.

12.9 The transitional arrangements included Child R having a tour of SS1 in late June and also attending a week long summer school in August which covered issues around literacy, numeracy and emotional resilience. Child R was reported to have enjoyed the week. He was allocated an inclusion mentor as part of the transition plan and arrangements were made to monitor any future absences.

12.10 Child R started in Year seven at SS1 in early September. His attendance for the first term was recorded at 89.7% with fifteen school authorised absences[7] on health grounds for complaints such as toothache, having a high temperature and a stomach bug. His attendance in term two was 71% with thirty two absences on health grounds. Term three gave 76% attendance and thirty one absences on health grounds of which twenty three occurred in the last four weeks of term prior to the end of the school

[7] Sessions are counted for both the morning and the afternoon, so two sessions absence would equate to one full day.

year. The school reported that his attendance was generally at an acceptable level for the majority of year 7 (at 76%) and did not cause any major concern until the last six weeks of the summer term of 2013.

2013

12.11 The GP at Surg1 received a telephone call from MR in late January asking for a home visit for Child R. This was declined as only housebound patients merited a home visit; instead a surgery appointment was offered. Although she had legally previously been granted unsupervised contact with Child R it was noteworthy that, despite not living in the family home, it was she that had made the call to the GP, although FR was also present at the time.

12.12 Child R's absences due to health complaints (headaches, chest infections, dental appointments, sickness bug, and colds) emerged as an issue for SS1 between January to March. An attendance meeting was held in early March 2013 involving the Head of Year, the education welfare officer (EWO2) and Child R's father. It was agreed to monitor Child R's attendance as it was near the persistent absence threshold. His father was asked by EWO2 to provide written confirmation of any illness from a doctor in the event of any future absences on health grounds.

12.13 Child R did not attend an appointment for the asthma clinic in late March and a letter was sent for a further appointment. The school was informed by FR a few days later of Child R's absence because of an asthma attack and that he would (hopefully) return the next day. In fact, he was absent for the rest of the week which was accepted by SS1, ostensibly on health grounds. There was no record from the school whether FR provided any medical confirmation of the asthma episode as previously agreed at the meeting of early March.

12.14 MR continued to receive adult mental health services during the spring of 2013.

12.15 In late April 2013 the school was informed by Child R's mother that his father had been rushed to hospital overnight leaving MR to look after Child R. There was no record of this incident in FR's GP record. MR said that Child R was upset and would be absent for the day. He returned to school the next day and attended for the rest of the week. Despite there being no recorded information held by the school on MF, the educational welfare officer (EWO2) expressed concern to her head of year (HY) about Child R being in the care of his mother whilst FR was in hospital. It was not recorded upon what grounds the concerns were based. HY agreed to discuss the situation with the school safeguarding officer (SSGO1) and

update EWO2. There was no record of this happening, whether the concerns had been addressed or what the outcome was. Child R was absent in late April, due to a reported (not known whether by MR or FR) asthma attack.

12.16 Child R did not attend an appointment at the asthma clinic in mid -May 2013.

12.17 In mid-May a staff nurse (StN1) at the Accident and Emergency department at Hospital 1 contacted Cumbria Council Emergency Duty Service enquiring about Child R, following a recent hospital contact with his mother. StN1 was told that Cumbria Children Services had had no contact with Child R since 2010 and the address given by his mother was the one recorded in 2010. The School Nursing service and Surg1 were notified by the paediatric liaison service of the hospital contact with MR.

12.18 Child R was reported by his father to the school as having had an asthma attack in mid- May 2013. MR continued to have contact with adult mental health services but declined any longer term involvement with a specialist service. MR's GP was asked to follow up.

12.19 Child R was absent in the last week of June and the first week of July with a viral infection, as reported by his father. FR had informed the school that Child R had been prescribed 'Stronger antibiotics' by the GP although there was no record of this in the GP notes. These were recorded as authorised absences by the school on health grounds, although no medical documentation from the GP was provided to the school by FR as previously requested. He was highlighted for safeguarding as 'sessions missed' in early July and returned to school a few days later. EWO1 wrote a formal letter to FR notifying him of Child R's persistent absence. This stated that because his attendance was below 85% it was going to be monitored and reviewed from the beginning of the new school year in September 2013.

12.20 Child R started Year eight in September. By the end of the month his father was notifying the school of health related absences such as a dental appointment. He missed several days in October and November due to reported asthma attacks, attendance at asthma clinic (NB there was no Surg 1 record of any attendance reportedly at the beginning of November 2013) and a bad chest. A further letter was sent to FR by EWO1 in late November stating the school's concerns for Child R's absences. The letter set out the attendance plan which, amongst other things, required FR to provide evidence from Child R's GP (appointment card, letter) to confirm the reasons for any future absences. It (the letter) stated that in the event that Child R's attendance remained at the level (of concern), 'It may result

in a referral for further support action'. It was not made clear what the nature of 'support action' entailed.

12.21 The Attendance Improvement Plan (Amber Action Plan) of November 2013 required that Child R needed to achieve above 96% attendance. If there was no improvement in attendance, 'This may lead to a referral to the Educational Welfare Officers'. Child R's attendance was to be closely monitored and his progress reviewed weekly for the next eight weeks until the Review meeting scheduled for January 2014.

12.22 Further absences occurred in November and December. FR attended a GP consultation in mid- December 2013 when it was noted that he was a 'Single parent looks after twelve year old ' autistic'(sic) child; no problems though child has missed school recently'. The reference to Child R being autistic was incorrect.

2014

12.23 Child R was absent on several occasions from mid-January through February with reported asthma, chest infections and difficulties in sleeping. There was no record of the Review scheduled for January having taken place. EWO2 undertook a home visit in February but nobody was in. A letter was sent to FR in late February from school stating its concern for Child R's continuing absences. A meeting was arranged for early March to discuss how to improve attendance and offer Child R more support.

12.24 EWO2 and FR agreed by phone (FR having cancelled a previously arranged meeting) in early March that Child R would start in the school's Year eight 'Nurture' group (small group lessons). He started soon after and reportedly appeared happy in school and was said to be enjoying it. At around the same time references were made to Child R having been involved in a bullying incident involving two other pupils. The episode was handled by the Head of Year.

12.25 Child R was absent from early March and was reported by FR to have been upset following the 'bullying' incident the previous day. EWO2 visited the home a few days later but there was no reply. FR notified the school in mid-March that he had been admitted to hospital (which was not recorded and there was no record of the admission in the GP notes) and that Child R was with his maternal grandparents in Manchester for the week. He arranged to contact EWO2 the next day to discuss the matter.

12.26 FR met with school staff in late March and said that Child R had been under a great deal of pressure because of issues around a family member's

recent criminal conviction which had caused him some anxieties. It was agreed that a short term, half-time timetable would be put in place so he could access support in school without increasing his anxieties.

12.27 In mid-May FR contacted the school to say that another pupil was hitting Child R and 'winding him up' on a daily basis. Action was taken by staff who informed both sets of parents. Child R was kept off school for a week by his father in early June because of a family emergency involving his sister in Manchester. There was nobody else to look after Child R so he was taken by his father to Manchester. These absences were classified as unauthorised.

12.28 Child R was absent from school in late June and early July reportedly unwell. EWO2 arranged to undertake a home visit in mid-July and was told by FR that Child R had been to Hospital 1 for a stomach test and was sleeping. There were no medical records to corroborate this report and none were provided by FR. EWO2 attempted a home visit a few days later but was unable to access the flat complex. FR was texted and informed that a safeguarding visit would take place as Child R had not been seen for some time. Child R returned to school the next day. He was absent on the last day of term.

12.29 Child R was seen at Surg1 in early September for lower back pain. There was no precipitating injury, or 'red flag' (serious) symptoms. He was prescribed paracetamol, ibuprofen and gentle exercise.

12.30 Child R made a good start to the new school year in September and had a full attendance for the first three weeks of the new term. He received support from the inclusion mentor. He was absent (authorised) from late September for approximately two weeks due to a bad cold and chest infection and returned in early October . FR told the inclusion mentor that, 'he tried to make the right decisions but struggles as a single parent and does his best'. The school received a voicemail saying that Child R was absent due to a sickness bug.

12.31 Child R was found dead in October at his father's address. FR called for an ambulance in the early morning. FR told attending Police and ambulance staff that he had given Child R a morphine tablet the previous night to help him sleep because he had a headache.

13. Analysis

13.1 The analysis is informed by a consideration of each Term of Reference using the material from the practitioner learning event, the combined chronology, the meeting with FR and other sources as previously mentioned.

A. To consider transition arrangements for Child R from Junior School to Secondary School. Were effective plans and arrangements in place?

13.2 Academically, Child R was thought to be at the lower ability of performance but above the 'Special needs' level. He was described as an 'articulate' student. Staff at SS1 were told by the primary school of Child R's problematic attendance record caused by reported illness absences through asthma. Mindful of this SS1 staff included him and his father in an 'enhanced' transition approach in preparation for starting at the school in September 2012 as set out in paragraph 12.9 above. FR acknowledged that this course of action had been supportive.

13.3 The transition plan to SS1 was partially successful in so far as Child R's attendance in the first term at his secondary school was 90% (rounded up). Albeit, not at the DfE recognised level of acceptable attendance of 96%, it did mark an improvement on the previous level of attendance at his primary school (PS1).

B. To consider the effectiveness, or otherwise, of Child R's attendance plan implemented by his Secondary School (SS1).

13.4 Despite the partial success of the transition plan, Child R was not able to sustain an acceptable level of attendance for the remainder of his time at the school (SS1), despite the provision of an Attendance Improvement Plan.

13.5 FR was informed in July 2013 in a letter from the school, that Child R had been identified as being at risk of, 'Persistent Absence'[8] defined by the Department for Education (DfE) as attendance of less than 85% over the school year. [9]The DfE's expectation is that students need to maintain an attendance of over 93%.

13.6 This letter reminded Child R's father that, '*Good school attendance is vital for your child to achieve their personal best and I hope you will be*

[8] Whether authorised or unauthorised according to the SS1 'Attendance for Learning Policy'.

[9] Persistent absence is defined by the DfE as 'A pupil enrolment is identified as a persistent absentee if they miss around 15%or more of all possible sessions'. See DfE ' A Guide to absence statistics' (October 2015)

supportive of (the school) in improving your child's attendance. We would like to support you in meeting your legal requirements and hope that Child R will return to the New Build in September and will attend regularly'. An Action Plan was sent along with the letter.

13.7 Given Child R's previous history of poor school attendance, the March 2013 intervention of the meeting with FR and the continuing low attendance figures for terms two and three, this would suggest the response was not effective and there should have been a more robust comeback from the school. It would have been reasonable for the school to have convened a meeting with FR and Child R to have addressed his poor attendance and agreed on a viable improvement plan to be reviewed at the end of the first term of the new academic year (2013/14). FR admitted in the meeting with the lead reviewer that he was a 'Soft touch' with his son and pandered to his desire to avoid attending school. He also underestimated the importance of education. A meeting with the school could have addressed these issues and helped FR to understand the critical importance of good school attendance for his son's overall wellbeing.

13.8 In any event, despite the July Action Plan, Child R's attendance in 2013/14 continued to be below 93%, with a 58% yearly presence, a 37.5% authorised absence and a 4.3% unauthorised absence record. His continuing pattern of persistent absence resulted in the school issuing a further letter in October 2013 to FR. The accompanying Attendance Improvement Plan set out the following expectations of him:

- 'Ensure that Child R attends school every day unless unable due to ill health or other unavoidable, reasonable circumstance. Child R is expected to achieve at least 94% attendance over the 6 week period up to the next review beginning January 2014.[10]
- Evidence will be required via a GP (appointment card, letter etc.) if reoccurring or persistent illness or other to confirm reason for absence. A Health Care Plan can be put in place if the GP recommends one for Child R's asthma.
- Contact school by 8.30a.m the same day if Child R is absent from school.'

13.9 The letter stated that, '*If Child R continues to attend at this level it may result in a referral for further support action'*. What sort of 'support action' was not made clear. There should have been clarity around possible consequences for non- compliance and the continuation of poor

[10] This is inconsistent with the actual attendance improvement plan which stated that attendance should be above 96% to be reviewed over the next eight weeks.

attendance. FR was invited to contact EWO1 to discuss any concerns or issues at home or school regarding why Child R was not attending regularly. In addition, FR was provided with a copy of a letter that he could take to the GP for evidence and advice purposes. FR did not take up the school's invitation for a meeting with the EWO and there continued to be no evidence of reported illness provided by FR from the GP.

13.10 Given Child R's long standing record of persistent absence, lack of any medical confirmation of illness and the two previous attendance interventions by the school in the previous year, there should have been a more robust response by SS1 in October 2013. In the lead reviewer's opinion, it would have been a proportionate and entirely reasonable response for the school to have been more pro-active and initiated a meeting with FR and Child R (requiring their presence), including liaison with the school nursing service, to address his absence.

13.11 Such a response would have signalled to FR (and Child R) that the school was, firstly concerned about the absences, and secondly, could have encouraged FR's active partnership, participation and ownership/signup to the Attendance plan.

13.12 In the event of FR's continuing avoidance and non-cooperation by not providing medical documentation of Child R's illness, which in itself should have raised questions as to why, it would have been reasonable for the school to have considered escalating into more formal action. This could have included seeking advice and support from the local authority Inclusion Officer and considering use of the pathway for children whose attendance was causing concern. (As set out in Appendix 2 of Cumbria Children's Services 'School Absence Enforcement Policy' (2013) – see Appendix 3 of this report).

13.13 The October 2013 intervention could also have been an opportunity for the school to have explored with FR and Child R whether some form of 'Common Assessment/Early Help' assessment and support might have been useful , albeit that the Policy was not well embedded within Cumbria at the time; in addition to assistance from the school's Educational Welfare service.

13.14 There was no evidence that the scheduled Review meeting of January 2014 took place. It is not known why this did not happen. This was an opportunity lost by the school to maintain momentum and focus with the plan and hold FR accountable for his legal responsibility to ensure his son's education.

13.15 Instead of holding the attendance Review in January 2014, a decision was made to have a meeting with FR in early March to discuss how to improve attendance. FR said that he was unable to attend but agreed by phone to Child R starting a 'Nurture' (small group) group. There appeared to be no reference to the previous Attendance Plan or any rationale as to why and how a 'Nurture' group linked into it or met the needs of Child R. Moreover, there was no indication of what the consequences would be for non-adherence.

13.16 The Nurture group did not improve Child R's attendance which continued to be at the 'persistent absence' level, ostensibly on health grounds. There was no further reference to an attendance plan up to the death of Child R.

13.17 Having identified concerns regarding attendance as early as March 2013 the school allowed the situation to 'drift' despite several further opportunities to take robust and timely action. Examples of these occasions are given at paragraphs 13.7, 13.10 and 13.14 above.

C. To review the health needs of Child R – including non-attendance at appointments, asthma management, behaviours and whether neglect/emotional issues were considered.

13.18 Child R had very mild stage 2 asthma which was managed by an annual appointment at the asthma clinic and the use of an inhaler. Despite the significant absences from school, due reportedly to asthma and associated respiratory conditions, the medical opinion (presented at the Learning Event) suggested that Child R was not a particularly sickly child. This was confirmed by his father at the meeting with the lead reviewer and panel chair.

13.19 According to the GP records Child R attended the asthma clinic at Surg 1 (under the supervision of the asthma nurse) on one occasion in March 2012 for a review when he was noted to be ' doing well' and continued on step 2 of the asthma pathway. He did not attend the 2013 review despite a letter being sent in April followed up by a telephone call which was not answered. There was no record of Child R being offered a review in 2014. However, there are several references in the school records to Child R attending the clinic in 2013/14 which were not reflected in Surg 1 records.

13.20 The GP and asthma nurse at Surg 1 were not aware of Child R's significant school absences (ostensibly) on health grounds. Child R's health needs fell within the normal limits for a young person of his age. They were adequately met and appropriately managed by the primary health services.

He was not a particularly sickly child contrary to the impression created by his persistent absences from school. Neglect and emotional issues were not considered by the health agencies, as from their perspective there was no evidential basis on which to do so.

13.21 There was no evidence to suggest to SS1 that Child R suffered from significant neglect, emotional deprivation or was a behaviourally challenging student. SS1 noted that he was a pleasant, well-mannered and polite individual with a good sense of humour who had a strong and supportive friendship group of close friends. The school reported that he had no challenging behaviour and was well presented in class, smartly dressed and appeared adequately looked after by his father. It reported that Child R was loved by his father who, it was noted, tried to encourage his son's independence but could be overprotective at times, which Child R sometimes manipulated to his advantage. This was corroborated by his father at the meeting with the lead reviewer and panel chair. In short, Child R did not present with any obvious or tangible emotional or behavioural issues at school which might have suggested any safeguarding or welfare concerns that required a referral to Children's Social Care.

D. To consider the voice of the child – was the case mainly adult led? How visible was Child R?

13.22 Child R was provided with an inclusion mentor to facilitate the transition from his primary school to SS1 and was reportedly able to communicate his wishes and feelings to that person and the teaching staff. His attendance at the summer school in August 2012 indicated an acceptable degree of child focus in respect of the school transition process.

13.23 However, Child R had no direct involvement or participation in the four interventions (namely, the March 2013 meeting between the school and FR, the two letters to FR of July and October 2013 and the March 2014 discussion) made by SS1 with FR regarding Child R's absences. These involved FR only and in that sense was adult focused. There was no evidence that Child R's views were sought as to why he was having so much time away from school and how this might be impacting on his educational development.

13.24 Nor were his wishes and feelings obtained regarding the drawing up of the attendance plans and the responsibilities he had to attend school on a regular basis. He had no involvement in the planning or decision making around the attempts at improving his attendance and in that respect the process could not be said to be ' child focused'.

13.25 The SCR noted that there was relatively little recording in the multi-agency chronology on Child R in comparison to the significant adults in his life. It was therefore difficult to get a sense of his 'lived experience' and an idea of what life was like for him.

E. To consider the social needs of Child R, including family environment.

F. To consider domestic violence and substance misuse issues and review whether mental health needs were taken into account and whether the impact of these issues in the family were considered to have had an impact on Child R's needs.

13.26 Information from Cumbria Police indicates that there were several reported domestic abuse incidents between Child R's parents during 2003-2007. There have been no reported domestic abuse incidents since 2007 involving FR or any other person. Therefore, the evidence suggests that Child R had not been exposed to domestic abuse since 2007.

13.27 FR self-medicated in an attempt to relieve various pains by illegally buying morphine and other medication from local acquaintances. It was one of his morphine capsules that caused the death of Child R, in an attempt at responding to his son's reported headache. Pre-trial evidence indicated that FR did not abuse alcohol or suffer from any mental illness during the period leading up to and on the day of Child R's death. FR told professionals before his trial that he was a full time father and the sole carer for Child R with whom he described as having a loving relationship. He was (and is) devastated at the death of his son.

13.28 Child R had lived with his father since the age of three and was made the subject of a residence order to him in 2009. According to FR, Child R had contact with his mother every two months. She had unsupervised contact and lived close by to Child R and his father until 2014 when she went to live in the Manchester area. She had had a long term involvement with local mental health agencies for severe and enduring mental health problems.

13.29 It is not possible, on the presented evidence, to say with any precision how far, if at all, Child R was impacted by his mother's long standing mental health issues. He was observed by the school to be a happy and sociable child who did not manifest any significant emotional or behavioural problems in school. There was no evidence from the health agencies that he suffered from notable emotional or behavioural difficulties.

14 Key Findings and Conclusions

14.1 None of the agencies involved with Child R were responsible for his death. Indeed, no criticism was made by the Judge of any agency during the trial of FR who alone must bear the responsibility for his son's tragic death. Moreover, Child R's death was not predictable by professionals. In particular and notwithstanding the attendance issues mentioned below, it must be emphasised that the school (SS1) was in no way responsible for or contributed to the death of Child R.

14.2 Early and persistent action to address Child R's absence from school would have been appropriate. This said, having an effective attendance improvement plan or Common Assessment plan (later to become known as an 'Early Help' plan) may have promoted Child R's welfare but in itself would not necessarily have prevented his untimely death.

14.3 There were no concerns about Child R that would have reasonably led professionals to think that he was being subject to significant harm through abuse or neglect. His circumstances did not meet the threshold for a referral to Children's Social Care. However, the co-ordination of an early help response could have been effective in addressing attendance and supporting FR in his role as a sole parent.

14.4 The remainder of the key findings and conclusions can be set against each of the Terms of Reference and are shown in the table below:

TOR	Key Findings and Conclusions
A. To consider transition arrangements for Child R from Junior School to Secondary School. Were effective plans and arrangements in place?	1) The transition plan to SS1 was partially successful, as Child R's attendance in the first term at his secondary school was 90% (rounded up). This is not at the DfE recognised level of acceptable attendance of 96%, but it did mark an improvement on the previous level of attendance at his primary school (PS1).
B. To consider the effectiveness, or otherwise, of Child R's attendance plan implemented by his Secondary School (SS1).	2) The attendance plans for Child R were not effective and were subject to a degree of drift. They were not successful because the school did not follow up in a sufficiently robust or timely manner on its own attendance improvement plans. 3) All schools in Cumbria (including Free Schools and Academies), where it has not happened, should positively embrace the take up and implementation of the Early Help strategy, in accordance with current Statutory Guidance (see section 16, 'Keeping Children Safe in Education-Statutory guidance for schools and colleges' (July 2015).[11]

[11] **NB** This states that, 'Where a child and family would benefit from co-ordinated support from more than one agency (for example education, health, housing, police) there should be an inter-agency assessment. These assessments should identify what help the child and family require to prevent needs escalating to a point where intervention would be needed via a statutory assessment under the Children Act: 1989. The **Early Help**

TOR	Key Findings and Conclusions
	4) This would complement and bring 'Added value' to an effective implementation of the 'Attendance for Learning' strategy, where there are concerns about a student's attendance, including those on authorised health grounds. Consideration for Early Help intervention could be 'triggered' by an agreed threshold of absences/attendance, say (for example) at the 90% attendance (persistent absence) level. 5) In addition, this would be consistent with schools' wider statutory safeguarding responsibilities set out in 'Working Together' 2015 and associated Guidance, (see note 10 above) and given that poor school attendance can be a potential, early marker for child neglect and persistent difficulties within a family that require attention. 6) Cumbria schools, including SS1 should consider how to respond to a child's needs, including whether there is any evidence of neglect, when a student reaches the persistent absence threshold of 85% and whether there are any issues around the impairment of a young person's health and general development.
C. To review the health needs of Child R – including non-attendance at appointments, asthma management, behaviours and whether neglect/emotional issues were considered.	7) Child R's health needs fell within the normal limits for a young person of his age. They were adequately met and appropriately managed by the primary health services. He was not a particularly sickly child contrary to the impression created by his persistent absences from school. Neglect and emotional issues were not considered by the health agencies, as from their perspective there was no evidential basis on which to do so.
D. To consider the voice of the child – was the case mainly adult led? How visible was Child R?	8) Child R was not involved in the planning or decision making around the attempts at improving his attendance and in that respect the process could not be said to be ' child focused'. It seems that his interests were mediated through his father. 9) Consideration needs to be given to finding ways of directly involving students in the planning and decision making process around developing school Attendance Improvement Plans and their reviews.
E. To consider the social needs of Child R, including family environment. **F. To consider domestic violence and substance misuse issues and review whether mental health needs were taken into account and whether the impact of these issues in the family were considered to have had an impact on Child R's needs.**	10) There was no evidence to suggest that Child R was exposed to any domestic abuse between 2011 and October 2014. FR did not have any known mental health issues during his care of Child R. Moreover, there was no indication that FR abused illegal substances or alcohol. Although it is clear that his use of illegally bought painkillers and mistakenly giving his son a morphine capsule proved to be tragically lethal to Child R. 11) It is not possible to say with any accuracy how far Child R was impacted by his mother's long standing mental health issues. He was observed by the school to be a happy and sociable child who did not show any significant emotional or behavioural problems in school. There was no evidence from the health agencies that he suffered from notable emotional or behavioural difficulties. 12) It does not appear that there was any significant consideration given by adult mental health, the school nursing service or MR's GP to the potential impact of MR's mental health on Child R. Clearly, the key lesson from this episode is the need for adult focused services to think more holistically ('Team around the Family') around the impact for safeguarding and welfare on children of their parents' problems.

Assessment (Lead Reviewer's emphasis) should be undertaken by a lead professional who could be a **teacher,** special educational needs co-ordinator, General Practitioner (GP), family support worker and/or health visitor.

14.5 Cumbria LSCB will develop an action plan based on the above findings made in this report which is included in the LSCB Response Document that accompanies its publication. The key learning points of this SCR can be found in the Response Document.

15. Glossary

- CAF-Common Assessment Framework
- CCG-Clinical Commissioning Group (General Practitioners)
- DfE-Department for Education
- EWO1-Education Welfare Officer 1 at SS1
- EWO2-Education Welfare Officer 2 at SS1
- Child R
- FR- Child R's father
- MR-Child R's mother
- HY1- Head of Year at SS1
- PS1-Child R's primary school
- SCR-Serious Case Review
- SS1-Child R 's secondary school
- SSG01-Safeguarding Officer at SS1
- Surg1- Child R 's GP
- StN1 at Hospital 1-Staff Nurse at Hospital 1
- SN1-School Nurse
- TAF-Team around the Family

16. References

- Cumbria County Council (August 2013): Children’s Services School Absence
- Enforcement Policy (Enforcement Guidance)
- Cumbria Early Help Strategy (2014)
- DfE (2013): ‘Working Together to Safeguard Children’
- DfE (2015): Working Together to Safeguard Children’
- DfE (October 2014): ‘School Attendance, Departmental Advice for Maintained Schools, Academies, Independent Schools and Local Authorities’
- DfE (July 2015): ‘Keeping Children Safe in Education-Statutory Guidance for Schools and Colleges’
- DfE (October 2015): ‘ A Guide to absence statistics’
- Social Care Institute of Excellence (SCIE) (2008); Learning Together to Safeguard Children, Developing a Multi-agency Systems Approach for Case Reviews’
- SS1 (undated): ‘ Attendance for Learning Policy’
- SS1 (January 2014): ‘Attendance for Learning Policy’
- Ofsted (May 2013): School Report on SS1
- Ofsted (2014): SS1 Data Dashboard

Appendix 1

Key Practice Episodes

1. Could Child R and his father have benefitted from some Early Help/Common Assessment support and if so what steps were taken by agencies to provide this?

2. How effective were Child R's absences handled by the school?

3. How effective were Child R's health needs met?

4. Was a holistic, 'Focus Family' approach taken by agencies?

Appendix 2

Organisational Context

1. Contextually, SS1 in 2013/14 reportedly had 104 (8.7% of the total pupil population) students with a percentage attendance classed as persistent absence with 53 the same as or lower than Child R. The school had 92 students with 'cause for concern' and 8 subject to child protection plans. The student population was 1195 with 41.5% eligible for free school meals which placed the school at the top end of the second quintile.[12]

2. SS1 had been judged by Ofsted (as of May 2013) as 'Inadequate' and in, 'Special measures', during the timeframe in question. Of significance was the observation that, '*Although attendance is improving, it remains below the national average. The achievement of many students is held back because they do not attend the (school) regularly enough'.* (Ofsted School Report, 15-16.05. 2013, page 1)

3. In relation to improving student achievement, the Report identified the need for, '*Improving the attendance of all groups of students, and reducing more rapidly the proportion of students who are persistently absent from the (school)'.* (ibid, page 4)

4. According to Ofsted (School Data Dashboard, 2014) attendance between 2012 to 2014 was 92.2%, 92.3% and 93.3% for the three years, an increase of 1%, with the attendance rate being in the bottom 20% of all schools.

Government Guidance and Local Policy

5. Regular school attendance is according to the Department for Education (DfE),

   'Central to raising standards in education and ensuring all pupils fulfil their potential……pupils need to attend school regularly to benefit from their education.' DfE, School Attendance, Departmental Advice for maintained schools, academies, independent schools and local authorities, October 2014, section 1, page 4)

6. In relation to the issue of authorised absence from school, Cumbria Children's Services School Absence Enforcement Policy of August 2013, issued by the

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[12] Free school meals are a proxy measure for relative social deprivation. A school in the 1 quintile (20%) is in the highest quintile at 44.3-94.1% (2014). SS1 was just outside this quintile. See Ofsted School Data Dashboard for SS1.

local authority's Access and Inclusion Team states that, '*If a child is ill or unable to attend school for some reason, parents should provide an explanation for this non-attendance. The school will determine whether the child's absence will be authorised*[13] *or not. For repeated or regular periods of illness the school will request verification is provided such as a medical certificate from the family doctor prior to authorising any absence'.* (Enforcement Guidance, August 2013,3)

7. Where, '*the child's absence falls below 85% and there is no sustained improvement despite school intervention the school should consider a referral to (Cumbria) Children's Services following the Attendance Protocol (Appendix2)*[14]*.'* Moreover, ' *Any pupil whose attendance is less than 85% and where school interventions have failed to achieve an improvement in the pupil's attendance should be discussed with the Local Authority Inclusion Officer for advice on next steps'* (Ibid,3)

8. Poor attendance at school can sometimes be a 'marker' for child neglect or an early warning for safeguarding concerns. In such circumstances there may be the requirement for an early help assessment offer (formerly known as a Common Assessment), leading to agency intervention to support the family; or even consideration of the use of formal child protection measures in the event of suspected or actual significant harm.

[13] NB 'Authorised absence means that the absence has been authorised by the Head teacher, not by the parent.' (Cumbria Children Services School Absence Enforcement Policy, 2013,12)
[14] See Appendix 2 of this report.

Appendix 3

Appendix 2 of the Cumbria County Council School Absence Enforcement Policy

Enforcement Guidance

August 2013 (revised)

School Attendance Process

This draft shows an outline of the proposed pathway for children whose attendance is causing concern. The pathway sits within the continuum of need and the Common Assessment Framework (CAF). It identifies three main groups of children and young people who may have poor attendance:

1. Those who fail to attend school for a variety of reasons e.g. repeated unauthorised family holidays but for whom there is no fundamental obstacle to attendance. These children can be regarded as those who may require additional support and this could be provided by a single agency. In these circumstances it is expected that schools will operate procedures to secure improved attendance including the use of attendance panels.

2. Those who may have a chaotic family background or short term needs either school or home based and intervention will improve attendance. The needs of these children and young people may require more than one support service and a CAF should be initiated or a more specialist assessment may need to take place through the CAF process. When completing the assessment schools should focus on identifying those areas of need and desired outcomes. Children's Services will contribute to the multi-agency team which will decide how the child's needs are to be met.

3. Those who face significant challenges in their home or social circumstances which are having a detrimental effect not only on their attendance but also their wellbeing. A specialist assessment will be required in these circumstances and this should be requested through the CAF process. If the child is suffering or at risk of significant harm, self harm and/or high risk of harm to others child protection procedures should be followed.

If there is no improvement after three months of intervention contact should be made with the Inclusion Officer who will lead on any enforcement action.

The proposed pathway seeks to address the wide ranging reasons for non-attendance.

It is the school's responsibility to monitor and report on attendance and the parent's responsibility to ensure attendance. It is expected that schools will initially take the lead in managing non-attendance through close monitoring of pupil attendance and regular contact with home. Schools should seek to assess the reasons for nonattendance and address them wherever possible.