Lessons to be learned from Serious Case Review "Colin"

X Local Safeguarding Children Board (XLSCB) conducted a Serious Case Review into the death of a child "Colin". Colin died following an incident which took place while he was in the care of professionals during a planned activity.

XLSCB considered the requirement to publish the Report in this case and it felt that the circumstances surrounding the death of Colin are such that the publication of any meaningful summary, even after redaction, would be likely to lead to the identification of Colin and his family. The view of XLSCB was that due to the family's specific circumstances this could potentially place them at risk. XLSCB have therefore taken the decision not to publish the Report however further consideration has been given to sharing the learning from this review.

While many of the lessons learned in this case are felt to only be relevant to local agencies it was agreed by XLSCB that some of the learning could be of benefit to other agencies across the country. This report highlights two key areas of learning that may be of benefit to your LSCB.

Planned Activities for Children

The incident that led to Colin's death took place while he was on a planned activity in the care of professionals. The review recommended that a thorough risk assessment and greater level of discussion should take place at a multi-disciplinary level prior to children being allowed on a programme of planned activities. This planning should involve parents and include obtaining parental consent. The review recommended that agencies should develop detailed practice guidance and risk assessment procedures for taking children or young people on external visits/activities. These procedures should include recent best practice as identified by the Health and Safety Executive in respect of educational visits.

Provision of Oxygen for Casualties

Colin was transported from the scene of the incident to hospital in a helicopter. During transport Colin could not be provided with oxygen as the helicopter did not routinely carry oxygen. This issue was compounded when Colin arrived at hospital and was transferred onto a trolley. The transfer trolley also did not have oxygen available which meant Colin was only given oxygen when he arrived in the treatment room. The review recommended that a daily audit is carried out in hospitals to ensure that a canister of oxygen is attached to the patient transfer trolley as part of the regular resuscitation equipment required when the hospital take over the care of a patient.