OSCB publishes historic Serious Case Review of 'Child R'

Oxfordshire Safeguarding Children Board (OSCB) today published the findings of its safeguarding practice review concerning 'Child R', who died in an out of county residential placement some distance from Oxfordshire in February 2013. Child R had taken her own life.

Child R had previously been in foster care in Oxfordshire and had also been treated in an Oxfordshire in-patient psychiatric unit prior to moving to the residential home. She is referred to as Child 'R' in the review to preserve her anonymity.

Derek Benson, **Independent Chair of Oxfordshire Safeguarding Children Board (OSCB)**, said: "This was a tragedy, and my thoughts are with the family at this extremely difficult time."

He explained that there was a delay in completion and publication of the review as it was necessary for police and health and safety investigations to be completed first.

Mr Benson said: "I can understand that the significant delay may have caused uncertainty and upset to those who were close to Child R."

Before her eventual transfer to foster carers, Child R had experienced substantial childhood trauma. Investigations were carried out by the police, but no prosecution took place.

The residential home (now closed) – which was not in Oxfordshire – pleaded guilty to a breach of health and safety legislation in September 2020 and received a fine.

The purpose of the OSCB review was to identify ways that agencies – police, the courts, mental health services, the residential home and Oxfordshire County Council's children's social care services – could have worked better together to safeguard Child R; to assess progress made in improvements since 2013 for children in similar circumstances; and to make recommendations for further enhancements in services as they exist today.

Mr Benson said: "We have been able to draw on what happened to Child R to identify where real changes to practice in Oxfordshire have been implemented. This includes how families are helped at an earlier point; how services listen to and respond to children when they tell us their very serious concerns; how children are supported when living in a residential placement a long way from home; the very detailed work that is needed to prevent self-harm and suicide; and how we check those services are doing what they say they will.

"Considerable improvements have been made in Oxfordshire since Child R's death in 2013, but we will never be complacent and welcome new recommendations formed around our current safeguarding systems, to reduce the risk of such a tragedy happening again."

Many of the recommendations in the review had already been addressed at earlier points and new recommendations are being acted upon by local organisations.