

Plymouth Local Safeguarding Children Board

Serious Case Review for 'EG' Executive Summary February 2007

Introduction

The purpose of this document is to provide an overview of the outcomes and recommendations of the serious case review commissioned by Plymouth's Local Safeguarding Children Board (PLSCB) into the death of a child.

The aim of a serious case review is not to assign blame, but to ensure that lessons are learned and recommendations are made to the agencies involved in order to avoid similar situations reoccurring in the future.

In the interest of public immunity names will not be used in this document. Instead an individual's title or the position they held will be sited, for example, mother, child or children's services, police.

If you would like further information about serious case reviews and how they are conducted, please refer to the 'Working Together to Safeguard Children' document published by the Department of Health (ISBN 011 322309 9).

Brief case history

The child at the centre of this case died in September 2005 following the withdrawal of life support. A post mortem later confirmed the child died as a result of hanging.

On 30 November 2005 the then Chair of Plymouth's Area Child Protection Committee wrote to the parents notifying them of the need to undertake a Serious Case Review. A Terms of Reference was subsequently produced by the Serious Case Review Sub Group of the now Local Safeguarding Children's Board on 27 June 2006 and an independent overview report author was commissioned. Specific considerations for this review were considered to be as follows:

- Review the involvement of all agencies with members of the family from the time of recognition of the younger sibling's disabilities to the time of the child's death. Additionally, the reviewer will consider the actions and plans put in place by the strategy meeting
- Were the needs of all the children in the family kept in mind by all the agencies?
- Were there any indications in the child's presentation that he/she may have been in distress?
- Were appropriate assessments undertaken with the family, given the younger sibling's disabilities?
- Were appropriate services offered to meet the assessed needs of the family?

In the full serious case review report information about family history was included in order to provide the background leading up to the family being involved with various agencies in Plymouth. A chronology of events from 1994 to 2005 was also included in order to provide an account of the work and interactions of the professional agencies involved. Interviews with the members of staff involved and some family members were also conducted.

It was from this evidence that the recommendations and lessons to be learned highlighted in the serious case review were identified. Those recommendations form the content for this summary.

Lessons learned and recommendations

The family had left their hometown for a fresh start in Plymouth. During the time period assessed as part of this review, the family consisted of mother, stepfather and three children. They had very little external support from family or friends. Both adult carers worked and the youngest sibling required fairly intensive input from the Children and Adolescent Mental Health Service.

The child at the centre of this review aroused no concern from professionals. He/she was regarded as a model pupil in school being unusually mature, self sufficient and caring. He/she loved school and was popular with peers and staff alike. He/she also had outside interests including football. The child's enthusiasm could also make him/her impulsive and he/she has been described as a 'daredevil'.

The child presented to have been generally happy with a positive personality and the family appeared to have been in a less pressured phase at the time of the incident.

From a comment made to the mother and the note that he/she wrote it is clear that in that moment the child did intend to take his/her own life.

There is no evidence to indicate that this was premeditated, influenced by anything he/she had read or seen, or linked to any longer period of unhappiness.

However, there are still some lessons to be learned by each agency in this case. The recommendations below highlight the key areas for improvement identified in the serious case review report:

Individual agency recommendations

Recommendation for Children and Young Peoples Strategic Partnership

- In those circumstances where a child with disabilities is receiving a service, the lead agency for the child must consider whether the siblings should receive an assessment in their own right

Recommendations for Plymouth City Council Children's Social Care services

- Plymouth City Council's Children's Services department should ensure that all Initial Assessments are completed within the timescales and are signed off by the Team Manager
- Plymouth City Council's Children's Services department should ensure that their Young Carers services are well advertised and open to siblings where their assessed needs indicate that they meet the criteria, and that the referral process is clear to all partner agencies and parents
- In the event of serious cases of child self-harm requiring extensive inter-agency liaison, Plymouth City Council's Children's Services department should ensure that one Duty Manager takes responsibility for the case overview

Recommendations for the Westcountry Ambulance Service

- The West Country Ambulance Service should review its Control Instruction with Devon and Cornwall Constabulary in relation to hanging incidents. This is to ensure that the text is more robust and unequivocal in relation to the anticipated Police response

Recommendations for Plymouth Hospitals NHS Trust

- When a child attends the Accident and Emergency Department with life threatening self-harm, the Police and social services must be informed as soon as possible.
- Plymouth Hospitals NHS Trust should review its procedures for assisting the notification of all relevant family members, particularly those with Parental Responsibility, of the

whereabouts of children admitted for critical and life threatening in-patient treatment

Conclusion

To conclude, this was a tragic incident that could not have been predicted by the agencies involved with the family through the support offered in relation to the youngest sibling's disabilities.

From a comment made to the mother and the note that he/she wrote it is clear that in that moment the child did intend to take his/her own life.

There is no evidence to indicate that this was premeditated, influenced by anything he/she had read or seen, or linked to any longer period of unhappiness.

There are some lessons to be learned by each agency in this case, which have been outlined in the recommendations section of this report, but it is clear that this incident could not have been prevented by the intervention of any one agency.