CHILD C

A SERIOUS CASE REVIEW

EXECUTIVE SUMMARY

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On behalf of the Portsmouth Safeguarding Children Board
June 2011

1.1 This report is written following the death of a baby, Child C. The cause of death was identified as positional asphyxia – that is, he was unable to breathe properly because of the position in which he was lying.

1.2 The nature of the death of Child C, in the context of substantial involvement of various agencies with his family, led the Portsmouth Safeguarding Children Board[1] to conduct a Serious Case Review in line with statutory requirements, as set out in the government's guidance[2].

1.3 This is the Executive Summary from that Review. It outlines the background to the case, and the broad issues it raises. It is less full than such reports usually are, because the circumstances are such that publication of fuller reports would probably lead to the identification of the family.

1.4 Child C's mother, Ms D, had been known to various agencies since her early teenage years. There were many concerns about her very troubled adolescence and what might have led to her outwardly difficult behaviour. At sixteen years of age she formed a relationship with Child C's father, Mr E, and they have had a number of children together.

1.5 Ms D was repeatedly subjected to domestic abuse, sexual and financial exploitation. Although she made attempts to leave Mr E, and was considerably assisted in this by some of the services contributing to this Review, these attempts were never sustained for long. She was emotionally dependent on Mr E and, in some ways, he assisted her with the care of the children. There were also issues which may have motivated him to sustain the relationship.

1.6 Ms D was known to have abused alcohol and to have shown signs, at times, of mental ill-health. She was also found guilty of a serious criminal offence. There were continuing concerns for the welfare of her children. However, the child protection arrangements developed by the various agencies involved with the family were repeatedly ineffective. Plans lacked clarity and were not enforced. Too many agencies were involved without adequate reference to each other. There was no disharmony between agencies but communications were often unsatisfactory. Child Protection Conference administration did not always work well. Ms D and Mr E were effectively able to disregard the fact that the children were subject to Child Protection Plans.

1.7 It is right to acknowledge that the children have, until the death of Child C, generally presented as healthy, loved and well cared for by their parents. However, there are signs that their development has been and might increasingly come to be adversely affected by their home circumstances.

[1] Local Safeguarding Children's Boards were established in 2006 as the statutory mechanism for the safeguarding and protection of the welfare of children.

[2] Working Together to Safeguard Children (2010)

1.8 Despite the background of substantial involvement agencies failed to consider Child C's circumstances fully at a pre-birth Child Protection Conference. He subsequently became subject to a Child Protection Plan, (which was in place when he died) principally again because of the background of domestic violence in his family. He was well cared for and loved before his death but that death may have been prevented. His parents had not followed advice about "safe sleeping" and had left him unattended for some hours, while they slept. No criminal proceedings arise from his death.

1.9 This Review involved many statutory and voluntary agencies. It has brought to light a number of issues about the ways in which those agencies work, individually and together, to protect children. Those issues have in turn led the Portsmouth Safeguarding Children Board to draw up an Action Plan, which aims to ensure that the lessons learnt from this Review are taken fully into account in managing and delivering services to children and their families.