HAMPSHIRE
SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD I

13.11.14

Contents

1 INTRODUCTION

1.1 BACKGROUND & DECISION TO INITIATE A SERIOUS CASE REVIEW

1.1.1 On a weekday in mid-March 2014 at approximately 11.30 'child I' (a female of approximately 6 weeks of age born in the UK to Saudi Arabian parents) was presented by her parents to the GP Practice at which she had been registered. The baby was noted to be floppy and cyanotic (a bluish discolouration of the skin suggestive of a lack of oxygen in the blood) and the father of the child indicated that his daughter had not been breathing for at least 15 minutes.

1.1.2 Cardio-pulmonary resuscitation was begun immediately and a 999 call was initiated. Resuscitation was continued by the paramedics who attended the scene and by staff at the local hospital to which the child was taken. These efforts proved unsuccessful and the child was pronounced dead at 13.31. Standard procedures for responding to all 'unexpected child deaths' were initiated.

1.1.3 At the time of her presentation at the hospital emergency department, child I had no external bruising and an ophthalmology review offered no evidence of retinal haemorrhages i.e. there were no obvious signs of abuse.

1.1.4 An initial post-mortem 4 days later revealed a skull fracture. Both parents were arrested on suspicion of murder and later bailed. At the time this serious case review was initiated, final post-mortem results were still awaited and a criminal investigation was continuing (on 03.11.14 on advice from the Crown Prosecution Service (CPS) the Police informed the parents that there would be no criminal charges and bail conditions were lifted; the parents returned to Saudi Arabia days later).

1.1.5 The County's 'serious case review panel' had considered the case on 14.04.14 and recommended that a serious case review was required. This recommendation was upheld by the independent chairperson of Hampshire's Safeguarding Children Board Ms Maggie Blyth 16.04.14 and the Department for Education and regulatory bodies Ofsted and Care Quality Commission were subsequently notified of this decision.

1.1.6 The remainder of this introduction explains the purpose and conduct of the serious case review which was completed between July and October 2014.

1.1.7 The report that follows in sections 2-6 evaluates the services that were provided from the time that mother's pregnancy with child I became known to local agencies through to the baby's death. On the basis of that evaluation (itself informed by one to one discussions described in section 2 and a learning event for all involved staff), overall findings, conclusions and recommended system improvements are made.

1.1.8 Though formal submission of the recommendations (all of which have now been accepted by Hampshire's Safeguarding Children Board) was postponed until the conclusion of the concurrent criminal investigation, the more urgent or significant of them were acted upon during the Autumn of 2014.

1.1.9 The current expectation is that this report will be published on Hampshire's Local Safeguarding Children Board website by February 2015.

1.2 PURPOSE & CONDUCT OF THE SERIOUS CASE REVIEW

PURPOSE

1.2.1 Regulation 5 Local Safeguarding Children Boards Regulations 2006 requires Safeguarding Children Boards (LSCBs) to undertake reviews of 'serious cases' in accordance with procedures in *Working Together to Safeguard Children* HM Government [latest edition 2013]. A 'serious case' is one in which abuse or neglect is known or suspected and either the child has died or been seriously harmed, and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard the child.

1.2.2 Its purpose is to:

- 'Establish what lessons can be learned about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- Identify clearly what those lessons are within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result and
- As a consequence, improve intra and inter-agency working and better safeguard and promote the welfare of children'

1.2.3 A serious case review is not concerned with the attribution of culpability which is a matter for a criminal court. The issues of concern is this case are provided as sub-headings and analysed in section 4. Sections 5 and 6 respectively, offer conclusions and proposed improvements to local systems. A copy of this report is being sent to the government-appointed national panel of experts and to the Department for Education (DfE).

CONDUCT

Serious case review group

1.2.4 The review group consisted of the:

- Interim Designated Doctor for Safeguarding Children Hampshire
- Designated Nurse for Safeguarding Children Hampshire
- District Service Manager Hampshire Children's Social Care
- Service Manager SSAFA (welfare service providers for members of the Armed Forces and their families)
- Local Safeguarding Children Board Manager (who resigned during the course of this serious case review)
- Detective Chief Inspector Hampshire Constabulary

Lead reviewer role / independent authorship

1.2.5 An independently authored report was commissioned from **www.caeuk.org** (an independent consultancy with experience of over 50 serious case reviews). It was agreed that upon submission of relevant material, the lead reviewer Fergus Smith would:

- Collate all material submitted to the serious case review
- Conduct supplementary enquiries e.g. discussions with relevant individuals or staff groups
- Develop for consideration by the review group a narrative of agencies' involvement, an evaluation of its quality, conclusions and recommendations for action by Hampshire's Safeguarding Children Board, member agencies and (if relevant) other local or national agencies

Learning event

1.2.6 In addition to one to one conversations with involved professionals, a learning event for all those involved was convened. The event enabled a facilitated exchange of experiences and opinions and served to enhance understanding of and commitment to the ways in which local services could be improved.

Family involvement

1.2.7 At the request of the Hampshire Constabulary's senior investigating officer and to avoid any risk of contaminating evidence of potential use in the criminal investigation, neither parent was asked to discuss their experiences of local services whilst that investigation was current. Instead, the lead reviewer met the parents at the office of their legal representative and a translated letter (for mother) and an explanation in English (for father) about the fact and purpose of the serious case review was provided.

1.2.8 A female bilingual solicitor also facilitated the exercise which may (it is hoped) have served to ensure that (reflecting the UK's notion of gender equality) father's perspective did not predominate.

1.2.9 Upon receipt of confirmation on 11.11.14 by the lead reviewer that neither parent was to be prosecuted for any criminal offence, a letter offering a further meeting and an opportunity to contribute to the serious case review was immediately delivered by hand. No response was received and it is understood that the couple have returned to Saudi Arabia.

Anonymisation

1.2.10 To protect the identity of child I, family members and involved professionals, identifying detail has been removed from what is in all other respects a complete and transparent account.

2 FAMILY CONTEXT & AGENCIES INVOLVED

2.1 FAMILY CONTEXT

2.1.1 Child I's father is an officer in the Saudi Arabian Navy seconded for training to a base in Hampshire. Following their marriage, his wife (also a Saudi national) was entitled to join him. Accommodation and welfare support is commissioned by an independent contractor to provide the technical and practical needs of the Saudi officers.

2.1.2 The above contractor referred to hereafter as the 'welfare service provider' meets the need for both family accommodation and a level of more personal support required for those entering an unfamiliar country and culture e.g. ensuring GP registration, enrolment of children of compulsory school age etc.

2.1.3 The welfare service provider consists of a manager and two welfare officers which in their own estimation is sufficient to provide a good and reliable level of general support. In this case the welfare officer was directly involved with both parents through attendance with mother at most ante and post natal health-related appointments.

2.1.4 Child I is understood to have been the couple's first child. Of central significance to the services offered to the family is that although father (now approaching the end of a 4 years posting to the UK) speaks fluent English, his wife speaks none.

2.2 SOURCES OF INFORMATION

2.2.1 The following agencies were identified as having information of particular relevance:

- Portsmouth Hospitals NHS Trust (which provided gynaecology, midwifery and emergency care services)
- Southern Health NHS Foundation Trust (health visiting)
- A GP Practice (consultations with mother and attempted resuscitation of child I)

2.2.2 The welfare service provider was subsequently identified as a source of relevant information and willingly and very helpfully co-operated with the review process.

2.3 SUPPLEMENTARY DISCUSSIONS

2.3.1 Chronologies and reports from the above agencies were supplemented (for which review group members are grateful) by one to one discussions with:

- The GP consulted by the parents
- A manager and a welfare officer from the welfare service provider
- The involved midwife and health visitor

3 INVOLVEMENT WITH LOCAL SERVICES

3.1 INTRODUCTION

3.1.1 The remainder of section 3 lays out in chronological order and includes some (italicised) comments about the services provided. Section 4 provides an analysis and 5 and 6 respectively, findings and conclusions, and recommendations.

3.2 EVENTS

PREGNANCY

3.2.1 In mid-June 2013 the GP made a routine referral of mother to the Gynaecology Unit at the hospital. Tests confirmed that mother was about 4 weeks into her pregnancy. An attempt to contact an interpreting service to assist communication with mother was unsuccessful. At a follow-up visit when mother was accompanied by the welfare officer from the Base, attempts to reach the translation service succeeded.

Comment: *the inability to access the service during mother's first visit raises the question of the effectiveness of current arrangements. A recommendation is provided in section 6*.

3.2.2 The GP was sent a routine discharge summary and community midwife 1 (CM1) became aware of the pregnancy at her weekly collection of notifications from the Practice. Arrangement for ante-natal care were unintentionally delayed until early September because (father indicated) mother had been back to Saudi Arabia. The welfare officer has been able to confirm that both parents completed this trip home.

3.2.3 At the first contact with CM1 (at which health, including mental health history was sought) the offer of an interpreter was made but declined by father who was accompanying his wife. Arabic leaflets were provided on this occasion (as was translated pain relief-related literature nearer the birth).

3.2.4 Mother subsequently attended all ante-natal appointments and consented to all recommended screening. On each occasion mother was either supported by her husband or by the same welfare officer (who was though, unable to speak Arabic). *No* concerns were identified during the antenatal period.

BIRTH OF CHILD I, & POST NATAL SUPPORT

3.2.5 A commendable attempt by HV1 to complete an *ante-natal* home visit was thwarted by child I's early arrival toward the end of January 2014. The birth was uneventful though mother subsequently required blood transfusions for loss of blood. By chance, a duty doctor was able to speak Arabic and provide required explanations and reassurance. Information about mother and her baby was, as per standard practice, shared with the post natal co-ordinator, GP and health visitor (HV1). Advice provided at the hospital included 'safe sleeping'.

3.2.6 Mother and child I were seen on 7 uneventful occasions by midwives in February with some contacts at home and some at a maternity centre. Father was present at all contacts and on one occasion when an interpreter was offered he declined.

3.2.7 The report provided by the hospital Trust confirms that no concerns about coping were identified during this period, though a second community midwife (CM2) referred mother back to her GP during the second week of February because of a minor anomaly in a blood test.

MOTHER'S ATTENDANCE AT GP & PRESENTATION AT EMERGENCY DEPARTMENT

3.2.8 On 10.02.14 (day 10 of child I's life) mother had attended the GP Practice accompanied only by her husband who described how his wife was aching all over her body and was dizzy. On examination, mother was tearful; her abdomen was noted to be soft with some minor bleeding related to the birth. The GP spoke to the husband about post natal depression.

3.2.9 The following day (11.02.14) father brought his wife to the emergency department of the hospital because she was still unwell. He described a '2 day history of worsening fatigue with episodes of shortness of breath, dizziness and palpitation'.

3.2.10 Father described his wife's homesickness and cited the GP's reference to possible post natal depression. The impression noted in records was of mother's 'low mood, possibly post natal depression'. Mother was advised to seek advice from GP or midwife. The former, though not the latter was notified of this attendance.

FURTHER CONSULTATIONS WITH GP & MIDWIFE

3.2.11 On 12.02.14 the records indicate that mother again consulted her GP Practice. The records within the chronology provided to the serious case review indicate that mother had 'fallen down the stairs yesterday and is in a lot of pain'; she was noted to be bottle-feeding child I. Mother was examined and prescribed pain killers by GP2.

Comment: *insofar as the hospital records make no mention of falling down stairs, it seems that, on the balance of probabilities, it is likely to have happened after the presentation. The* possibility *of domestic abuse was not apparently considered and would anyway have been very difficult to explore whilst father was acting as an interpreter*.

3.2.12 On 16.02.14 (day 16 for child I) CM1 made her final home visit and father acted as interpreter. The midwife provided routine safety-related advice and removed unnecessary and potentially hazardous bedding etc from the cot of child I. At HV1's visit 2 days earlier she had noted that child I was 'swaddled' in blankets and had advised she be placed with her feet near the bottom of the cot (in accordance with current Public Health guidance). HV1 had subsequently raised no concerns with the midwife or GP.

Comment: *it may be that the parents failed to fully appreciate or comply with advice from the midwife (and indeed the hospital prior to the baby's discharge). It remains a matter of speculation whether these events illustrate insufficient understanding and/or a cultural distinction with respect to appropriate care of neonates*.

3.2.13 Post natal depression was discussed by CM1 and father reiterated his view that mother was *not* depressed but homesick. He said she was 'due to return to Saudi Arabia next month' and 'has a circle of friends who visit regularly'. The welfare officer was able to confirm that the small number of Saudi wives on Base did generally offer mutual support. CM1 did not observe evidence of post natal depression and formally discharged mother to the care of GP and health visitor with advice to be sought from them if need be.

HEALTH VISITING SERVICE

3.2.14 The first home visit by health visitor HV1 had been on 14.02.14 and pre-dated formal discharge from midwifery care. It was undertaken in accordance with the national 'Healthy Child Programme and Southern Health NHS Foundation Trust policy 'New Birth Visits by Health Visiting Team (2011). The welfare officer was not present on this occasion because she was aware that the father of child I would be available.

3.2.15 At this initial visit HV1 usefully saw child I's bedroom and noted it was 'clean, warm and bright with age-appropriate toys'. HV1 also noted the parents were responsive to child I's need and that she could be soothed by them. This observed child-parent reciprocity offered evidence of a potential for developing a close attachment.

3.2.16 Safer sleeping was discussed and advice (seemingly comparable to that provided by her midwife colleague) given as the optimal position in the cot to minimise the risk of 'sudden infant death syndrome'.

3.2.17 HV1 had not suggested use of an interpreter and a subsequent interview confirmed that she (and she believed colleagues) were unaware such a resource was available to them, nor how to access it. The inability to communicate directly with the mother of child I clearly reduced the value of conversations. The Southern Health NHS Foundation Trust does have a policy (Equality, Diversity and Human Rights Policy 2013) which commits the organisation to use of interpreters as/when needed.

Comment: *without universal understanding and use of the above policy, individuals are at risk of being disadvantaged and a recommendation about how to respond to the systemic weakness is included in section 6*.

3.2.18 At the initial meeting with HV1 she was told that mother and child I would be visiting the extended family in Saudi Arabia within 3 weeks where immunisations would be arranged. A return 'after Easter' was planned. Information provided by the welfare service provider indicates that there was indeed a plan that mother would return to Saudi Arabia. Postponement of that trip appears to have been caused by a (not unusual) delay in the return of father's passport from the Passport Office.

3.2.19 Because the planned trip would have delayed the standard GP post natal assessment HV1 considered making alternative arrangements. The plan was that health visiting would continue to be provided at the 'universal' level (as opposed to 'universal plus' or 'universal plus partnership' both of which would have reflected a recognition of respectively greater levels of difficulties).

3.2.20 In the absence of any specific concerns, HV1 did not initiate a discussion with the GP about child I and had no reason to doubt the veracity of a statement from father in a phone conversation on 28.02.14 that mother and child were leaving for Saudi the following week so as to stay with the baby's maternal grandmother.

3.2.21 HV1 remained unaware that mother and baby had *not* in fact flown to Saudi until she learned of the child's death in March. Thus, for the remainder of the period under review, she had no further opportunity to learn more of mother's mood state nor how child I was developing.

3.2.22 HV1 also had no knowledge of mother's attendance at the hospital's emergency department nor her consultations with GP1 the day before and day after that attendance.

3.2.23 Though ad hoc communication is said to occur if/when a patient is of concern (and neither mother nor child I ever was), routine liaison between the GP Practice and its linked health visitors takes place only quarterly.

4 ANALYSIS

4.1 INTRODUCTION

4.1.1 The relative performance of each named agency with respect to questions 4.2 to 4.6 (the terms of reference for this serious case review) is considered below.

4.2 KEY EVENTS, ASSESSMENTS, DECISIONS, PLANS & SERVICES OFFERED. WERE ANY CHILD CARE OR SAFEGUARDING CONCERNS RECOGNISED & RESPONDED TO APPROPRIATELY? DID ACTIONS ACCORD WITH ASSESSMENTS & DECISIONS MADE; WERE APPROPRIATE SERVICES OFFERED / PROVIDED OR RELEVANT ENQUIRIES MADE IN THE LIGHT OF ASSESSMENTS; TO WHAT EXTENT WERE THE CHILD'S NEEDS / VIEWS / WISHES TAKEN INTO ACCOUNT ?

HOSPITAL

4.2.1 The only issue of relevance to this serious case review with respect to mother's initial contact at the Gynaecology Unit was that medical staff discerned the need, tried but were unable to obtain an interpreter. At her second appointment when accompanied by the welfare officer, an interpreting service *was* accessed. The welfare officer was able to say that from her experience difficulties in accessing an interpreter was not unusual.

4.2.2 The response of the hospital's emergency department to mother's presentation on 11.02.14 was unremarkable except that the GP and not the community midwife (who remained of central significance), was notified of the event. Insofar as the advice given had been to contact the midwife or GP about what was recorded as 'low mood, possibly post natal depression', this was a *potentially* significant oversight.

4.2.3 Until the hospital's final contact with child I the day she died, no safeguarding-related issues had emerged and all health-related needs had been routinely responded to.

MIDWIFERY SERVICE

4.2.4 At her first meeting with the mother of child I, CM1 offered the services of an interpreter but accepted the decision of father that one was not required. Whilst wholly understandable this arrangement (which prevailed throughout the ante natal period) denied mother any opportunity she might have wanted to speak for herself e.g. about domestic abuse (albeit no clear evidence of that possibility subsequently emerged).

4.2.5 CM1 having established that the parents were first cousins, made an appropriate referral for an obstetric opinion about levels of increased risk to the foetus. The advice received was to continue with 'midwife-led' care.

4.2.6 Ante natal care was essentially unremarkable and a good level of post natal support was provided and nothing untoward noted. On the single occasion an appointment was cancelled (11.02.14) it was satisfactorily explained by father as a result of his wife having consulted the GP only a day earlier.

4.2.7 The possibility of post natal depression was considered at her last contact on 16.02.14 (day 16) but CM1 (a very experienced midwife) noted no indication of the condition. CM1 would also have been aware that HV1 had completed her initial visit 2 days earlier and not shared any concerns.

4.2.8 Self-evidently, child I was pre-verbal. There were though some key opportunities for her needs to be recognised when she was seen undressed by a hospital paediatrician and later by midwifery support workers who were encouraging mother's efforts to breastfeed. None perceived there to be any cause for concern.

GP SERVICE

4.2.9 Though NHS England commission the service and has notified all Hampshire GPs of that fact, GP1 did not offer mother an independent interpreter. At interview she indicated that her previous experience of trying to access interpreters has generally been frustrating and ineffective. The doctor instead used 'Google Translate' or father. At the consultation on 04.03.14 her concerns about post natal depression were enough to prompt a prescription of 20 mg of the anti-depressant Fluoxetine (a standard treatment for various types of depression including post natal). The GP failed though to initiate other measures that might in combination have served to increase the level of psychological support:

- Alerting the health visitor or midwife
- Completing any form of risk assessment
- Liaison with the Welfare Service at the Base and/or SSAFA
- Arranging counselling

4.2.10 An interview with the GP revealed that she was anyway unaware of the role of a dedicated support service at the Naval Base and how that was to be distinguished from the local Children's Social Care. No examination of child I was completed by GP1.

4.2.11 Though they are currently being reviewed, the National Institute for Health & Clinical Excellence (NICE) guidelines 'Antenatal and Postnatal Mental Health: Clinical Management and Service guidance' CG45 February 2007 recommend a combined approach of talking therapy and medication in cases of post natal depression.

HEALTH VISITING SERVICE

4.2.12 HV1's commendable offer of an ante natal visit was overtaken by the birth of child I at around the proposed day. Because HV1 was unaware of how to access an interpretation service her planned visit would anyway have had to have been facilitated by child I's father.

4.2.13 From the feedback she received from the midwife and welfare officer HV1 had not anticipated there being any additional needs and the standard 'universal service' only was to be offered. Her records of the new birth visit are clear and comprehensive and include relevant indicators e.g. parent's sensitivity to their child's need and the baby's positive response to her parents.

4.2.14 Had the routine 6 week developmental check proceeded, it would have included a basic evaluation of mother's mood state.

4.2.15 HV1 was told by father of his wife's low mood state and palpitations. Records suggest these issues were not explored or considered sufficient to require action. *No* concerns were identified that would have required a referral to a GP nor (*had* there been any indicators of a risk of significant harm to child I) to Children's Social Care.

4.3 LEVEL & EFFECTIVENESS OF INFORMATION EXCHANGE AND COMMUNICATION IN & ACROSS AGENCIES; ANY GAPS THAT MIGHT HAVE IMPACTED UPON ASSESSMENT, SERVICE PROVISION OR OUTCOMES ?

HOSPITAL

4.3.1 Internal communication within the hospital was unproblematic. The failure of the emergency department to notify the community midwife has already been cited.

MIDWIFERY SERVICE

4.3.2 CM1 had initiated an appropriate internal referral during the ante natal period but was denied the benefit of knowing about the discussion about post natal depression at either the GP consultation on 10.02.14 or the presentation at the hospital emergency department next day.

4.3.3 CW1 had appropriately informed all relevant parties of the child's birth and discharge. It emerged during this review, that no dedicated form exists for case handovers between midwives and health visitors, which are therefore generally oral.

GP SERVICE

4.3.4 The GP Practice had completed a pro-forma to notify the Community Midwifery Service of mother's pregnancy and need to be 'booked in'.

4.3.5 Mother had not received her antenatal care from the GP Practice, nor had a 'shared care' arrangement been put in place. The records suggest that the GP, having formed a tentative view about post natal depression initiated no contact with either midwife, health visitor nor with the welfare service at the Naval Base that she would, from previous contact, have known was involved.

4.3.6 A concern identified by the author of the report evaluating GP services viz: was GP1's use of English itself a barrier to communication, was followed up. A joint interview by the designated doctor and overview author was completed with GP1 and professional colleagues were questioned. The results provided reassurance that this doctor's use of English appears sufficient for the role she has.

HEALTH VISITING SERVICE

4.3.7 Unless there are issues of concern neither health visitors or GPs routinely discuss families appearing to have no additional needs.

4.3.8 In the belief mother and child would, because of the reported trip home have missed the GP post natal review, HV1 planned to sort out an alternative arrangement. This intention was unfulfilled by 28.02.14 when HV1 phoned father and was told that the trip was to happen 'next week'. Passport difficulties caused its postponement.

4.4 WAS THE WORK CONSISTENT WITH EACH AGENCY'S & LSCB POLICY & PROCEDURE FOR SAFEGUARDING & PROMOTING THE WELFARE OF CHILDREN & WITH WIDER PROFESSIONAL STANDARDS ?

HOSPITAL

4.4.1 The doctors in the Gynaecology Unit and Emergency Department had no occasion to consider the need for any safeguarding response. Confirmation received that all had received all training required by policy and local agreement is reassuring.

MIDWIFERY SERVICE

4.4.2 The midwife's safeguarding training was also at the required level and up to date. On the basis of what she knew and observed she had no reason to consider any 'safeguarding response'. She discharged her central professional role in accordance with standard professional expectations.

GP SERVICE

4.4.3 The contact with mother was very limited. Records of those contacts offer no evidence that any *unmet* needs of the family might have been explored as envisioned in the current statutory guidance *Working Together to Safeguard Children* 2013.

4.4.4 Though no explicit safeguarding issues were anyway apparent, it seems unlikely that the GP would *at the time* have been aware of or have read this current safeguarding children guidance.

4.4.5 The Practice has subsequently indicated that it medical staff had by September 2014 completed child protection training at the appropriate level 3.

HEALTH VISITING SERVICE

4.4.6 The limited involvement by HV1 was (with the exception of not addressing the need for professional interpretation) conducted in accordance with professional expectations. The perceived circumstances did not trigger any consideration of the local safeguarding procedures.

4.4.7 The 6-8 week assessment (if completed) would have included maternal mood assessment as well health of the baby. It is likely child I would have been taken back to Saudi Arabia by her parents well before the national 'Healthy Child Programme' (at its universal level of service provision) would have provided the 8-12 month health reviews, and any additional visits the family might have made to the clinic.

4.5 WERE THERE ANY ORGANISATIONAL DIFFICULTIES BEING EXPERIENCED WITHIN OR BETWEEN AGENCIES E.G. INSUFFICIENT CAPACITY?

4.5.1 None of the responses by agencies or individuals appear to have been adversely impacted upon by shortage of resources. Clearly, with respect to the GP Practice, there was a significant training and staff induction deficit.

4.5.2 Similarly, the fact that HV1 was unaware of the availability of interpreting services is primarily a training / personal development issue.

4.6 IMPLICATIONS FOR WAYS OF WORKING (TRAINING-SINGLE & MULTI-AGENCY); MANAGEMENT, SUPERVISION; WORKING IN PARTNERSHIP ?

HOSPITAL

4.6.1 Safeguarding children training is mandatory for all hospital staff. Level 2 is the minimum requirement for the Gynaecology Unit and Emergency Department. Level 3 is the minimum for Maternity, Obstetric and Paediatrics. All staff involved with child I or her parents had received the relevant level of training. Equality and diversity training is also mandatory for all staff and all those involved had completed it.

GP SERVICE

4.6.2 Interviews with the GP confirmed that she had received *at the time, no* child safeguarding training and had no knowledge of where to access relevant information. Nor was she aware at the time of how to access professional supervision e.g. from the named doctor or safeguarding team.

HEALTH VISITING SERVICE

4.6.3 The events preceding the death of child I highlight a need for more effective induction of new health visitors and ongoing training that includes the need to, and means by which, interpreting / translation services can be accessed.

5 FINDINGS & CONCLUSIONS

5.1 FINDINGS

DECISION TO CONVENE, & CONDUCT OF THE SERIOUS CASE REVIEW

5.1.1 The decision to initiate a serious case review was made promptly and material submitted from each relevant agency was written by suitably experienced professionals who had had no involvement in the provision, supervision or management of services provided. The period selected for review was a proportionate and appropriate one.

PREDICTABLE OR PREVENTABLE DEATH?

5.1.2 Given the absence (beyond some initial concern about mother's possible post natal depression) of any indicators of risk to her child, the sudden, arguably non-accidental death of child I could not reasonably have been foreseen or necessarily prevented by actions that might reasonably have been expected of any involved professional.

SYSTEMIC & INDIVIDUAL STRENGTHS AND WEAKNESSES ?

5.1.3 The continuity of midwifery care seen in this case is clearly desirable and not always achieved. In all other respects (and in sharp contrast to the tragic outcome) professional contacts were characterised by their very ordinariness.

5.1.4 There were some examples of sound practice by individuals:

- Both health visitor and community midwife discussed and took practical steps to reduce an evidence-based risk of sudden infant death syndrome
- The welfare officer employed via the contractual arrangements consequent upon strategic arrangements between UK and Saudi Arabia was (within the limits of her role and inability to speak Arabic) very supportive of both parents

5.1.5 There were also some examples of sub-optimal arrangements or practice:

- The GP was insufficiently trained with respect to child safeguarding and with local multi-agency arrangements
- Though its actual impact remains uncertain, the under-use of interpreting services (even when available) denied child I's mother the potential opportunity to express views / feelings that *might* have contrasted with those of her husband
- Some *minor* weakness in record-keeping standards by midwives has been noted (some illegible handwriting and absence of signatures) though none impacted upon service provided
- Some scope also exists within the contracted welfare service provider on Base to develop a formal child safeguarding policy and a confidential interpretation service for non-English speaking family members of visiting Saudi students

5.2 CONCLUSIONS

EFFECTIVENESS OF COMMUNICATION WITH PATIENTS

5.2.1 The effectiveness of communication with the mother of child I was significantly compromised by the recurring failure to access an accredited interpreter and a dependence instead on her husband's account of what his wife felt or wished.

5.2.2 *However*, discussion at the learning event convened with involved staff (as well as the lead reviewer's own brief encounter with the couple) highlighted how difficult it is to ensure effective service delivery across cultural divides.

5.2.3 In this case the relatively passive and subservient position of females in Saudi families (as well a probable uncertainty about the trustworthiness of UK authority figures) represented additional barriers to accessing mother's real wishes and feelings. At no point during professionals' contacts with the couple were there sufficient grounds to propose far less insist upon, mother being seen alone.

SCOPE FOR SERVICE IMPROVEMENTS / INITIATIVES TAKEN

5.2.4 Improvements are needed to the following:

- Reliability of access to interpreting services for medical / midwifery staff at the hospital[1]
- Awareness of the importance of using, and confidence about how to access interpreting services amongst midwives, health visitors and GPs
- GPs' knowledge of and ability to use local multi-agency safeguarding children procedures
- (Though *not* in any way related to the death of child I), the 'safeguarding children' and 'accessing interpreters' policy of the welfare service provider

5.2.5 Some *current* initiatives remove the need for what would otherwise be recommended improvements for local services:

- Current trialling of the GP referral form to Midwifery Services so that more social history (including it is presumed, ethnicity / preferred language) is included
- A current review of supervision arrangements within the Portsmouth Hospitals NHS Trust

5.2.6 The remaining recommendations in section 6 offer practical steps to overcome remaining system weaknesses.

[1] NICE Guidelines 2012 (CG 110) para. 1.3.10 'Communication with women who have difficulty in reading or speaking English…should be provided with an interpreter (who may be a link worker or advocate but not a family member, legal guardian or partner) who can communicate with her in her preferred language.

6 RECOMMENDATIONS

6.1 INTRODUCTION

6.1.1 The following recommendations for Hampshire's Safeguarding Children Board represent a proportionate and pragmatic response to the lessons learned (derived from reports and debates at panel and with involved professionals).

6.1.2 The Board should, in accordance with an accompanying detailed action plan, monitor the effective implementation of its recommendations.

NHS England Local Area Team (LAT)
1. The LAT should introduce arrangements which seek to ensure via induction processes that all GPs have sufficient appreciation of locally agreed multi-agency safeguarding procedures (including sources of supervision) *before* they begin to practice locally
2. Practices that provide a service to Forces' families should be offered context-specific training
Clinical Commissioning Group (CCG)
3. The CCG should review and confirm the frequency and effectiveness of health visitor / GP liaison opportunities amongst local Practices
Relevant General Practice
4. Confirmation should be provided by the GP Practice involved in this case, to the NHS England Local Area Team that all medical staff have now completed safeguarding children training (level 3)
Portsmouth Hospitals NHS Foundation Trust
Community Midwifery Service
5. The service should review its liaison arrangements with the welfare service provider that supports families such as those of child I
Emergency Department
6. The Emergency Department should take all practical steps to ensure that information emerging from its contacts is shared in a timely manner with other relevant services
7. The Trust should review its current arrangements for medical staff to access interpreters and initiate any required improvements so as to ensure reliable facilitation of effective communication with patients
Southern Health NHS Foundation Trust
Health Visiting Service
8. The Trust's safeguarding children training (levels 1,2 and 3) should include reference to and reinforcement of the current 'Equality, Diversity and Human Rights (2013) Policy so that the need to and means of accessing interpreting / translation services become universally known
9. The Trust should immediately inform current staff how to access: • The guidelines in document 5 'Interpreting and Translating' in the toolkit associated with the above policy • Written information in languages other than English with particular reference to 'sudden infant death syndrome'
Welfare Support Service
10. The contracted welfare service provider on Base should develop a formal child safeguarding policy and a confidential interpretation service for non-English speaking family members of visiting Saudi students

7 GLOSSARY OF ABBREVIATIONS

Agency / Abbreviation	Meaning
Roles	**Meaning**
CM1	Community midwife
CM2	Community midwife
GP1	General Practitioner
GP2	General practitioner
HV1	Health visitor
Welfare officer	Employee of Welfare Service Provider

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