Kingston LSCB Serious Case Review re Child B May 2015

Executive Summary

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"I knew from the moment I met him what a great guy he was. He would always put others first, something you really noticed in games and just talking on Skype, you just couldn't help like the guy. He really was a pleasure to be around".

"An average boy. 15 years of age, intelligent, funny, a great guy. As I am writing this thread I speak for many people, who all had the pleasure of knowing B. Who will all miss him so dearly". Tributes to Child B by the online community.

Serious Case Review

Child B, a Korean young person, 15 years old, took his own life by jumping from a height in July 2014. The LSCB Chair took the decision to initiate a Serious Case Review (SCR) "as abuse was known or suspected and a child had died". Working Together 2013 5.1.

A multi agency Panel met to oversee the learning and improvement review, and also carried out staff interviews of those who had worked with the family. The Panel included the Designed Nurse for Safeguarding Children, Public Health, Kingston Council, Achieving for Children, CAMHS, [Child & Adolescent Mental Health Services, SWLSG], Met Police, Designated Doctor, Kingston Hospital, Education Inclusion Lead, AfC, Senior Lawyer Social Care & Education Team.

Chronologies were requested from all involved agencies and 18 practitioner conversations and briefings took place to consider learning.

The story

Child B had lived in the UK since he was six. At the age of ten, he was subject to a Child Protection Plan after he disclosed that his father had hit him with a golf club. He was briefly accommodated in foster care. At the time, the father was working long hours to make ends meet and leaving his sons alone for much of the time. Following the Child Protection Plan, a Child in Need plan was made and then the case was closed in 2011.

In 2012, Child B was involved in theft and children's social care again was involved. The family was made homeless and was struggling financially. Early in 2014, Child B was referred to the Young Carers' project, his father having had an accident which left him with health problems. There was considerable support for the family.

In July 2014, Child B used his father's credit card to pay for some £500 of online games. He committed suicide the day after this came to light, having told his school that he wanted to kill himself. The school responded appropriately to this information, and communicated with Children's Social Care. In the process of the risk assessment, some information was not fully taken into consideration, and Child B himself said he was happy to go home. Support was planned for the following day. The review has found that Child B's death was not predictable or preventable, but that there is local learning.

The review brought four findings for the LSCB to assure:

1. The functioning of the point of access to Children's Social Care is dependent on the sharing of relevant information with the right people in a timely way, underpinned by procedures or protocols that are known and used by everybody involved.

2. Although some individual practitioners expressed some confidence in their skills and knowledge about young people who express the intent to kill themselves, this confidence is not spread across the multi agency work group. This suggests that more or better training and/or awareness is needed and access to support to assess at primary mental health worker level.

3. If a minority community makes few demands on statutory services, and is not well represented among service users or providers, its culture is liable to remain hidden or poorly understood. The impact is felt when statutory services need to get involved and do so, on the basis of insufficient understanding of the culture, attitudes and beliefs of the service user. There is then a heightened risk of poor outcomes.

4. Critical Incident Stress Management across member agencies and its effectiveness.

The Board was also to ensure good practice around hearing the child's voice, the involvement of parents in case planning, the quality of report writing, and local responses to private fostering.

Child B's father has played a full part in this review, for which the LSCB is very grateful. Child B's father can see how Child B became dislocated from family life, as he became more involved in online gaming, and thinks that Child B died as he had taken money from his father's bank account and knew he should not be doing this. He wants to warn parents about computer games, in order to prevent another such tragedy occurring. He says *"Raising Child B, I did not know how to express my love and give him a sense of peace and protection".*

The review brought out the good practice of Child B's local school, who were immediately supported by the Samaritans after the news of his death was made public. The Assistant Head took a guiding role working with students and parents; there was support from the Educational Psychologist and Health Link Worker. During the school holidays, a support rota was organised and the following new term, students planned a service, a memorial tree and more latterly, an entry in the year book.

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