Learning from the Serious Case Review for Child R

Background to review

This summary collates key learning from a historic review commissioned in 2013, following the death of Child R. Child R was thirteen years and seven months old when she died in an out of county residential placement.

Due to the nature and circumstances of her death, Oxfordshire Safeguarding Children Board commissioned a serious case review. Concurrent inquiries by the Police and the Health and Safety Executive meant it was not possible to complete and publish a review at that time.

Police inquiries concluded in July 2018 however, health and safety inquiries were protracted, and it was not until September 2020 that the residential home pleaded guilty to a breach of health and safety legislation.

In June 2021, further details became available from the coroner which pointed to important learning from Child R's time in the residential home.

Child R was much-loved by her family and friends. Professionals in Oxfordshire who supported Child R cared for her deeply. Her death deeply affected many people, and from 2013 onwards, there has been a wish to understand what happened, why it happened and any lessons for future work with children in similar circumstances. As a result, there have been a series of recommendations and actions.

This summary focuses on the areas highlighted in the report where gaps still exist and need addressing.

Key findings:

- Working to keep children safe within their families continues to be a challenge and there is a need to ensure that improvements made since child R was a child are embedded into practice particularly in relation to identifying neglect and the provision of early help
- Placement Planning and managing the complex needs of children we care for needs sufficient placement availability, clarity of role across the professional network and systems that scrutinise and challenge how well the child's needs can be met
- Where there is a risk of suicide, children we care for should have a clearly articulated suicide prevention plan which takes account of emotional, behavioural and situational risks

Themes in common with other Oxfordshire case reviews:

- Early identification of neglect and abuse
- Challenges of working with children who have experienced significant trauma
- Lack of suitable accommodation to meet Child R's needs, including the provision of therapeutic support
- Effective partnership working and risk management

Strengths in practice with Child R:

- A comprehensive care package was put in place to support Child R's foster placement which enabled her to have a positive experience of happy family life
- A strong ethos of working sensitively with and caring deeply about Oxfordshire's children and young people was evident from staff who worked with Child R

The System Today:

In summary, the system-check of current practice in Oxfordshire identified many areas where practice today is vastly different to practice when Child R was a small child, as follows:

- Much work has been done in relation to working with complex family situations. Neglect is a common theme and there is a continuing focus on supporting practitioners to identify and respond to neglect
- There is ongoing work to improve practice in relation to Early Help. Progress so far includes an updated Threshold of Needs document, a Joint Activity Pathway between children's and adults' services, bespoke training for health visitors and the police, and targeted joint working between Early Years Managers and the Locality and Community Support Service. As a result, there has been an increase in the number of Early Help Assessments completed in 2021, comparative to previous years
- There is evidence of change since Child R spoke to police about her own abuse. In recent investigations, where no further action was taken, the police took time to consider the potential impact of the outcome on the children and how best to explain to the children why there had been no prosecution. This was addressed through letter writing and carefully explaining what had happened. Since Child R's death there has also been considerable expansion of local therapeutic services which were not available to Child R.
- Children's Services has driven regional and local work to develop placements that meet increasingly complex needs of children we care for

Key learning points for practitioners:

- Act on early concerns, using the Early Help Assessment (EHA) to better understand what is going on and to decide the best way forward. If you are not confident in using the assessment, EHA training is available, or you can seek support from your LCSS link worker or Designated Safeguarding Lead (DSL)
- Use available tools, for example neglect tools to support your practice, and contribute to effective assessments and plans
- Ensure that assessments consider the whole family, e.g., who is in the family, do you have a genogram and what are the family members' needs, family background? Does your assessment consider the child's social context? Have all the children in the family been seen individually and their voices heard?
- Consider whether you have spoken to everyone you need to, that all involved agencies have contributed to assessments and that you are sharing relevant information to strengthen your analysis
- Keep a firm focus on potential risk, reflect on existing evidence and assessment, re-assess risk factors and triggers, and use escalation when risks are not reducing despite intervention

Key learning points for managers:

- Promote the use of the Early Help Assessment and multi-agency tools to develop a better understanding of the child's lived experience, e.g., neglect tools, Multi-Agency Chronologies, genograms
- Support practitioners to refer to the Complex Child Panel where interventions have not led to improved outcomes for children and families, and/or to escalate if there are concerns that the needs of a child are not being met in placement

Key learning points for the safeguarding system:

- The review report noted the importance of all relevant agencies actively contributing to assessment, to strengthen the analysis and quality of evidence should legal proceedings be required
- Work is required with Universal Services to embed the use of the Early Help Assessment and multi-agency tools, to improve practice around the early identification of abuse and neglect
- All agency leads to promote the use of multi-agency chronologies, and the multi-agency chronology practitioner portal, to improve practice in recognising and recording significant events in children's lives and the impact they have
- The framework for identifying, commissioning and monitoring placements that meet the needs of individual children should be embedded and monitored to ensure that information held on the suitability of out of county homes is comprehensive and up to date, and protocols are fit for purpose. Placement plans must also set out specific expectations, roles and responsibilities including levels of staffing, how often checks will be carried out on children day and night and the meaning of 'waking night cover'
- Work should be undertaken across health and social care to develop a common language to describe the therapeutic (mental health) needs of children in care and the different types of interventions that should be used to meet their needs. This should be disseminated to all relevant staff to ensure that children's needs are understood, and the appropriate interventions are commissioned and/or put in place
- Placement plans for children where there is a risk of suicide, must include a clearly set out suicide prevention plan, and risk assessments undertaken to identify and eliminate individual and specific risks highlighted, e.g., ligature points. Plan should be clear on individual roles and responsibilities

If you do one thing……

Ensure that assessments and plans are holistic and understand children's needs within their family, wider social context and current environment:

- Are they clear about the full extent of risk and trauma experienced and what the child needs as a consequence?
- Have all children's voices been heard and listened to in the work?
- Have all relevant agencies been involved to take a co-ordinated approach?
- Have you considered the use of relevant multi-agency tools to inform the child's assessment or plan?
- Are assessments and plans purposeful and SMART so that progress can be measured?

National Learning from this Review

Placement insufficiency

There is a national picture of placements not being able to meet increasingly complex needs and, as a result, children being placed away from their home areas. This issue has been recognised in Oxfordshire.

Work is underway locally and regionally to increase the number of local placements that can meet the needs of children we care for, and to raise this concern at a national level.

Did you know? The following links offer useful further information and guidance:

- ✓ **OSCB Multi-Agency Toolkit**
  Tools and interventions to improve practice and inform assessments and plans, for use by any practitioner or volunteer working with children, young people and families, e.g., Threshold of Needs, Early Help Assessment tools and resources, neglect guidance and tools, multi-agency chronologies
- ✓ **Complex child panel terms of reference**
  Sets out the function and responsibilities of the panel, criteria for referral and intended outcomes
- ✓ **Training**
  Core and themed courses including Early Help Assessment, Neglect, Trauma Informed Practice