Serious Case Review : R

Executive Summary
Summary of the facts of the case

This report summarises the findings of a Serious Case Review that was conducted to examine, and to critically evaluate, the circumstances which led to the death of R who died in hospital two days after sustaining a sub-dural haemorrhage at home where she lived with her mother and maternal grandparents. Her mother’s partner, who was not the natural father, was present when it became apparent that R was acutely unwell. He was arrested the following day. There is an ongoing police investigation into the circumstances of the death.

Equality and diversity issues were considered throughout the review but were not identified as contributory features of this case.

R was born by emergency Caesarean section in response to her mother’s pre-eclampsia at hospital at a gestational age of 27 weeks and 6 days. R was cared for on a neonatal intensive care unit where she made good progress and was discharged at the equivalent of 36 weeks gestation.

R failed to gain weight at a sufficient rate following discharge, but this was not addressed adequately by the health visiting service when R was brought to the clinic by her mother on eight occasions over a 17 week period.

On the day of the injury to R, her mother’s partner noticed R was gasping for breath. An ambulance was called and R was admitted to hospital. A CT scan showed a large subdural haemorrhage. Her condition was rapidly stabilised and she was transferred to a specialist hospital. A repeat CT scan showed a deteriorating situation which was irreversible by surgery. In a joint decision with the family, medical staff withdrew treatment and R died shortly afterwards in her mothers arms.

Terms of Reference

The LSCB Serious Case Review Panel agreed the following Terms of Reference for this particular case:

1 The involvement that agencies had with R's mother from Year 10 and her partner from Year 10.

2 The care provided to R and her mother prior to her birth, from the date her mother became aware that she was pregnant.

3 The nature of support provided within the Maternity Unit, including preparation and support arrangements in relation to discharge (Special Care Baby Unit). Transition from Midwife to Health Visitor to be included in the IMR and Chronology.

4 Ongoing support provided to R and the carers, including a focus on parenting roles, and how this impacted on baby R's emotional and physical development. All agencies to consider their role actual or potential.

5 Agency interventions in relation to R's admission to hospital, following the summoning of the emergency services.

6 After care/support to the family following R’s death.
Whether there are any ongoing safeguarding issues regarding children in the extended family.

Methodology used for the Review
The Serious Case Review Panel was chaired by an independent chairperson and comprised representatives from key statutory agencies.

Given the potentially specialist nature of the Review, care was taken to select an Independent Author who had a good level of expertise and experience in the completion of similar review reports.

The following agencies had some direct involvement with R, her mother and her mother’s partner and were required to undertake an Individual Management Review.

- Hospitals
- Primary Care Trust
- Schools
- Police
- Council Services
- Connexions

Managers conducting the Individual Management Reviews were not directly involved in services provided for the child, nor the immediate line manager of the practitioners involved.

Selected agency representatives were brought together to form a Serious Case Review Working Group. The Serious Case Review Panel took responsibility for the Terms of Reference and the overall quality of the report.

The agencies represented on the Serious Case Review Panel were:-

- Independent Chairperson
- Primary Care Trust
- Police
- NSPCC
- Council Services
- NHS Hospitals Trust
- The Independent Author also attended

The agencies represented on the Serious Case Review Working Group were:-

- LSCB Business Manager - Chairperson
- Independent Author
- Hospital
- Primary Care Trust
- Police
- NHS Hospitals Trust
- Council Services

R’s mother and maternal grandmother both contributed to and informed the review. Some of the agencies Individual Management Reviews have clearly identified weaknesses in their working processes which have been addressed in the agency action plans.

Principal Findings
The antenatal care given to R’s mother and R’s initial hospital care were of a high standard. Support and supervision was given in parenting skills to R’s mother by the
hospital staff during R’s stay. She developed these skills and demonstrated she was able to independently care for R. This is commended. R’s mother also demonstrated a continuing commitment to R’s welfare and development which continued until R’s death.

The Health Visiting service was not involved in a hospital discharge planning meeting and the need for a Common Assessment of Need was not considered by the hospital.

After R’s discharge from hospital her mother took her on eight occasions to the Health Visiting service expressing concerns that R was not putting on weight as well as her mother thought that she should. The Health Visitors noted and charted the lack of weight gain, but no timely or effective steps were taken to intervene. R’s mother continued to express her concerns.

Health services were the only agencies involved in R’s care prior to the final admission to hospital.

After sustaining the sub-dural haematoma, the care given to R and the support provided to her family was of a high standard.

Following her death, the bereavement support given to the family by the hospital and police was also of a high standard.

The extent of the involvement of the mother’s partner in the domestic arrangement of R was not noted. In effect, he was an ‘invisible partner’.

Neither the CYPS nor police were significantly involved prior to the time of the final event. Timely and effective action was taken once they were involved. Sudden unexpected death in infancy (SUDI) and child protection procedures were appropriately initiated and acted upon.

No concerns of a safeguarding nature were identified or predicted prior to the final admission to hospital. The Serious Case Review has identified no evidence that any agency could have acted to prevent the death. However, there has been some useful learning identified for the agencies involved to develop more effective working in the future.

**Learning Points**

Health Visitors must be involved in planning future care requirements of children prior to their discharge from hospital when the child has required prolonged intensive care.

Continuing training is required for all staff to ensure good record keeping standards are maintained.

Sufficient and timely information sharing between agencies is a prerequisite of effective provision of services.

The principles of a SUDI protocol are transferable to all child life threatening events.

All staff need to be alert to the concept of a ‘hidden male’ involved with clients / patients.

**Recommendations**

The recommendations of those individual agency IMRs that contain recommendations are endorsed in the overview report and attached as an appendix to that report.
LSCB Recommendations

Recommendation 1
The serious case review report should be shared with all agencies involved with baby R, her mother and the mother’s partner and any actions identified should be shared with all staff to inform through structured training to include:

- Practice to improve service delivery
- The essential importance in recording patient/client information
- Review of any follow up and frequency of contacts to clients/patients in line with good practice

Recommendation 2
The LSCB Chair should send a copy of this report to the Chief Executives of each organisation to ensure compliance with the recommendations involving all providers.

Recommendation 3
The LSCB chair should consider inviting DCSF to prepare a standard template to assist agencies in preparing individual agency reports for the purposes of Serious Case Reviews.

Recommendation 4
The LSCB chair should ensure that a robust mechanism is established to monitor and evaluate the implementation of IMR recommendations.

Recommendation 5
In order to address the issues relating to the importance of role of the “hidden male” within families, LSCB should undertake raising awareness to include training for all practitioner working with families to ensure significant male visitors/ carers within families are always considered when undertaking assessments and developing plans.

Connexions

Recommendation 1
Information sharing arrangements with Hospital and Job Centre Plus to be reviewed to enhance existing information shared.

Recommendation 2
Safeguarding concerns should be raised with all staff in respect of this serious case review to inform them of the key importance of each member of staff to review client records irrespective of being on their caseload. This should be through a structured training session to include:-

- Review of basic details
- Client history particularly where there are periods of dis-engagement and change of addresses which could possible indicate safeguarding and support needs for the young person
- More proactive approach to young people who experience several periods of disengagement
- To be very aware of information recorded in the aide memoir and take responsibility for seeking clarity from a member of the management team about safety and well being concerns for a young person at the earliest opportunity. In particular with vulnerable young people they should clarify exactly what their
condition is, in this case whether RAG was actually pregnant, and not rely on a negative response.

**Recommendation 3**

Supervision practice between GMCP Managers and Personal Advisers (PA’s) should review recording and outreach practice of staff as part of caseload supervision. Ensure that actions are agreed, completed and followed up and that safeguarding practice is promoted to all.

**Learning Establishment**

**Recommendation 1**

Review Record sharing with all schools in the area ensure they understand the expectations in relation to accurately and timely information sharing.

**Recommendation 2**

Ensure that all new staff to are fully conversant with the procedures around information sharing.

**NHS Hospitals Trust**

This SCR has highlighted the poor quality of information sharing between the Health Visitor Service and Midwifery/Neonatal service at the Hospital.

**Recommendation 1**

As a matter of priority the Health Visitor Manager or her representative should liaise with the manager of Special Care Baby Unit and the manager of Midwifery to develop a protocol to improve communication at the interface between Midwifery, SCBU and Health Visitors. The protocol should comply with the Child in Need and Common Assessment Framework. It should not take more that 3 months to achieve this recommendation.

**Primary Care Trust**

**Recommendation 1**

In the next 12 months the school nursing service should devise a system to ensure that the school nursing service have the correct contact details for all children who do not attend following invitation, as per Trust protocol, for their final booster immunisation. Once this has been established the school nursing service should ensure that immunisation information is offered to the child to ensure that the decision not to attend for the immunisation is an informed one. Consideration should be given to gradually introducing this system, with set realistic percentages which should increase over the next three years, to ensure that this recommendation is achievable.

**Recommendation 2**

HV1 requires re training in the following
- Record keeping
- Growth and nutrition

However HV1 has now left the Trust, the finding of this report will be shared with her new employer.
Recommendation 3

The role of the Family Health Co-ordinators would benefit from a review and strong consideration should be given to releasing from caseload commitments. This would allow them to assume their full responsibilities with regard to management oversight and clinical governance and multi agency working to ensure a more efficient use of children centre and health visitor resources.

Recommendation 4

All NNEB’s involved in this report require retraining in

- Record keeping
- Growth and Nutrition

This should be done as a matter of urgency to prevent any further incidence of this nature. There should be clear management guidelines that incorporate clinical supervision and management oversight of cases to manage further risk. This will assess and monitor the NNEB’s competency following the retraining. It should not take longer than three months to complete the retraining and to establish a structure of clinical supervision for the NNEB’S.

Recommendation 5

Within the next 6 months the Health Visiting Manager should ensure that protocol for corporate caseload are revised. This must include

- Clear terms of reference for the team
- Clear lines of accountability for all team members.
- A robust communication system for all members of the health visiting team.
- A system to ensure information received by the health visiting team is read, acknowledge and prioritised.
- A method to identify children with faltering growth who are attending clinic and an action plan for their management.
- Audit tools developed to ensure these protocols are being adhered to.
- Full training should be provided to ensure all members of the health visiting team understand the concept of corporate working and that lines of management accountability are unambiguous.
- Compliance will be monitored through clinical supervision and through the established Family Health Co-ordinator meetings.

Recommendation 6

Family Health Co-ordinators under the supervision of the Health Visitor Manager should undertake an audit of Health Visitor records to determine which, if any Health Visitor’s, require master class training. This should be completed within 6 months.

Recommendation 7

In the next 12 months local specific in depth protocols need to be developed by the health visiting service regarding record keeping. This will ensure that they are able to interpret the Trusts protocol at local service levels.
This should include;

- Clear guidance when to record information.
- When to generate a child’s record
- Define what information should be recorded in which section.
- The expected content
- A mechanism for acknowledging correspondence is read and actioned by the appropriate professional.
- It is clearly documented whether a child is in receipt of universal or targeted health visiting service.
- Evidence of analysis of the content of the record to formulate future plans
- This will be monitored through annual record’s audit and clinical supervision.

Recommendation 7

Within the next 6 months the health visiting teams need to develop protocols to ensure that there are clear communication networks between the health visiting service and the GP. This is particular relevant to ensure that immunisation details are received by the health visiting team from GP practices to ensure immunisation status is accurate.

Recommendation 8

All members of the Health visiting teams should attend faltering Growth and Nutrition training annually as part of the mandatory training scheme.

Recommendation 9

As a priority Health visitor should ensure that the NNEB’s who are in attendance at baby clinic are able to identify and refer babies with faltering growth to the Health Visitors as per faltering growth guideline. This will be achieved through clinical supervision.

Hospital

Recommendation 1

CH1 to feedback the outcome of the IMR, Overview Report findings and Recommendations, to Trust Executive Board and Clinical Governance leads within the organisation.

Recommendation 2

CH1 to feedback the outcome of the IMR, Overview Report findings and recommendations, to relevant professionals including PICU, Bereavement Service and child protection team throughout the organisation within safeguarding mandatory training events

Schools

This review has demonstrated that the information sharing between schools and its partner agencies is not always as effective as it should be in providing a comprehensive service to clients. In particular, the transfer of information, which should have occurred following RAG’s move to Swansea did not happen.
Recommendation 1

A member of the schools senior leadership team should be identified, immediately, to lead on attendance. They should monitor the accuracy of attendance records and the effectiveness of the school’s processes for addressing attendance problems. They should have an overview of the work of the school’s attendance officer.

Recommendation 2

The high level of persistent absence is an on-going issue for the school, therefore, this senior leader should report on this area to the governing body each term until the issue is resolved.

Recommendation 3

The school should consider what opportunities for alternative provision are available for younger pupils who, for whatever reason, are not attending. School should identify when and how should external agencies become involved with a pupil?

Recommendation 4

For each pupil identified as having poor attendance, the school should clearly identify a lead professional, who will take responsibility for managing the whole process and ensuring proper records are kept. This should happen immediately.

Recommendation 5

The school should review its internal arrangements for managing poor attendance. This should include consideration of how and when it engages with hard-to-reach families, the arrangements for home visits and the related roles of the Educational Welfare Officer and the school’s own attendance officer. The review should examine the quality of records kept to ensure that patterns of behaviour are identified and opportunities are not missed to re-engage pupils at an early stage.

Recommendation 6

The school has appointed a new Inclusion Manager (SENCo) who has established new procedures for supporting pupils on the SEN Register. He should be supported by an identified line manager on the school’s senior leadership team, who will ensure that he is provided with appropriate training. (No formal training has yet been provided). Together, they should monitor the implementation of the school’s SEN policy. If necessary, the school should draw on external support, from the Local Authority or other schools, to evaluate and improve its practice.

Overall Education

Recommendation 1

No pupil’s attendance should be allowed to fall below 80% for a significant period without a full investigation and an action plan being established. This plan should be supported by external agencies and monitored regularly. The school should aim to have achieved the government target to reduce persistent absence by the end of the next academic year (July 2010).
Recommendation 2

SEN provision should be clearly evaluated as part of the school’s systematic self-evaluation cycle. Findings should be recorded within the school’s new Self Evaluation Form (SEF) by December 2009 and any recommendations included in the next school development plan (by March 2010).

Children and Young People’s Services

Recommendation 1

That EDT and IT section ensure the ability of EDT to use the Strategy Discussion pro forma within ICS.

Recommendation 2

That all social workers are briefed on the need to include basic information on their ICS recording eg who is present during home visits, purpose of the visit, analysis of information and outcome. For social workers to sign the case notes.

Recommendation 3

Team Managers to be informed that initial assessments on family members should not be transferred to another team on an open case.

Recommendation 4

That social workers are reminded that they should include all relevant adults and children on ICS and link them to records under the ‘relationships’ tab.

Recommendation 5

A protocol to be drawn up to outline how CYPS monitors agreements for supervised contact within families over a period of time.

Recommendation 6

Staff are reminded that minutes of meetings must be inputted onto ICS.

Police

Recommendation 1

Wherever possible the author of Individual Management Reports should be totally independent and have no line management responsibility for any Police Officers who have interacted with the subjects of IMR reports. To ensure such compliance, the Police have recently introduced a ‘BUDDY’ system for IMR authors to ensure an extra layer of independence. The BCU is teamed with another Areas BCU for this purpose and it is intended that future IMR reports will be produced for the Police by the another areas SIO and vice versa. This should be seen as good practice.
Recommendation 2

The introduction of an accredited Family Liaison Officer when the collapse of Baby R was still being treated as an ALTE was a positive one. This undoubtedly assisted the Police to obtain crucial early evidence to aid the investigation. Similarly it has benefited the family who have been signposted appropriately into support networks. Consideration should be given to allocating FLO services to all families where an ALTE occurs to a child.

Recommendation 3

The investigation into the collapse of Baby R has been treated as significant by the Police BCU. As such a Senior Investigating Officer and a team of officers were appointed to conduct the investigation within hours of the initial report. This has undoubtedly helped to progress the enquiry quickly and expeditiously and is evidence of good practice.

Recommendation 4

Following the collapse of Baby R an early review of the investigation was carried out by the Police Serious Case Review Unit. This helped provide direction to the SIO and the investigation team. This type of early review should be considered good practice and utilised in similar cases in the future.

Recommendation 5

It is apparent that SUDI protocols have been followed throughout the investigation into the collapse of Baby R. The SUDI protocol has worked well in this case and should be utilised on every occasion where a child suffers an Acute Life Threatening Event.

Recommendation 6

Although an early strategy meeting was convened with the appropriate level of attendance, it is apparent that minutes from that meeting were not shared in a timely manner. This can leave agencies in a position of vulnerability and a process should be introduced within the Family Crime Investigation Unit to ensure minutes of meetings are shared in a timely and appropriate manner.