CUMBRIA LSCB

CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

Learning from Serious Case Reviews – Child R

This short briefing summarises the findings and lessons from a Serious Case Review (SCR) into the death of Child R in Cumbria in October 2014 – the SCR focusses specifically on how agencies worked together and individually from the beginning of Child R's last year at his Primary School in September 2011 to October 2014.

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 R's story

Child R was aged thirteen and died at home, whilst in the care of his father. The cause of his 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. Child R's father pleaded guilty to the manslaughter of his son and received a four year custodial sentence. 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. His parents 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.

It is widely believed that Child R and his father could have benefitted from Early Help and the findings of this case are centred on that premise.

THEME 1: Transition arrangements from Junior School to Secondary School

Finding 1

In this case the transition plan to Secondary Schools had limited impact on attendance.

Lesson to be learned

Transition plans should:

- Include well-defined success criteria
- Include a defined timescale for completion and review
- Record the voice of the child

Do you ensure that Transition Plans result in effective attendance management?

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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THEME 2: Effectiveness of Attendance plans

Finding 2

In this case 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.

Lesson to be learned

Attendance plans should:

- Be child focused
- Be robustly followed through with parents in line with school policy and practice and local authority guidance.
- Reviews are held in line with agreed policy and practice.
- Drift is avoided.
- Medical/health evidence of absence on health grounds is corroborated to inform attendance plans
- Parents/Carers and students should be actively involved in plans around transition and attendance and have a direct voice in these processes.
- Consultation should take place with the local authority Inclusion Service in line with current policy and guidance.

School practitioners: In all Attendance Plans, where attendance falls below 85%, consideration should be given to initiating an Early Help Assessment with reasons for not proceeding with this clearly recorded.

THEME 3: Use of Early Help in Schools

Finding 3

In this case the secondary school did not positively embrace the take up and implementation of the Cumbria LSCB Early Help strategy.

Lesson to be learned

School staff should consider undertaking an Early Help Assessment as part of a wider package of support when a student's absence reaches or exceeds the Department for Education (DfE) threshold for 'Persistent Absence'.

Where an Early Help Assessment is undertaken because of persistent absence due to health needs the School Nurse must be involved.

THEME 4: Recognising persistent absence as a potential indicator of Neglect

Finding 4

In this case the school did not consider the high levels of absence as a potential indicator of Neglect

Lesson to be learned

Where an Early Help Assessment is undertaken because of persistent absence due to health needs the School Nurse must be involved.

Schools staff should consider the possibility of neglect when a student's absence reaches or exceeds the DfE threshold for 'Persistent Absence', and whether there are any issues around the young person's health and general development.

THEME 5: Impact of parents' mental health and/or substance misuse on their children

Finding 5

In this case practitioners did not consider the impact of parents' mental health and substance misuse on the child's emotional wellbeing.

Lesson to be learned

When a parent or significant family member (regardless of their level of contact with the child) has mental health and/or substance misuse issues practitioners must always consider and take account of the impact of this on the emotional wellbeing of the child.

Do you follow the LSCB policies on Working with Children of Parents who Misuse Substances and Working with Children of Parents with Mental Health Problems? (Policy)