Plymouth Local Safeguarding Children Board

Serious Case Review for ‘ST’
Executive Summary
February 2007

Public Document

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 young person at the centre of this case was pronounced dead on arrival at Derriford Hospital in November 2004. The cause of death was asphyxiation by a bandana.

Following meetings by the then Plymouth Area Child Protection Committee, it was agreed that a Serious Case Review would be undertaken. An independent overview report author was commissioned in June 2006 by the Serious Case Review Sub Group of the now Local Safeguarding Children Board and terms of reference for the review were subsequently agreed in July 2006. Specific considerations for this review were considered to be as follows:

- Establish that there was appropriate information sharing between agencies when the family moved from Hampshire
- Establish that information was shared appropriately between agencies following the young person's death and support offered to 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 incident. A chronology of events from September 2004, when the family arrived in Plymouth, to the young person's death in November 2004 was also included in order to provide an account of the work and interactions of the professional agencies involved.

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 in Hampshire to move to Plymouth in September 2004. During the time period assessed as part of this review, the family consisted of mother, stepfather, two step siblings and an auntie.

The young person started school on the third Monday of term and made friends quickly. It seemed he/she was popular and had many friends. The school reported that there had been some problems with schoolwork and help was given for planning a support system. He/she was well respected by staff and students.

There do not appear to be any issues of significance that may have predicted the young person's death.

Individual agencies were appropriately involved and there were no significant needs identified for any of the family members by any agency. School support was also appropriate.

There are no recommendations for any agency as a result of this review.

Conclusion

To conclude, this was a tragic accident. There were no predictive factors that may have led to any concern about the young person's mental health that would have led to a conclusion of suicide.

Individual agencies were all appropriately involved and there are no recommendations for improvement as a result of this case.