NHS Ayrshire & Arran

Meeting: **Ayrshire and Arran NHS Board**

Meeting date: **Monday 23 May 2022**

Title: **Child P – Significant Case Review**

Responsible Director: **Jennifer Wilson, Nurse Director**

Report Author: **Attica Wheeler, Associate Nurse Director Women and Children's Services**

1. Purpose

This is presented to the Board for:
- Decision

This paper relates to:
- Emerging issue

This aligns to the following NHS Scotland quality ambition(s):
- Safe

2. Report summary

2.1 Situation

A significant case review was commissioned by South Ayrshire Child Protection Committee in late 2020 following the tragic death of an infant, Child P, in November 2017, aged 7 weeks.

The purpose of this paper is to provide assurance to Board Members that the recommendations from this review are being fully implemented across our Health and Care system. Board Members are asked to support the remitting of Healthcare Governance committee to monitor delivery of the action plan.

2.2 Background

Child P was born on 11 September 2017 at 39 weeks gestation within the Ayrshire Maternity Unit, NHS Ayrshire and Arran. Child P was born in good health following a Caesarean birth due to fetal distress in labour. During pregnancy, no safeguarding concerns were noted by either midwifery or health visiting teams. Child P had 15 interactions with health care during his lifetime.

On 01 November 2017 an ambulance was called to attend and paramedics were required to perform CPR on Child P. It was reported to the ambulance crew that the baby had choked on his morning feed.

CPR was continued in the Ambulance and Emergency Department. Child P was intubated and sedated then transferred to the Royal Hospital for Sick Children and onward to the Royal Hospital Children's Intensive Care Unit. Investigations including a CT Scan which confirmed Skull, Fracture Subdural Haemorrhage and Diffuse Hypoxic Brain Injury. Multiple Injuries were diagnosed and a decision was made to cease ventilation due to brain death.

Child P was extubated on 03 November 2017 and died from Cardio-respiratory arrest aged seven weeks old. Child P's father was convicted of culpable homicide in June 2021 at the high court in Glasgow.

As per standard processes following the death of a healthy baby, a report was submitted to the Chair of the Child Protection Committee. This report was subsequently submitted to the Chief Officers Group for Ayrshire and Arran who then commissioned a Significant Case Review (SCR).

An external review report was undertaken by an Independent Chair and shared in January 2022. The report included recommendations for NHS Ayrshire & Arran.

2.3 Assessment

The recommendations of the report have been fully accepted and work has commenced to implement this as follows:

- A short life working group has been formed with the first meeting on Tuesday 29 March 2022. This group will co-ordinate completion of the action plan with feedback to the corporate team.
- Structured feedback sessions to staff regarding the findings from the report
- Timelines to compare services from 2017 to present with a gap analysis.
- A training needs analysis for the Multi-Disciplinary Team
- Review of the Paediatric Short Stay Assessment Unit standards

The full, redacted, report can be accessed via the following link (link will be live from 12 noon on 23 May 2022).

https://hscp.south-ayrshire.gov.uk/media/4704/SCLR-Child-P-23-March-2022/pdf/Child_P_SCR_Redacted.pdf?m=637879388092330000

An initial action plan with proposed short, medium and long term actions was submitted for completion by the multidisciplinary team for both the acute and partnership settings.

The six key themes that were of focus on the action plan were as follows:

- Child Health Surveillance
- Short Stay Paediatric Assessment Unit Standards
- Child Protection Training
- Effective Multi-agency working around child deaths
- Inclusion of Partners in child health services
- Standard Operating Procedures for Crying Baby

The full action plan can be found at **Appendix 1**.

2.3.1 Quality/patient care

Learning from all adverse events is imperative in terms of changing practice that will improve patient outcomes and reduce the risk of adverse events re-occurring.

2.3.2 Workforce

Any costs associated with workforce implications as a result of this report will be reported via the appropriate management/governance channels. This will include investment in staff training.

2.3.3 Financial

Any costs associated with the recommendations of this report will be reported via the appropriate management/governance channels. This will include investment in staff training.

2.3.4 Risk assessment/management

Learning from all adverse events is a pivotal and standard part of our Risk Management Approach and is imperative in terms of changing practice that will improve patient outcomes and reduce the risk of adverse events re-occurring.

2.3.6 Other impacts

- Best value
  - Governance and accountability

- Compliance with Corporate Objectives

Create compassionate partnerships between patients, their families and those delivering health and care services which respect individual needs and values; and result in the people using our services having a positive experience of care to get the outcome they expect

2.3.7 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate:

- Engagement has taken place with staff and family as appropriate throughout the course of this review.

2.3.8 Route to the meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Initial Case Review – 21 August 2020
- Chief Officers Group – 26 August 2020
- Significant Case Review – 20 October 2020
- Chief Officers Group – 22 March 2022
- NHS Board (Private Session) 28 March 2022
- Chief Officers Group – 05 May 2022

2.4 Recommendation

For decision. Board Members are asked to support the remitting of Healthcare Governance committee to monitor delivery of the action plan, and to note that the recommendations from this review are being fully implemented across our Health and Care system.

3. List of appendices

The following appendices are included with this report:

- Appendix No 1, Significant Case Review – Action Plan

SCR Child P **NHS Ayrshire & Arran** **Final Action Plan**

Lead Director: **Nurse Director**

Timeframe criteria: **Immediate:** by 30 June 2022 **Medium term:** June 2022 – March 2023 **Long term:** 31 March 2023 onwards

Issue	Learning Point from Report	Agency	Lead Person	Actions	Timeframe
1. Child health surveillance effectiveness	1.1 Need for audit of clinical standards to guide future training/supervision for child health surveillance	NHS Ayrshire and Arran	AND – South Health and Social Care Partnership	• Get clarity from national guidance with regard to R&R for HVs, GPs and the 6 week health check. • Understand practice across all our GP and HV colleagues • Raise awareness of expected standards of practice for 6 week health check with GP and HV staff	30 June 2022
	1.2 Need for action to involve fathers by maternity and community child health services	NHS Ayrshire and Arran	AND Women and Children's Services / AND – South Health and Social Care Partnership	• Understand what resources are available now in 2022 and how we are using them? Develop a plan to use them more widely • Raise issue nationally with NES and SG colleagues for potential national learning and further resources.	30 June 2022 31 March 2023 and onwards
	1.3 Instigation of programme of support for new parents of crying babies	NHS Ayrshire and Arran	AND – South Health and Social Care Partnership / AND Women and Children's Services	• Understand what resources are available now in 2022 and how we are using them? Develop a plan to use them more widely • Raise issue nationally with NES and SG colleagues for potential national learning and further resources.	30 June 2022 31 March 2023 and onwards
	1.4 Review of training materials for early years practitioners regarding	NHS Ayrshire and Arran NES	Chief Nurse Public Protection / Lead Clinician for Child Protection	• Understand what resources are available now in 2022 and how we are using them? Develop a plan to use them more widely	30 June 2022

	management of infantile colic & risk of AHT			• Raise issue nationally with NES and SG colleagues for potential national learning and further resources.	31 March 2023 and onwards
2. Child protection training	2.1 Learning needs analysis to clarify training coverage and guide future policy	NHS Ayrshire and Arran	Chief Nurse Public Protection	• Undertake a training needs analysis (TNA) to analyse what the current education and training needs are of different disciplines and specialties. • Review current NHSAA learning programme and ensure connected directly to Intercollegiate Guideline requirements and recommended needs of specific staff groups. • Link with all 3 CPC officers to ensure multi agency training plans are able to contribute to meeting the NHS A&A training needs.	30 June 2022 **IN PROGRESS AND ON TRACK** 30 June 2022 **COMPLETE** 30 June 2022 **IN PROGRESS AND ON TRACK**
	2.2 Requirement for relevant clinical staff groups to confirm / update their skills and competencies to level 3 including GPs and community midwives	NHS Ayrshire and Arran	Chief Nurse Public Protection / Lead Clinician for Child Protection	• This will be guided by the above TNA and Intercollegiate Guidance • Scope and plan any additional resource requirements • Establish organisation wide assurance mechanism for capturing medical child protection training undertaken (currently done via appraisal system across NHS Scotland)	30 September 2022 30 September 2022 31 March 2023
	2.3 Discussion with national colleagues needed to consider amending online revalidation system	NHS Ayrshire and Arran NES/Scottish government	Nurse Director / Medical Director	• Medical Director to write to Chief Medical Officer with regard to this recommendation and ask for national action.	30 June 2022 **IN PROGRESS AND ON TRACK**

	to require GP refresher courses in child protection			• Medical and Nurse Directors to commission Deputy Medical Director for Primary Care to work with GP colleagues locally with regard to an agreed position on Child Protection Training.	30 September 2022
3. Hospital Short Stay Unit Standards	3.1 Instigation of standard operating procedure for SSPAU Crosshouse University Hospital	NHS Ayrshire and Arran	General Manager Women and Children's Services / Paediatrician / AND Women and Children's Services	• Develop explicit SOPs for the unit to standardise practice and support consistent decision making	30 June 2023 **IN PROGRESS AND ON TRACK**
	3.2 Need for review of clinical input to SSPAU to ensure RCPCH standards are met	NHS Ayrshire and Arran	General Manager Women and Children's Services / Paediatrician / AND Women and Children's Services	• Undertake self-assessment against the standards to inform immediate work required • Review previous RCPCH assessment of unit undertaken in 2017 and resulting business case for any immediate actions • Request repeat assessment by RCPCH to understand 2022 position and include totality of the unscheduled care Paediatric journey.	30 June 2022 30 June 2022 Request by 30 June 2022. Will be dependent on RCPCH for completion.
	3.3 Need to ensure awareness/significance of multiple contacts with NHS by parents seeking help	NHS Ayrshire and Arran	General Manager Women and Children's Services / Paediatrician / AND Women and Children's Services / AND South Health and Social Care Partnership	• Scope and confirm what access SSPAU staff have to the multiple primary and community care IT systems that hold child health records (including NHS24). What needs to be done to improve access if required? • Confirm under GIRFEC which professional has oversight and should be notified of all NHS contacts (routine and non-routine)	30 June 2022

	3.4 Need to enhance training specifically to assist in excluding AHT in a baby with non- specific symptoms	NHS Ayrshire and Arran	Chief Nurse Public Protection / Lead Clinician for Child Protection	• See other CP training actions above and also learning point 1.4 and associated actions	As other learning points
4. Interagency effectiveness around commissioning an ICR/SCR	4.1 Need to ensure processes enable timely referral of suspicious child deaths are robust	South Ayrshire Child Protection Committee	CPC Chair	• The Nurse Director led a group during 2019 to develop Pan-Ayrshire IRD processes and these were approved by all 3 Ayrshire CPCs and COGs in March 2020. • The SACPC now receives an IRD audit report every 6 months on process and outcome.	30 June 2022 **COMPLETE**
			Director of Public Health	• As per national guidance the DPH is currently establishing a pan-Ayrshire Child Death Oversight Process (CDOP) which will be hosted by NHS A&A. • All 3 COGs have been involved in these discussions to date and are fully sighted on progress.	30 June 2022 **IN PROGRESS AND ON TRACK**
5. Interagency effectiveness concerning availability of MOD records	5.1 Need to ensure MOD understands importance of making veteran's records available in terms of their experience in service and later possible mental health issues	NHS Ayrshire and Arran / Scottish Government	Medical Director	• Medical Director to write and flag this issue to Chief Medical Officer for any appropriate action nationally.	30 June 2023 **IN PROGRESS AND ON TRACK**