Derbyshire Local Safeguarding Children Board

Serious Case Review

Overview Report

In respect of Child

BDS12

November 2013

Report Author

Glenys Johnston OBE
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Summary of findings

CONCLUSION
The death of any child is a profound tragedy for any family and creates distress for the professionals involved. This Serious Case Review has identified some sound professional practice including the provision of care and advice to BDS’s mother however, despite the known risks to children of substance misusing parents, there were some significant failings. These included:

• The failure to take into consideration the history of both parents, their relationship with each other and with their close, extended family to inform a sound assessment of the risks to their young son.

• A lack of compliance by a number of professionals with DSCB Multi-agency Child Protection Procedures and refer the family to Children’s Social Care in the light of the risk factors that were known before BDS was born and before he was discharged home.

• Some professionals thinking that a referral to Children’s Social Care would be a failure in their practice and their support to the family.

• The failure of drug treatment professionals to:
  - Prioritise the safety of BDS over the needs of his mother by considering and comparing her reports of her illicit drug use,
  - Robustly risk assess Mother as to her suitability for having methadone in the home where she had the care of her very young son, and to review this as circumstances changed and incidents occurred, sharing information with other professionals as necessary.
  - Reflect on chronological evidence, to identify that her intention to becoming drug free was not resulting in sufficient change. However, drug treatment is not time limited and ‘sufficient change’ is difficult to define.

• An over reliance on Mother’s ‘engagement’ with services as evidence that she was compliant with the advice given and a lack of professional challenge and cynicism.

• The lack of focus on Father, the impact of his health problems, history, relationship with Mother and any support needs he may have had in relation to living with a substance misuser.

• Poor information sharing between health professionals.

• An over reliance by universal health services on specialist health professionals to inform them of concerns, instead of seeking information for themselves.

• A lack of effective recording systems that would have enabled information to be shared and accessed.

• Professional supervision that depended on the supervisee identifying safeguarding concerns and raising cases, rather than this being guided by the organisation.
• Some agencies not being sufficiently vigilant about the attendance of their staff at appropriate training.

• Some professionals being unaware of the findings of the previous Interagency Management Review in respect of Child M, other SCRs and research.

The issue of whether the death of BDS could have been predicted and/or prevented is a challenging question. At one level there were many indicators that Mother and Father cared well for their child, followed advice and engaged in the services that were offered, despite these at times being a demanding number and range for any parents. They did not avoid contact with agencies or their son being seen by a number of professionals. BDS was known to and seen by a number of universal or specialist services. The family had the support of their extended family and appeared to have developed a good relationship with each other. At times Mother made good progress on reducing her use of methadone, itself an indicator that her intention to become drug free was being achieved however, this was not sustained.

It is unlikely that unannounced home visits would on their own, have identified that Mother was, as has been suggested devious, giving her child illicit drugs and her own methadone, obtaining and providing drug free urine samples from another person to ensure her urine tests were negative and she could continue to be prescribed methadone and selling her methadone to fund the purchase of illicit drugs. However, there were sufficient known risk factors in both parents’ past and a significant amount of research and professional guidance to warrant professional concern and for involved professionals to refer the family to Children’s Social Care. Had this happened and a robust comprehensive assessment had taken place, the child would in all probability have become the subject of a Child Protection Plan. This would have resulted in clear expectations of the parents, together with clear consequences if they failed to comply. The plan could also have included rigorous monitoring through testing BDS for the presence of substances or alcohol, although not common practice at the time.

If the parents had failed to comply with a Child Protection Plan, consideration would have been given to implementing Care Proceedings and seeking BDS’s removal. However, some children on child protection plans are harmed by their parents and some die despite the best efforts of professional agencies. We cannot say with all certainty that if the child had been referred to Children’s Social Care, BDS would be alive today but my view is that this should have happened and would have increased his safeguarding and protection and would probably, but not certainly, have prevented his untimely death.

Recommendations
These recommendations are in addition to those made by each agency and are directed at DCSB which should:

1. Ensure that in updating the Inter-agency Child Protection Procedures requirements in relation:
   a.) to the protection of children whose parents use substances or alcohol;
   b.) unborn babies, and
   c.) domestic abuse
   are fit for purpose.
2. Ascertain whether there is a systemic culture of resistance, by agencies, to making referrals to Children’s Social Care and if so, address this.

3. Explore the feasibility of commissioning tests on all children who are the subject of Child Protection Plans and whose parent/s are known substance users.

4. Receive reports from all agencies represented on the board in relation to compliance with their agency training requirements.

5. Receive reports from all agencies represented on the board in relation to effective supervision arrangements including the consideration of all cases that involve vulnerable children.

6. Conduct regular audits to monitor the effectiveness of multi-agency working including the use of the Common Assessment Framework (CAF).

7. The current Derbyshire review of the CAF process to reinforce a ‘Think Family’ or ‘team around the child’ approach.

8. Consider a public and professional awareness raising campaign in relation to the risks to children of substance and alcohol misusing parents to increase vigilance and reporting by all parties.

9. Co-ordinate a multi-agency, cross-organisation work stream to develop an overarching strategy for professionals in Derbyshire who work with substance misusing parents or their children. It should be accessible to all organisations and provide specific guidance which includes the issues highlighted in the recommendation at the end of the report. Work streams to be developed, to include senior and operational level managers from health organisations involved in this review and children’s social care and police.

10. Ensure that all providers of substance misuse services in Derbyshire undertake a review of the arrangements for the prescription and monitoring of methadone for parents with children under 5 years of age. This should include:
    • A review of prescribing guidelines (including policies and procedures).
    • A review of those guidelines for parents with children under 5 years of age.
    • An explicit identification of risks and steps taken to mitigate such risks with related action plans.

To ensure compliance with:
    • The required risk assessment,
    • Guidance to parents,
    • ‘Think family’ standards, and the
    • Distribution of safe storage box facilities for all service users who have children under 5 years of age.

Furthermore, the database should be shared with both Health and Social Care Providers across Derby and Derbyshire.
In relation to health agencies:

11. A pathway should be developed to ensure a multi-agency assessment is always undertaken, led by a prescriber from the drug services, or prescribing GP, before methadone is taken home when children and young people under the age of 18, reside at the house or visit it.

12. Prescribers should regularly ask their patients about their contact with any children and review the prescription in the light of this or new information; and

13. All prescribing services should always consider the role and capability of non- drug abusing partners and ensure that they are seen alone and if appropriate, referred to services that can support them in their safeguarding role.

14. Electronic Systems should be developed to ensure that all drug using adults who may present risks to children are flagged accordingly.

In making the above recommendations it is assumed that DSCB will:

15. Monitor the implementation of all the individual agency recommendations that follow from this review and previous SCRs and included below.

16. Will disseminate the learning from these reviews.

17. Seek evidence that the learning has been applied in practice and has improved the safeguarding and protection of children; and

18. Will address the learning that has emerged about the DSCB SCR process, in particular the competencies of staff to carry out individual management reviews and the issue of accessing parent’s medical information.

1. Introduction

1.1 This Serious Case Review (SCR) overview report brings together, and draws overall conclusions from, information and analysis contained in the Independent Management Reviews (IMR), the Health Overview Report and supplementary information from the criminal prosecution of the parents. It does not seek to repeat the detail of the IMRs or the recommendations they made.

The circumstances that led to this Serious Case Review

1.2 This SCR concerns a two year old boy, BDS, who died on 13th March 2012 following a cardiac arrest caused by having swallowed some of his mother’s methadone which was in a child’s beaker.

1.3 BDS was born on 6th November 2009; he lived with his Mother and Father.

1.4 BDS’s Mother is a long-term substance abuser; she took class 1 drugs (including heroin and crack cocaine) for several years. She was prescribed methadone but continued to
use heroin and other illegal drugs, in varying amounts, throughout the period covered by this review.

1.5 BDS’s Father is not reported to use class 1 drugs but he has acknowledged that he occasionally smoked cannabis. He is alleged to have controlled the family finances as a way of helping Mother to reduce her drug use. Information that has emerged during this review indicates that domestic abuse may have been a feature of their relationship, but none of the IMRs provide any detail or evidence of this.

1.6 On 18th January 2013 both parents were found guilty of manslaughter and Mother was found guilty of cruelty to a child under the age of 16.

2. The Serious Case Review Process

2.1 On 30th March 2012 the SCR Sub-Committee of Derbyshire Safeguarding Children Board (DSCB) decided that a SCR should be undertaken as the circumstances met the criteria set out in Working Together 2010, which requires that a review should be considered where a child dies, abuse and neglect are suspected and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. On 13th April 2012 DSCB ratified the decision of the SCR Sub-Committee and this was subsequently confirmed by the Independent Chair of the board.

2.2 Ofsted was notified of the decision to conduct a review on 17th April 2012. On the 29th June 2012 the Parliamentary Under Secretary of State for Children and Families advised that all SCRs completed after this date no longer required submission to Ofsted for evaluation, although a completed copy of the Overview Report should be submitted to the Department for Education.

The Purpose of the Review

2.3 The purpose of this review is to:
   a) Establish whether the death of this child was predictable and/or preventable.
   b) Establish whether there are any lessons to be learned from the case about the way in which professionals and organisations work together to safeguard and promote the welfare of children.
   c) Identify clearly what the lessons are, how they will be acted upon, and what is expected to change as a result; and
   d) As a consequence, to improve inter-agency working, better safeguard and promote the welfare of children.
   e) Additionally the review will consider whether learning from previous similar incidents had been sufficiently and effectively disseminated to relevant staff.

3 Terms of Reference

3.1 Subjects and period of the Review
3.2 The subjects of the review are: BDS and his Mother and Father

3.3 Following the first challenge meeting on the 29th June 2012, it was agreed that some family members would also be included in the review process, although limited information has been identified in relation to them.

3.4 During the 1st challenge meetings (parts 1 and 2) held on 29th June and 10th July
2012, further children were identified as being at potential risk. Relevant information was shared with Children’s Social Care (CSC) and appropriate safeguarding actions were taken.

**The Period to be covered by the review**

3.5 The period covered by the review is from BDS's conception in February 2009 to 14th March 2012, the day after his death. Relevant information outside this period has been included in summary form.

**4. Contributors to the SCR**

4.1 A number of independent individuals contributed to the review. These included:

- Christine Cassell, Independent Chair of the LSCB

- Maureen Darbon, Derby City Social Care Services the independent SCR Panel chair; Ms Darbon has had no previous involvement with the case.

- Glenys Johnston is the Overview Report author and has had no previous involvement in this case

4.2 **Members of the SCR Panel were:**

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<td>Police</td>
<td>Detective Superintendent Head of Public Protection Derbyshire Constabulary</td>
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<tr>
<td>Social Care</td>
<td>Derbyshire Children and Younger Adults Deputy Strategic Director</td>
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<tr>
<td>Health Overview</td>
<td>Designated Doctor Derbyshire CCGs.</td>
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<tr>
<td>NHS Derbyshire County</td>
<td>Chief Nurse and Quality Officer NHS North Derbyshire Clinical Commissioning Group</td>
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<tr>
<td>Derbyshire Community Health Services (DCHS)</td>
<td>Senior Nurse Advisor for Safeguarding</td>
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<td>Derby Hospitals Foundation Trust (DHFT)</td>
<td>Director Patient Experience and Chief Nurse</td>
</tr>
<tr>
<td>Derbyshire Healthcare NHS Foundation Trust DHCFT (Mental Health) and Substance misuse services</td>
<td>Head of Patient Safety, Deputy Director of Nursing</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Senior Public Health Commissioning Manager Public Heath Substance Misuse Commissioning</td>
</tr>
<tr>
<td>East Midlands Ambulance Service (EMAS)</td>
<td>Head of Safeguarding East Midlands Ambulance Service NHS Trust Nottinghamshire Divisional HQ</td>
</tr>
<tr>
<td>Nursery</td>
<td>Acting Assistant Director (Schools and Learning)</td>
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4.3 Agencies that provided Individual Management Reports included:

- Derbyshire Community Health Services (DCHS)
- NHS Derbyshire County
- Derbyshire Healthcare Foundation Trust (DHCFT) who, following 1st challenge meeting combined their IMR with Phoenix Futures.
- Derby Hospital NHS Foundation Trust (DHFS)
- Derbyshire Constabulary and,
- as Mother spent some time living in Derby City, Drug Treatment Clinic (part of Derby City Primary Care Trust (PCT) until April 2011)

4.4 **Summary reports were provided by**:

- Pharmacy 1
- Addaction
- East Midlands Ambulance Service NHS Trust
- Derbyshire County Council - Children & Younger Adults Services (DCC CAYA)

4.5 DSCB has had lead responsibility for the SCR as BDS was ordinarily resident in Derbyshire however, as Mother had lived in Derby City their LSCB has been engaged in and fully co-operated with, the review. The two boards have closely communicated and Derby City LSCB has confirmed their responsibility for ensuring that lessons that are relevant to their agencies are implemented.

5 **SCR Panel meetings**

5.1 Regular SCR panel meetings were held between May 2012 and March 2013 to oversee the process and challenge and quality assure IMRs and the Overview Report. Meetings were well attended by agencies and the Initial Overview Author attended all of them. In addition, due to the emerging complexities of the case, a meeting was held by the initial Overview Author and the Derbyshire County Council Strategic Partnership Manager with the Substance Misuse Services and Phoenix Futures to clarify arrangements.

5.2 I have not attended meetings that were convened before my appointment in February 2013 but the minutes of all the previous meetings have been made available to me and I have attended the two challenge meetings within the period of my involvement.

5.3 Delays occurred in the completion of the IMRs and the SCR process due to difficulties obtaining consent from the adults involved, in relation to accessing their medical records held by their General Practitioners. This issue is not the focus of the review but it and other review process issues have been identified and will be addressed by DSCB.

5.4 **Relevant national and local SCRs**

5.5 Known research which may assist the review, was used together with other relevant SCRs, learning reviews and serious incidents locally, in the region or nationally.

5.6 **Legal and expert advice**

5.7 It was agreed that if required, expert opinion would be sought regarding methadone
prescribing practice. This has not been necessary.

5.8 It was also agreed that if required, legal advice would be sought from Derbyshire County Council Legal Services in the first instance. Each agency would seek legal advice in relation to parental consent and the disclosure of files issues.

5.9 Media and Public Interest
5.10 The SCR Panel agreed that public, media interest and FOI requests would be managed before, during and after the review by the three main agencies: DCC CAYA; Derbyshire Police and Derbyshire Healthcare Foundation Trust (DHCFT)

5.11 Department for Education contact
5.12 It was agreed that contact with the Department of Education (DfE) would be maintained by DCC CAYA.

5.13 Parallel processes-coroner/criminal etc
5.14 During the process of the SCR both parents were convicted of manslaughter and received custodial sentences, Mother was also charged and convicted of cruelty against a child under 16. During the review and the criminal prosecution, relevant information was shared by the Police with the SCR panel. This information included the Judge’s Summing Up at the end of the trial and the findings of toxicology tests undertaken posthumously on BDS that identified that over a period of months, traces of cannabis, crack cocaine, heroin, dia-morphine and alcohol had been found in his system, suggesting that these drugs had probably been ingested directly rather than being absorbed passively, for example by touching furnishings in the house. Father had no traces of these drugs in his system but he admitted to using cannabis.

5.15 Following the criminal prosecution the Coroner informed the DSCB that the inquest would be adjourned indefinitely.

5.16 As BDS died suddenly and unexpectedly his death will be reviewed by the DSCB Child Death Overview Panel.

6. Immediate Actions Already Undertaken
6.1 In March 2012, early in the SCR, initial lessons were identified and action was immediately taken to implement these and improve the safeguarding of children in Derbyshire. The Police instructed all staff to inform the Central Referral Unit of any incident or intelligence concerning the safety of a child. DCC CAYA finalised the development of the Common Assessment (CAF) framework and this was signed off by Derbyshire Children’s Trust.

6.2 On 30th March 2012, early in the review process, it became evident (following Derbyshire Healthcare NHS Foundation Trust (DHCFT) taking over Substance Misuse Services for Southern Derbyshire), that the provider should undertake an immediate review of the arrangements for the prescription and monitoring of methadone for parents with children under 5 years. This would include:
- A review of prescribing guidelines (including policies and procedures).
- A review of those guidelines for parents with children under 5 years of age.
- A full review of the existing databases across all providers at the time of the incident. This is in line with recommendations from a previous serious case review involving parents who are using methadone in the home environment.
- An explicit identification of risks and steps taken to mitigate such risks with related
action plans.

6.3 Derbyshire Healthcare Foundation Trust completed a full review of its policies and procedures governing the prescribing, supervision, monitoring and compliance. Senior Directors and Clinical Leads identified that these policies and procedures were robust and effective. This led to new partners, Phoenix Futures adopting the Trust Governance Procedures as part of the partnership agreement.

6.4 The senior operational and safeguarding leads alongside senior clinicians from Substance Misuse Services revisited recommendations from a previous SCR, to ensure compliance with:
   - The required risk assessment,
   - Guidance to parents,
   - ‘Think family’ standards, and the
   - Distribution of safe storage box facilities for all service users who have children under the age of 5 years.

6.5 The Trust commissioned further actions to gain assurance of the safe storage box provision and compliance with the 'Think Family' standards of the home environment where there were children under 5 within the household. These actions were subject to monitoring and review by members of the Trust’s serious untoward incident panel and senior operational management. This demonstrated full compliance with the recommendation of a previous serious case review and offered assurance in the protection of both vulnerable adults and children.

6.6 DSCB further recommended that the database should be shared with both Health and Social Care Providers across Derby and Derbyshire. This work at the time of this report was underway, however, it was also noted that prescribers of methadone may not necessarily either be employed by, or under the direct supervision of, Derbyshire Healthcare Foundation Trust Misuse Services. It is therefore recommended that all other providers should adopt similar processes to gain the necessary assurance.

6.7 In partnership with commissioners, it was agreed that the Trust would participate in the development of an 'Intergenerational Risk Assessment Tool' for services providing intervention for service users or their family where there is a known drug misuse problem.

6.8 All these actions were supported through process of bench marking and drawing on best practice from national centres and the national treatment agency.

6.9 **Key Issues to be addressed by IMR and Summary authors**

6.10 On 30th March the SCR Panel identified the key issues to be addressed by agencies. Several are generic to all agencies and include those identified in Working Together 2010, others are agency specific. Additional issues were identified as the review progressed and incorporated in IMRs.

**All organisations**

6.11 Each IMR author was asked to address the following issues:
   - What was the involvement of the agency with this child and his parents throughout his life, including the ante-natal period?
   - What relevant information was known about key family members prior to this period?
   - Why their agency did not refer the family to the Children’s Centre?
   - Was evidence of risk identified by any agency, if so was it responded to in a
timely and appropriate way?
• Were risks escalated to line/senior managers?
• If risk was not identified, why not?
• Was relevant information about relevant extended family members considered and shared by agencies?
• Were responses timely?
• What was the impact of the family’s move to Derbyshire in 2009?
• Was there evidence of good practice?
• The context their agency was operating within at the time.
• To what extent learning and actions from the Child M Management review of 2009 have been implemented?
• Issues which relate to ethnicity, disability, faith or other aspects of diversity.
• Whether, given what was known at the time of their involvement, agencies and individuals acted in a manner that was proportionate and reasonable?
• Whether the death of the child could have been predicted and, irrespective of whether the incident was predictable, whether the incident could have been prevented?

6.12 Specific Issues for individual agencies:

6.13 Health Services, including drug therapy services, midwifery services, health visiting services and GP services.

6.14 It was agreed that in addition to the key issues detailed above, all healthcare providers should specifically:
• Review all clinical records and consider the effectiveness of assessment, care planning, intervention, and evaluation in respect of all family members;
• Identify what if any efforts were made to share information and convey any concerns about mother and father within and between health services and to other organisations;
• Interview key members of staff involved with BDS and his family, examining the appropriateness of their clinical approach and intervention; and
• Review care and treatment provided by clinical teams in relation to National and Trust Policy, Procedure, and Standards.

6.15 The following must be reviewed where related to BDS’s death being prevented:
   a) Record Keeping.
   b) Prescription of methadone.
   c) Supervision arrangements.
   d) Clinical Risk Assessment.
   e) Risk assessment of children aged less than five years of age, living with parents who are receiving drug treatment.
   f) NICE and NTA Guidance
   g) Safeguarding Children and Young People: Roles and competencies for Health Care Staff (Intercollegiate Document) (2010)
   h) Domestic Abuse Guidance.
   i) Multi-agency risk conference (MARAC) and inter agency working in the prevention and management of individuals presentation of risk to others.
   j) National Government guidance “Information Sharing: Guidance for practitioners and managers”.
   k) Derby and Derbyshire Safeguarding Children Procedures.
   l) Derby City 2007 Guidance regarding pregnant patients of drug treatment services

6.16 Specific issues were also identified for each organisation as follows:
6.17 Derbyshire Community Health Services
- Thoroughly examine the service provided by the health visiting team to the family with a particular consideration given to how this accounted for the parent’s circumstances and living arrangements.
- What was the communication between the non-medical prescriber, the health visitor and the GP and how was this recorded?
- Were the health visiting team aware of mother’s treatment with the drug therapy service and whether the safe storage of drugs guidance was adhered to?
- Thoroughly examine the actions taken in response to indications of the abusive nature of the parental relationship.
- Identify if and when the Common Assessment Framework (CAF) was initiated and how this was managed when the family moved from Derby City?
- Was there a service level agreement between Health Visitors and Children’s Centres and if so, was it implemented, in particular the requirement for Health Visitors to register children with the Children’s Centre?

6.18 Derbyshire Healthcare Services NHS Foundation Trust
- Thoroughly examine the general healthcare and treatment afforded to both mother and father with consideration given to the involvement of, and support provided to, BDS and other family members.
- Identify if and when a CAF was initiated and how this was managed when the family moved from Derby?
- The family lived in Derbyshire and the mother was prescribed methadone from a Derby City service, what was the rationale and implications of this?
- Was the amount and length of methadone prescription appropriate and did it take account of feedback from the Phoenix Keyworker?
- Were the GP and Health Visitor kept updated on mother’s drug treatment? What was the communication between the non-medical prescriber, the health visitor and the GP and how was this recorded?
- What was the process for the community pharmacist to inform the drug treatment service in the event of any concerns about mother’s compliance?
- Was the safe storage of drugs guidance adhered to?
- Was the policy on prescription of Methadone adhered to?
- Is the policy child-focussed?
- To what extent can the use of methadone in households with under-fives be deemed low risk? If so, how was this managed? Is the training and guidance for staff child-focussed?

6.19 Royal Derby Hospital NHS Foundation Trust
- Thoroughly examine the service provided by the midwifery team to mother and BDS with particular consideration given to what information was known about father and how the midwife’s assessment of the family accounted for the parents’ circumstances and living arrangements.
- Thoroughly examine the actions taken in response to indications of the abusive nature of the parental relationship.
- How were these affected by the family moving areas?
- Identify if and when a CAF was initiated and how this was managed when the family moved from Derby?
- The family lived in Derbyshire and the mother was prescribed methadone from a non–medical prescriber in a Derby City service, what were the rationale and the implications of this?
- Were the GP and Health Visitor kept updated on mother’s drug treatment by the
non-medical prescriber?
- Was the safe storage of drugs guidance adhered to and what was the non-medical prescriber’s role within that regarding actions and advice?
- Was the prescription of methadone policy being adhered to?
- How did the Emergency Department respond to the clinical emergency presented by BDS and how was the care handed over from EMAS?

6.20 **GP Services**
- Thoroughly examine the service provided by the GP practice team to BDS and his parents and how this information was drawn together to understand the family circumstance as a whole.
- What was the communication between the non-medical prescriber, the health visitor and the GP and how was this recorded?
- What actions were taken in response to indications of the abusive nature of the parental relationship and the impact of this on BDS?
- Was there consideration of the impact that mother’s drug use may be having on the parent’s ability to fully meet the needs of BDS?
- Did the GP seek safeguarding advice?

6.21 **East Midlands Ambulance Service (Summary)**
- Thoroughly examine the actions of the ambulance team taken in response to the initial emergency call by the family.
- Thoroughly examine the initial clinical response to the circumstances presenting to the ambulance team at the family home and the details of the child’s transfer to the ED Department and handover of care.
- Detail the subsequent call out 2 hours later.

6.22 **Pharmacy (Summary)**
- What arrangements are there in place at the pharmacy to accommodate the administration of Methadone?
- What was the process for the pharmacist to inform the drug treatment service in the event of any concerns about mother’s compliance?
- What training did staff at the pharmacy have in relation to child protection?
- Was L.E.S. guidance followed?

6.23 **Health Overview**
The Health Overview report will be compiled by the Designated Doctor and will focus on how health organisations have interacted together. This may generate additional recommendations for health organisations. The report will specifically:
- Address the above reports, ensuring they cover the criteria listed.
- Examine cross-cutting inter-professional issues across health care provision.

6.24 **Derbyshire Constabulary**
- Whether the investigation of potential crimes was appropriate and robust.
- A summary of all convictions relevant to safeguarding for both parents and relevant family members
- Whether mother or father was identified as a risk to themselves and/or others and the robustness of any arrangements made to safeguard BDS.
- Whether police involvement with father should have led to further actions to safeguard and promote the welfare of BDS.
- What efforts were made to convey concerns to other organisations where appropriate?
- What efforts were made to secure multi-agency involvement in the management...
of any identified risks?
- The effectiveness of information sharing.
- Give consideration to whether the escalation of risk was properly identified and responded to.
- Whether the family had been considered within MARAC arrangements.
- Was explicit consideration given to the urgent implementation of the MARAC process?
- Whether police response to the critical incident was within guidelines for incidents of this nature?
- When decisions were being made in relation to this situation how was the Child Protection Manager based within Central Referral Unit utilised?
- What advice and support was offered to mother to enable her and BDS to stay safe?

6.25 **Derbyshire County Council - Children & Younger Adults Services (summary report)**
The family were not known to specialist social care, the local multi-agency team or the Children’s Centre prior to this incident. The key issues for them to consider were therefore limited to:
- Whether a referral had been received from health or any other services?
- Was there a Service Level Agreement between Health Visitors and Children’s centres, and if so, was it implemented?
- What should have been the role of specialist drug social workers/Hidden Harm workers?
- Had a referral been received, what type of services may have been offered to a family in these circumstances?

6.26 **Derbyshire County Council – Schools and Learning - Pre-school nursery (summary report)**
- What information about BDS and his family was provided prior to placement?
- What assessment did they undertake and did they contact other agencies in doing so?

6.27 **Commissioned voluntary sector provider, Phoenix Futures**
- Thoroughly examine the healthcare and treatment afforded to both mother and father with consideration given to the involvement of, and support provided to, carers and family members.
- Thoroughly examine the actions taken in response to indications of the abusive nature of the parental relationship.
- What consideration was given to the needs of BDS in the care plan for the mother, and did this pay attention to his parent’s circumstances and living arrangements?
- What efforts were made to share information and convey concerns about mother and father with Health services and to any other organisations?
- How were these affected by the family moving house?
- Review all patient records and consider the effectiveness of assessment, care planning, intervention, and evaluation in respect of all family members.
- How was the key worker’s experience of mother shared with the non-medical prescriber to inform practice?
- Interview key members of the teams involved with the family, examining the clinical approach and intervention, including immediately following the ingestion of methadone.
- Review care and treatment provided by clinical teams in relation to National and
Derby and Derbyshire Policy, Procedure, and Standards. The following must be reviewed:

a) Record Keeping  
b) Prescription of methadone  
c) Supervision arrangements  
d) Clinical Risk Assessment  
e) NICE and NTA Guidance  
f) Domestic Abuse Guidance  
g) Government guidance “Information Sharing : Guidance for practitioners and managers”  
h) Derby and Derbyshire Safeguarding Children Procedures  
i) Derby City 2007 Guidance regarding pregnant patients of drug treatment services  
j) Give consideration to whether the escalation of risk was properly identified and responded to - was explicit consideration given to the implementation of the MARAC process.  
k) To what extent can the use of methadone in households with under-fives be deemed low risk? If so, how was this managed? Is the training and guidance for staff child-focussed?

6.28 Commissioned voluntary sector provider, Addaction (summary report)  
Report to include a statement confirming:  
• Whether they have worked with mother.  
• Agreement to release any records they hold.  
• Were they involved in 2009 in care/treatment?  
• Did they assess mother?  
• Any records they hold for mother indicating she has aliases.

7. The Involvement of the Family in the Review  
7.1 The Serious Case Review Sub-Committee agreed that the review would benefit from the involvement of family members including BDS’s parents. Adult family members have an important perspective to bring to the SCR process and can assist the LSCBs in gaining the best possible understanding of what happened, why and importantly what, if anything, might have prevented a child’s death or injury. Family members were informed of the SCR but were not interviewed until after their trial.

7.2 The contribution of Mother and Father  
7.3 On 6th March, I undertook interviews with both parents. I am grateful to Mother and Father for being willing to discuss some very sensitive and distressing issues and for their contribution to the learning from the SCR, much of which concurs with my findings and those from the IMRs.

7.4 Mother described her childhood and how she had met Father. As their relationship developed and she found she could trust him, she changed her mind about him not being involved in the upbringing of BDS and by the time he was born they were in a positive relationship and moved into together and then moved to live with extended family members after BDS’s birth. They continued to live there for approximately a year until they moved into a nearby property which meant that triggers for Mother’s drug use remained in close proximity.

7.5 Mother said that neither she nor Father drank alcohol. She wondered whether traces of alcohol could have been found in BDS as they frequently used alcohol hand cleaning lotion. She described how much pride she took in
BDS’s appearance and the care and pride she took in her home. She was very proud of the outcome of the parenting assessment undertaken by the Family Support Centre.

7.6 Both parents said they had no criticisms of any particular professional but had found some more helpful than others. Mother said that her first Keyworker at the Drug Treatment Clinic was far stricter than the second, who had had a tendency to “laugh off” her taking illicit drugs or positive urine tests and at times did not keep her appointment with Mother. She found her Key workers at Addaction very helpful as they would always follow things up for her. One of the workers also knew the whole family circumstances.

7.7 Mother strongly denied having told different staff different accounts of her illicit drug use; she said there would have been no point because the staff all worked in the same building and she assumed they spoke to one another. She said she had only tried to falsify her urine test on one occasion and had been “caught out” because the person from whom she obtained the urine had taken codeine which showed up as an opiate. Mother and Father both said that the falsification of urine tests was not uncommon and described how they knew of other patients who had done so. They both feel that because of this, tests should be taken by mouth swabs on every visit. They acknowledged that Mother had on occasions sold some of her methadone to a man she knew but that Father had tried to prevent this.

7.8 Mother and Father did not attempt to blame anyone one for BDS’s death, they said they had never given him any drugs and had been shocked to learn that some people did this. They described what happened as a ‘terrible accident’ that they and their family will pay for, for the rest of their lives. They accepted the mistake was Mother’s and that she had been neglectful in smoking illicit drugs in the flat, although this was never where she could be witnessed.

7.9 Mother said she had always been frightened that CSC would remove BDS, as she was a known drug user, she and Father both expressed surprise that they had not been seen by a social worker in hospital when their son was born, or when they returned home following this birth. They feel that had this happened and they had been warned in writing or through a Child Protection Plan, of the consequences of taking drugs at home i.e. that consideration would be given to removing BDS, this would have acted as a powerful deterrent.

7.10 Mother and Father said that the substance use workers focussed on Mother’s drug taking and never visited them at home or talked about their relationship or with their extended family. They said that professionals who visited them at home concentrated on childcare arrangements and did not discuss Mother’s drug use in any detail. There were no unannounced visits by any professional.

7.11 Father said that he had never been offered any support despite the fact that he was the partner of a substance dependent person. This issue was recognised and addressed in the Supporting Families and Carers NICE clinical guidance 51 and 52 of 2007 but not addressed in Derby City or in Derbyshire

7.12 Mother said that she had not attended the Children's Centre recommended by the Health Visitor because she had sufficient support from her family. She also knew several people who attended the Centre and with some of these there had been previous difficulties; she had not resisted attending so that BDS should not be seen. She spoke positively about the playgroup and how she had looked forward to collecting BDS after his session and hearing what he had been doing.
Mother and Father feel strongly that the dangers of even small quantities of methadone and the ingestion of drugs through smoking them in the vicinity of children should have been explained to them and should be widely promoted. Mother said she had been given a safe storage box by Addaction and had been told to keep the methadone in a safe place but little more than this. She kept her methadone in the safe storage box on her wardrobe, apart from the night of the incident. She said that no-one seemed to consider the presence of other prescribed drugs in the household which had increased the amount kept there. Mother said that she took her methadone in split doses, not because the whole dose made her nauseous as has been reported, but because she found the effect of the methadone lasted for longer if taken morning and evening.

They feel strongly that there was a lack of information to warn parents about the dangers of drugs; there was no information in Drug Treatment Clinic or at the Family Support Centre which she and Father attended and that they had taken leaflets to the staff there.

8. The Facts

Ethnic Cultural or Other Equality Issues

8.1 BDS was a white British boy and at the outset of the review there was no known history of faith that was thought likely to have an impact on this review.

8.2 There has been no information that suggests that either parent has a disability. At the time of BDS’s death the family lived in Derbyshire, in a town with a population of about 20,000, 96% of whom are white British. There is some drug use in the town. The proportion of children living in poverty in the district is lower than the average for England and most health and related indicators are around the average for Derbyshire. Derbyshire lies about 10 miles north of Derby – much of Mother’s health care took place in Derby City and she travelled to appointments without too much difficulty.

8.3 None of the IMRs fully explored the cultural context of BDS’s family environment, particular that of the drug culture. It is known that Mother also knew other drug users who lived nearby one of whom was reported by Mother to be a particular trigger for her drug use.

Information known at the time of BDS’s death

8.4 BDS died on 13th March 2012, at the age of 2 years and 4 months.

8.5 He was born in Derby City, but after his birth he moved with his mother to live with his extended family in Derbyshire, and subsequently to a flat in Derbyshire with both his parents. He received care from universal health services throughout his life.

8.6 His mother had used Class A drugs since her mid-teens representing a long history of substance misuse. At the time of BDS’s birth she was on a methadone programme, but using illicit drugs including heroin and cocaine.

8.7 His father periodically smoked cannabis and had significant health problems, for which he received treatment from universal health services.

8.8 BDS died suddenly and unexpectedly, having ingested a quantity of methadone which had been put into a child’s teacher beaker, a plastic cup with a lid with a
spout.

8.9 During the criminal prosecution of both parents, evidence was presented that indicated that he had ingested methadone on a number of occasions before his death and in all probability this had been as a result of being given it by one or both parents.

**Staff feedback**

8.10 On completion of each IMR, report arrangements will be made for feedback to staff involved in the case. There will also be a follow wider up feedback session once the SCR report has been completed, and before publication. This has subsequently taken place.

**The Serious Case Review Process**

8.11 The SCR was carried out well, there were regular challenge meetings to review drafts of reports and appropriate changes were made. There were however, some delays created by difficulties in accessing the parent’s medical records.

8.12 IMR reports were completed satisfactorily and made appropriate recommendations. I would like to highlight the IMR produced by Derby Hospitals NHS Foundation Trust and the Health Overview Report which both provided a wealth of information and decisive analysis supported by clear and substantial evidence.

**Publication**

8.13 The Government requires that LSCBs publish SCR Overview Reports in full, having first anonymised and prepared them in a form suitable for publication unless there are ‘compelling reasons relating to the welfare of children directly concerned in the case’. Following advice from Derbyshire County Council Data Protection Officers and independent counsel, the Independent Chair of DSCB agreed the report for publication.

9. **ANALYSIS**

9.1 **Family History**

9.2 Little is known about the relationship between Mother and Father. When Mother became pregnant with BDS she told professionals that she did not want her partner (Father) to be involved in the upbringing of the baby but over time her view about his involvement changed. By the time BDS was born their relationship had developed and Father was reported to be cooking for her and generally supporting her. He accompanied her to ante natal appointments and her appointments with substance misuse services and Mother told staff that he was helping her financially.

9.3 DCC CAYA provided historical case file information that indicates that prior to the timeline there had been no previous involvement with the family by the Safeguarding and Specialist services. Adult referrals were received on three occasions (1999, 2001 and 2002) for Residential Drug Rehabilitation services for Mother organised by Southern Derbyshire Mental Health Trust.

**Period 1: Summary of key events from 1998 to first booking with the pregnancy of BDS**

9.4 Mother was known to a range of health services including drug services for several years and was supported to stop using drugs but this was of varying
success. Despite being pleased at the thought of having a baby when she was first pregnant her illicit substance misuse increased; she reported using heroin and crack daily and explained that her social circumstances made it hard for her to stop.

**Evaluation of practice from 1998 to the first booking with the pregnancy of BDS**

9.5 During this period risks to Mother and unborn BDS were appropriately recognised but these were not shared appropriately with all agencies.

**Period 2: Summary of key events from first booking date to delivery of BDS on 6th November 2009**

9.6 Mother attended a number of services including specialist substance misuse services throughout her pregnancy and remained very positive about the prospect of becoming a mother. She expressed her intention to stop using drugs as she had been warned by professionals of the dangers to the unborn baby. She was open with professionals about her concerns that CSC would become involved with her and might remove her baby when it was born.

9.7 However, her intention to cease using drugs proved to be very difficult and despite her efforts she continued to use illicit substances in varying amounts throughout her pregnancy.

9.8 During the period of Mother’s pregnancy Father had some health problems some of which were caused by a traumatic experience.

**Evaluation of Practice from first booking date to delivery of BDS 6th November 2009**

9.9 From her first booking with the GP and Specialist Midwife, SMSM1 there was a failure by the majority of professionals to use known and emerging information about Mother’s vulnerability to form an accurate risk assessment of unborn BDS.

9.10 The GP did not appear to have undertaken any risk assessment or consider a referral to CSC, despite the historical vulnerabilities known about Mother and her current circumstances.

9.11 When Mother attended her first midwifery booking with the Specialist Midwife SMSM1, no details of Father were recorded as Mother said she did not want his involvement however the reasons for this were not explored and no domestic abuse enquiry was evident from the records.

9.12 The Specialist Midwife SMSM1 inappropriately agreed with Mother that a CAF should be undertaken by Women’s Work, the grounds for referral to CSC were met and this was the appropriate course of action, not for a CAF to be commenced.

9.13 The Specialist Midwife’s recording practice at the Drug Treatment Clinic was to enter her contacts using SystmOne electronic recording system (on the same day) following Trust and Professional standards but then had to write up her paper records, which were kept in isolation within the Obstetrics and Gynaecology Service. This dual system frequently caused a significant delay in recording practice¹ and there are numerous examples of this demonstrated in the integrated

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¹ Nursing Midwifery Council Record Keeping Standards & Derby Hospitals Record Keeping Standards 2010
During this antenatal period events occurred which should also have been considered in terms of risk to unborn BDS. A serious omission was the lack of any systematic gathering and sharing of information between professionals and agencies.

The meeting of October 2009 (described by IMR authors as a multi-agency meeting although it was predominantly attended by health and the hostel) was a significant opportunity to share information and conclude that a referral to CAYA should be made. However, it lacked focus with different individual management reports giving different aims or purposes for the meeting. Although safeguarding concerns had been previously identified, CSC were not invited to this meeting, contrary to procedures.

Following the meeting, a second meeting was arranged for after the birth of BDS. This was cancelled following Mother’s move to Derbyshire, this was a missed opportunity to transfer Mother to the Derbyshire Addaction Service; instead she continued receiving services from the Drug Treatment Clinic. A transfer meeting would have enabled a focused handover of care to Derbyshire and identify a potential link to other adults known to Mother, who was also receiving a service from Addaction.

A medical professional working within the Drug Treatment Clinic when interviewed as part of the SCR advised it had been left to the Specialist Midwife to decide whether a referral was made to CSC or not. This should have been a shared decision, following a collective holistic assessment, as everyone has a safeguarding responsibility to protect and promote the health and welfare of children, including the unborn.

This action may have been influenced by a lack of attendance at safeguarding training, the lack of access to Safeguarding Supervision or the perception that the Specialist Midwife was ‘the expert’ and had greater knowledge and expertise in this area than staff working within the clinic.

The need to ensure proactive practice within health services such as the Drug Treatment Clinic has been identified by previous SCRs. Laming (2009) also identified ‘that the safeguarding of vulnerable children (including the unborn) is often not viewed as a priority by GPs and health professionals in some areas.’

The hostel has offered further information to the SCR regarding their role and responsibility in this case. They are an adult focused service for homeless vulnerable single adults with a key remit of finding clients accommodation. They felt that once Mother was confirmed as pregnant they appropriately linked in with the Specialist Midwife who then took the lead with regards to Mother’s care. When Mother was displaying vulnerable behaviour in the initial part of her pregnancy they worked closely with the specialist services (Specialist Midwife) to relay any information that they felt they needed to know as well as spending time with Mother discussing her situation. They also brought Mother up at meetings to discuss her progress and raise any concerns, and staff also gave her extra support when required. However, it is my view that Mother’s absences should have been raised as a safeguarding issue.

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2 Laming (2009) also identified ‘that the safeguarding of vulnerable children (including the unborn) is often not viewed as a priority by GPs and health professionals in some areas’
**Period 3: Summary of Key Events During the Period from the birth of BDS 6th November 2009 to the primary birth visit**

9.21 When BDS was born he and his Mother were transferred for maternity post-natal care, in accordance with guidelines for babies born to mothers who are involved in substance misuse.

9.22 His birth notification was sent to the Health Visiting Team (Derby City) not Derbyshire where Mother intended to live. The same day the Specialist Midwife contacted the Community Team (unclear whether this was the Derby City or Derbyshire Team) informing them of Mother’s history and being discharged to their area. A request was made for the Health Visitor to be notified as soon as possible and for contact with DCC CAYA or the Specialist Midwife if there were any concerns.

9.23 On the 12th November GPwSI saw Mother at the Prescribing Clinic and said she was going to live in Derbyshire with BDS. GPwSI recorded ‘will await more info for discharge and transfer’ without identifying what further information was required or when transfer would take place. The same day Mother and BDS were seen by the Specialist Midwife for a post natal and baby check with ‘no abnormalities detected’. A prescription was given for two week’s supply of methadone as Mother was living locally. The following day, the Community Midwife advised Mother that if her stay was to be greater than two weeks she would need to register (in Derbyshire) with a GP. There is no indication that the Community Midwife communicated to the Health Visiting Service Mother’s intention to stay in Derbyshire.

9.24 BDS attended his GP as advised on the 20th and was seen by GP 10. Mother reported that she was receiving good support, was excited at being a mother and was coping well with the baby. There is no record of a discussion about Mother’s substance misuse or any assessment about the risks to BDS.

9.25 Health Visitor 5 sent Mother an appointment to see the family at home on the 24th November for the primary birth visit (BDS would be 18 days of age). Mother on receipt of the Health Visitor’s letter contacted the clinic by telephone and cancelled the primary birth visit as she was staying in Derbyshire. Mother was asked to contact the Midwife and request a home visit.

9.26 A Derby City Health Visitor left a telephone message for the Derbyshire Midwives to ring them but there appeared to be no contact with the Derbyshire Health Visiting Service to advise them that Mother and BDS (a highly vulnerable infant) had moved into their area and was due a primary birth visit.

9.27 The Derby City Health Visitor and a Health Visitor from Surgery 1 arranged for the Health Visiting Records for BDS to be forwarded to Derbyshire. The same day Mother did not attend the Prescribing Clinic to see GPwSI and her Substance Misuse Keyworker 2 but was seen by Community Midwife 10 and discharged from community midwifery care. No direct communication or handover to the Health Visitor was made following this discharge.

9.28 Mother saw SMSM1, Specialist Midwife in November and the records were updated with regards to BDS’s progress, Mother’s move to Derbyshire and current drug use. There appears to have been no assessment of risk around family members but an assumption they were supportive.
At the end of November, the Health Visitor visited the home to undertake the primary birth visit. This visit was within the CPHVA’s guidance timescales at the time and is a significant component of the work of all Health Visitors; it is often the first point of contact with the mother, child and family. The functions of the visit are:

I. Relationship development
II. Assessing the baby’s growth and development
III. Assessing the family situation in order to make a decision about the most appropriate care requirements.

During the home visit detailed information was noted with regards to BDS and Mother, she reported to be feeling well and enjoying motherhood. Emotional warmth and positive interaction between Mother and BDS were also noted. Mother was informed of the ‘no shaking babies’ policy, relevant contact numbers, appointments and standard health education information. Mother told the Health Visitor of her drug history, that she was currently on a methadone programme and under the care of the Specialist Midwife.

**Evaluation of Practice: During the Period from the Birth of BDS 6th November 2009 to the Primary Birth Visit**

Following BDS’s birth he exhibited a number of symptoms which could have been attributed to Neonatal Abstinence Syndrome. The DSCB inter-agency procedures state that where a baby, who is not already the subject of an inter-agency plan is observed to be experiencing withdrawal symptoms, the Midwifery Service must request a discharge planning meeting with CCS and the Health Visitor. This did not happen in this case, and was a missed opportunity for a focused assessment and plan at the point where the baby was safe in hospital.

Furthermore, during his period on the ward there was no information about Mother’s observed care of BDS (practical parenting or emotional attachment) the management of her substances whilst on the ward or the role of Father. There was no documented plan for monitoring Mother’s methadone whilst in hospital.

After BDS was born social or safeguarding concerns do not appear to have been identified by hospital staff, so they did not inform the Specialist Midwife as requested or inform CSC.

When BDS went home with his Mother, Derby City Community Midwifery Services visited Mother and baby but did not liaise with the Health Visiting Service in Derbyshire to notify them of Mother’s presence. This would have ensured that Mother received a primary birth visit promptly and had access to on-going support from the Health Visiting Service.

During her care of Mother and BDS the Health visitor did not routinely contact the drug workers to understand Mother’s drug use, had regularly contact been made with the drug workers Mother’s use of illicit drugs would have become known. Evidence to the SCR panel by the Trust IMR author advises that the recommendations from the Child M review had not been disseminated widely by the Trust and were not known by this Health Visitor.

At their first contact with BDS and his Mother in Derbyshire, neither the Midwife nor the Health Visitor undertook a robust assessment or gathered a comprehensive social history and they placed too much reliance on Mother’s own reported information. In addition, no information was gathered about Father,
domestic abuse was not discussed and any concerns with regard to other issues were not identified. What information that was gathered was not analysed from a safeguarding perspective.

9.37 Professionals did not always effectively share information with each other and in relation to where Mother and BDS were living on discharge, there appears to have been a lack of urgency in the communication between the Specialist Midwife, the Hospital Midwives, Community Midwives, Health Visitors and GP. When contact was made and professionals began to assess and form a view, they did not separate Mother’s needs and the needs of BDS. A clear picture about Mother, Father, the whole family and the risks to BDS, particularly Mother’s tendency to provide different accounts of her drug taking, was not gathered. At no point did anyone compare her commitment to giving up drugs with her actual drug taking. Whilst this was clearly poor practice it needs to be born in mind that BDS appeared to thrive; a positive bond developed between Mother and baby and they were living in what was seen as a positive and supportive arrangement.

Period 4: Summary of key events from November 2009 to March 2013

9.38 Pharmacy 1 took over responsibility for dispensing Mother’s prescriptions in November 2009 following her move to Derbyshire, either just before or immediately following the birth of BDS, although Mother had lived there for some weeks prior to his birth.

9.39 On 1st December Health Visitor 1 contacted SMSM1 who advised that the service would support Mother for six months alongside the Drug Treatment Clinic that Mother had attended all her appointments (not factually true) and was keen to receive support.

9.40 Mother did not attend the Prescribing Clinic on the 3rd December 2009 to see GpwSI but did attend a one to one with Substance Misuse Keyworker 2 (Phoenix Futures) and discussed a permanent move to Derbyshire, for more family support. Mother self-reported intermittent illicit use and Substance Misuse Keyworker 2 proactively challenged her as to BDS whereabouts when using, Mother said he was with his father when she took her drugs.

9.41 On the 7th December 2009 the Health Visitor visited the family home for a support visit. BDS was reported to be feeding well, was generally well and settled, waking only once at night. Mother reported to be feeling well and enjoying motherhood; she was observed to be confident when handling her son and seemed to be coping well. Mother was invited to attend the clinic. No ‘red book’ was available to record this visit. Housing problems were discussed and Mother stated her intention to apply for Local Authority housing.

9.42 Mother saw GpwSI at the Drug Treatment Clinic and reported weekly heroin use but she reported crack and heroin to the Specialist Midwife. She advised that she was not in withdrawal, and requested an increase in her dose to 100 mls which was refused. She was advised to split her dose with some being supervised and some unsupervised. No mention of the rationale for splitting the dose was documented and there is no record of safe storage of methadone being discussed.

9.43 The Health Visitor saw Mother and BDS at the family home for his six week check. No concerns were reported, his development was age appropriate and emotional warmth and positive interaction seen with both parents. Mother again
reported she was enjoying motherhood and was observed handling BDS confidently. Her Edinburgh post natal depression score was low. She reported she continued on the methadone programme and was accessing support. There is no mention of her illicit use. However, the Health Visitor identified Mother and BDS as needing an enhanced package of care.

9.44 When BDS was seen for his periodic infant development appointments his development was always seen to be satisfactory. Mother appeared very well and said she was overjoyed at having a baby. There appeared to be a close bond between BDS and his parents and they appeared to be well supported within the family networks.

9.45 After BDS’s birth and throughout his infancy Mother was open about her continued use of illicit drugs and was challenged about BDS’s whereabouts when she taking them. Harm minimisation advice was given and Mother reported boredom was the trigger for her illicit use and drug service workers helped Mother to look at possible alternatives and using her time more meaningfully. Her goals to achieve drug cessation were discussed and plans were reviewed. Mother signed an acknowledgement that she had been told of the risks of methadone and other substances to children and non-addicted individuals.

9.46 BDS was seen fairly regularly by a number of professionals including those involved in Mother’s drug treatment programme and those responsible for BDS’s care in the community; their records indicate that he always appeared healthy and well looked after. He was never seen to exhibit symptoms of continuing to be affected by the drugs his Mother used when she was pregnant or of having been given drugs after he was born. He was described as friendly and responsive and appeared to be attached to his parents. There was nothing about him or his home environment that raised concerns that all was not well nor that his behaviour might result in him being given drugs to quieten or console him.

9.47 Mother was not keen on going to local groups at the time but remained on her methadone programme with continued support from the Drug Treatment Clinic and SMSTM1. She reported not using any other drugs apart from the occasional ‘spliff’ and aimed to reduce her methadone in the future.

9.48 Mother was not raised at the Safeguarding Multi-Disciplinary Meeting. At a Key Worker meeting Mother’s care plan was reviewed by Substance Misuse Keyworker 1 who felt Mother had engaged well with the plan and its goals.

9.49 On the 23rd June 2011, Mother was seen at the Drug Treatment Clinic where a drug test was positive for heroin, cocaine, benzodiazepines and methadone. There appeared to be no challenge regarding this increase in illicit use or any consideration of safeguarding. Staff did not seek advice from a more experienced colleague or member of the safeguarding team.

9.50 In July, Substance Misuse Safeguarding Nurse confirmed on SystmOne where Mother lived however, the reason for this confirmation is not recorded nor a link made with Mother’s Derbyshire address, which would have identified that she lived outside the boundaries of the service. Soon afterwards the Substance Misuse Keyworker 1 at the Key Worker meeting identified that a safeguarding RAG status for Mother had been given as amber. There is no clarification as to what actions this safeguarding amber rating required.

9.51 On the 4th August, Mother was seen by GPwSI and gave an encouraging drug test
result, indicating that she was only positive for methadone. She self-reported no drug use in the previous week. A further encouraging drug test positive was given on the 1st September 2011.

9.52 In September 2011, the Police received information about the family. The report mentioned Mother’s methadone use but does not appear to link Father or Mother with BDS or the potential impact on parenting of drug dealing. The following day, Mother was seen by GpwSl at the Prescribing Clinic who asked about who had BDS, it is unclear who did. Again Mother gave a positive test for Methadone only use, her third such result.

9.53 On the 20th February 2012, Mother’s methadone split dosage was discussed at the NMP group led by GPwSl2. It was identified that a split dose was rarely required and clients must have clean drug tests and if there were any issues these should be discussed at the Multi-Disciplinary Meeting. It was later recorded that Mother did not want any change to her prescription. She reported BDS had started playschool and appeared to enjoy it.

9.54 On 3rd March 2012 the Police received the first intelligence that connected Father and Mother and a child, it stated that Father was selling heroin from the flat, to people who visited throughout the day and evening.

9.55 The following day, further Police intelligence was received stating the Mother was dealing from the flat with an unknown male. There appeared no link to the intelligence received the previous day about Father dealing and the presence of a child. Three days later an officer saw Mother and her young son in Derbyshire and the information was disseminated.

Evaluation of practice from November 2009 (the Primary Birth Visit) to 12th March 2012

9.56 The views identified at the October 2009 pre- birth meeting with regards to BDS, appear to have remained fixed throughout this period without an individual or shared re-consideration of subsequent events. Each event was treated as ‘a fresh start’ and each agency appeared to work in a ‘silo’ without jointly considering them as a pattern or considering them in the light of what was already known.

9.57 The overall view of professionals during this period was erroneously positive despite the evidence to the contrary.

Specialist midwifery

9.58 The Specialist Midwife’s decision to close the case when BDS was 10 months old was not documented but may have been due to Mother living in the Derbyshire area, outside the boundaries of the service or the Drug Treatment Clinic. This was an ideal opportunity to refer Mother and BDS to services in the county including Derbyshire Drug Treatment Services.(see para 9.67 below) The role of the Specialist Midwife appears to have been confusing as the midwife was the non-medical prescriber for the client as well as the midwife and employed by two different organisations, the Drug Treatment Clinic and Derby Hospital Trust. Following the establishment of this dual role there were no changes to the job description or lines of accountability for each role. As a result, there was a lack of clarity about role boundaries and tasks.

9.59 The comment from the Specialist Midwife during interview ‘that everyone had worked hard to keep Mother functioning at an acceptable level’ suggests that the service was adult and not child focused. In addition as ‘everyone’ had worked so
hard it may have felt as if they had failed if they had made a referral to CSC, rather than seeing CSC as an avenue of support for them and the families they work with.

**Health Visiting services**

9.60 Home visits were only made by the Health Visitor by appointment and there appeared no unplanned contacts which may have given a truer picture. On the surface Mother, Father and BDS appeared to be coping well, where observations of BDS were made he was well presented and there was emotional warmth and interaction between the parents and the baby. In addition the family appeared to be well supported and as a result no concerns were noted.

9.61 At the time of the Health Visitor’s involvement with BDS and his family the Health Visitor had been unaware of the recent recommendation from the Child M IMR about checking the safe box during home visits. This information had not been widely disseminated to all relevant health professionals by the Trust and therefore was not common practice.

9.62 At the time of BDS’s birth the Derbyshire Children’s Centre was fairly newly established. The Health Visitor appropriately gave Mother information about the centre at BDS’s 3 to 4 month review. Mother did not complete her referral form for the Centre or give her consent for the Centre to be contacted on her behalf. As no concerns had been identified and BDS was not the subject of a Child Protection Plan, it was left to Mother’s discretion as to whether she attended the centre or not and her non-engagement with the Centre was not seen as suspicious. The Health Visitor could do little more than recommend that Mother took BDS there for sessions.

9.63 Given that Mother had a partner who was at home all day and had the support of nearby family I am of the view that her not engaging with the Children’s Centre was not necessarily avoidant or should have aroused suspicion in the Health Visitor. Furthermore Mother did follow the Health Visitor’s advice regarding early educational opportunities by registering BDS at the local playgroup which he attended and enjoyed and his appearance and behaviour did not raise any concerns.

9.64 Although there is now evidence from Children’s Centres that the best engagement by parents is secured by Children’s Centre staff reaching out to them by making home visits and even accompanying them to their first sessions, this was not the practice required at the time.

**Drug treatment Services**

9.65 Throughout this period Mother consistently used illicit drugs, despite her commitment to becoming drug free, but this information did not contribute to a risk assessment and there was a failure to refer Mother to CSC despite sufficient information that indicated developing risks.

9.66 Mother’s contacts with the Drug Treatment Clinic and Phoenix Futures were by appointment as this is the basis on which the service operates because Mother lived outside the boundaries of the service. This should have alerted professionals involved that home visits were not being undertaken and triggered a handover to services covering the Derbyshire area. An ideal time for this to have occurred would have been when BDS was 10 months old (see para 9.58 above). This could have been achieved by either the Medical Director or Prescriber lead referring the family to Addaction in Derbyshire and informing all relevant agencies, or for a
professionals meeting to have been called to facilitate a holistic handover of care involving all relevant professionals from the Drug Treatment Clinic and Addaction Derbyshire. This may have resulted in different professionals, not previously involved in the case, reviewing and more robustly assessing the situation and referring to CSC. This would have resulted in a more robust assessment of Mother’s triggers for her illicit use and action planning. There was limited, if any, sharing of information, not helped by both services using different electronic systems.

9.67 Although Mother and BDS were discussed during some staff meetings in the drug treatment services, there appeared no on-going robust assessment of parenting capacity using historical information, relevant research with regards to parents who misuse substances to and any current concerns, no matter how minor. Again everything on the surface appeared positive and was reinforced by comments from Mother, but there were single incidents which individually may not have been significant but collectively may have raised concerns, for example Mother’s conflicting information to different professionals about the extent of her illicit use or not meeting the targets she set with her Key Worker. As a result no professional had a comprehensive view of the reality of the situation. On a number of occasions, Mother’s Key Worker challenged Mother as to BDS’s whereabouts when she used illicit drugs but accepted at face value that he was with his Father who did not misuse drugs.

9.68 Although BDS appeared well throughout this period too much reliance was placed on this, without sufficient assessment of Mother’s drug use. There are frequent references to her continuing to use illicit drugs and some significant missed appointments and failed drug tests. Staff involved in the drug treatment aspect of Mother’s care failed to compare the information she provided about her drug use which would have identified that she was giving conflicting reports and this may have led professionals to be suspicious. Professionals did not appear to challenge Mother, assess safeguarding concerns or continuously re-evaluate the situation and follow the advice from GPwSI 2 about the split dose and did not raise Mother’s continuing illicit drug use or the split does at the Multi –Disciplinary Meeting.

9.69 On a number of occasions, Mother worked with her Key Worker to set targets in relation to ceasing her illicit drug use. The plans included how these targets would be achieved, what evidence would be acceptable to demonstrate the targets had been met and what the consequences were if they were not met. At no point does there appear to have been any consideration as to whether Mother was selling her methadone to buy illicit drugs and that this could have accounted for her positive test.

9.70 The risks to children of a substance misusing parent are reduced if the other parent does not use drugs. In this case it was taken at face value that Father did not use illicit substances, this was never challenged or confirmed from a secondary source. A discussion with Father’s GP may have highlighted the GP’s previous concerns that Father may have used illicit drugs when Mother was pregnant with BDS and he had been treated for mental health problems. A full assessment would have identified his ability to protect BDS or not.
9.71 Studies have reported consistent patterns arising from the follow up of children born to drug dependant Mothers and exposed to drugs in utero and conclude that they are significantly at risk. The outlook was found to be more positive for Mothers who remained in treatment, although abuse still occurred in 41% of children. Given that research carried out in the last ten years highlights significant risk around children born to substance misusing Mothers, even when in treatment, a more robust management plan should have been identified and monitored.

9.72 Mother was appropriately issued with a safe-box (by the Drug Treatment Clinic) and advised verbally and in writing about the dangers of methadone to non-users and especially children. She also signed to say that she understood these dangers.

9.73 It is not clear whether the Health Visitor asked about Mother’s use of the safe-box and checked its whereabouts. Neither the family GPs nor the Community Midwives discussed the safe storage of drugs with Mother and no one from the Drug Treatment Clinic completed a home visit. The absence of home visits by the Drug Treatment Clinic staff was in accordance with the procedures at the time and was not a failing by staff, nevertheless it put the onus for checking safe storage inappropriately on the Health Visitor rather than there being a collective responsibility. An audit3 around the use of safe boxes identified that health professionals have a responsibility to provide information and guidance on safe storage of methadone (as happened in this case) but the information needs frequent reinforcement, evidence of compliance and assessment of attitudes and practice.

9.74 On a number of occasions Mother’s Key Worker failed to document her contacts with Mother, contrary to current recording guidance. As a result, important factors from a safeguarding aspect may have been missed by other professionals accessing these records. Not being aware of information which may have indicated escalating concerns or a concern when put together with other concerns to form a bigger picture, may have disadvantaged professionals undertaking any on-going risk assessment.

9.75 The lack of safeguarding supervision for substance misuse staff was due in part to resource issues which have now been addressed by the Trust. Further work has also been undertaken by DCHFT to embed safeguarding supervision in all supervision undertaken within the Drug Treatment Clinic or Phoenix Futures Service. This process will be audited through the Trust’s Clinical Governance framework to ensure the process remains fit for practice and meets the needs of clients, staff, the service and the organisation.

9.76 Safeguarding training was an issue in the Drug Treatment Clinic and Phoenix Futures, with a lack of clarity around the training professionals needed to attend and who had attended relevant training.

9.77 Management information on the patterns of referrals to CSC by the Drug Treatment Clinic has not provided clear information on referrals to CSC. The Clinic is reviewing their referral data and this may challenge or confirm the view that the culture within the clinic, about referring safeguarding concerns to CSC, was not to proactively promote this.

Pharmacy Services
The pharmacist from Pharmacy1 appropriately contacted the Drug Treatment Clinic on occasions in relation to Mother; these contacts were not recorded by the pharmacist although the receipt of the information was recorded by the Clinic.

GPS
The GPs interviewed by the Named Doctor IMR author expressed concern that Mother had been allowed to take home her methadone. Their assumption was that methadone was dispensed at the pharmacy on a daily basis and taken in full, whilst still on the premises. This suggests that no GP appeared to have discussed Mother’s methadone and illicit drug use with her. Although the GPs were updated by the Drug Treatment Clinic and other health professionals that Mother was receiving methadone, it appears that GPs saw Mother’s substance misuse as primarily the responsibility of the substance misuse service, resulting in their only dealing with issues presented to them on the day. When seen by the GPs although there were no specific concerns in relation to Mother’s care of BDS, better practice would have been for her drug use and its potential impact on parenting to have been periodically explored.

The GPs held key historical medical and social information about Mother and Father which should have been linked when the family were all registered with one practice; this suggests that such risk factors are not routinely taken into account by health professionals when working with parents who have drug or mental health problems.

Mother and Father were not registered with the same GP practice until November 2011 which impacted on the ability of health professionals to link the parents as a couple and consider their information in relation to the safeguarding of the children. None of the GPs appeared to have identified that Father was in a relationship with Mother and lived with her and a child they therefore did not explore whether any concerns had been identified.

Police
The Police had a number of contacts with both parents and intelligence reports at different levels. They did not connect the couple together as parents or identify that they had a small child living with them, whilst ‘dealing drugs day and night from the premises’. Although this information only came together during the final month of BDS’s life there was still a failure to recognise the safeguarding concerns.

Period 5: The Day of the Incident that led to BDS’s death on 13th March 2012
At 10.31 on the 13th March Mother made a 999 call to the Emergency Operations Centre (EOC) her chief concern was recorded as an overdose of methadone in an unresponsive two year old. The call was prioritised as a RED1.

When ambulance staff arrived at BDS’s home Mother, Father and were present. The history is annotated by ambulance staff as: ‘parents state that the patient has climbed up and drank methadone’ unclear where from, amount, or what time. The methadone was prescribed to mother. BDS was found in an upstairs flat at the address, supine on the floor with his father doing mouth to mouth resuscitation. Advanced Paediatric Life Support was commenced. The police were contacted by the EOC to attend the incident.’
9.85 The ambulance left the scene and arrived at Derby Royal Children’s Hospital after a pre-alert to the hospital was made. At the hospital, BDS’s care was handed over to the Consultant in Emergency Medicine. Resuscitation was attempted and he was transferred to Child Emergency Department (CED). A Child Protection medical was undertaken (no injuries or additional concerns were identified). The Police attended the hospital and both parents were arrested and later charged with manslaughter and remanded on conditional bail.

**Evaluation of Practice on the Day of the Incident that led to BDS’s death on 13th March 2012**

9.86 Practice on the day of the incident was appropriate. EMAS attended the family home within agreed target times and transferred BDS to hospital, appropriately informing Derby Hospital in advance of their attendance.

9.87 EMAS followed their safeguarding policy and informed the police immediately of their call out to the family home. They later made a safeguarding referral to Children’s Social Care. However, some unrelated learning has been appropriately addressed within the EMAS IMR and has led to minor policy amendment.

9.88 The police attended the family home and Derby Hospital Accident and Emergency Department and spoke with staff and both parents. Social Care undertook agency checks within minutes of BDS’s arrival at Derby Hospital.

9.89 **Research and Other Serious Case Reviews**

9.90 The Terms of Reference for this SCR included a review of similar serious case reviews involving parents who misused substances.

9.91 A review of research and previous serious case reviews around the (a) accidental overdose of methadone by children and (b) the parenting practice of giving methadone to children to keep them quiet or ensure they sleep through the night, has revealed a paucity of such research but did identify some historical anecdotal evidence. The lack of research around this growing and important significant risk indicator for children may be influenced by professionals:

- Not being aware of the practice where parents may administer methadone or other illicit drugs to their children for a variety of reasons.
- Not considering the practice when assessing risk.
- Not routinely asking parents who misuse substances if they have ever given their children illicit substances.
- Not routinely undertaking toxicology hair testing on all children admitted to hospitals or attending Accident & Emergency Departments with reported accidental overdoses of any illicit drugs.

9.92 This SCR relates to the death of a child in Derbyshire but the deaths of other children due to having also been given methadone and/or illicit drugs have also occurred in several parts of the UK, indicating that tragically the practice of giving their children drugs is not unknown and not confined to Derbyshire.

9.93 As identified by Hagell\(^4\), it is always easier for professionals to identify danger by intent rather than danger by default or omission (neglect). When parents may be unaware of the effects of their own behaviours on meeting their child needs including the dangers of methadone they may deflect professional assessments

\(^4\) A (1998) Dangerous Care: Page Bros Norwich
by statements such as 'they have turned my life around' or 'I will be able to stop once the baby is born' as happened in this case. Because the parents always appeared really positive and spoke warmly of BDS this distracted professionals from looking at what might happen when Mother used illicit substances and how this might impact on her ability to parent appropriately and safely.

9.94 In addition, Hagell identified that for some people drugs are part of a high risk lifestyle, a significant number of which were present in both Mother and Father for example the following:
- Continuing use of illicit drugs.
- Impact of alcohol not assessed, although evidenced by the police on two occasions of Mother’s involvement.
- Local trigger factors for Mother’s illicit use.
- Father’s previous mental health issues.
- Dealing drugs from the family home.
- Long history of illicit drug use including 3 – 4 failed rehabilitation attempts.
- Chaotic housing history including time spent in homeless accommodation.
- Failure to keep appointments or comply with treatments.

9.95 Alcohol and substance misuse features in numerous risk assessment models around parenting capacity and research evidence appears to support the view that this is likely to be related to child abuse and neglect, a factor not fully appreciated or assessed by the professionals in this case, who too often assessed risk from an adult perspective rather than a child’s and exploring what is it going to be like for a child in this family.

9.96 Research has clearly identified that adults who abuse drugs can be adequate parents when they comply with treatment but that those who default from treatment programmes pose significant risks to their children. Problems may arise as a result of a chaotic lifestyle which may include flight from contact with helping agencies, placing the child with different caretakers and other neglectful behaviours. The impact of parents' general lifestyle on the unborn child / child as well as any risks posed to them during their parents’ altered mental state when actively using, need to be considered and assessed. Although early concerns did arise in this case they never progressed as far as a core assessment and therefore never reached a threshold of concern via a referral to children’s social care.

9.97 Substance misuse affects parenting capacity directly through its effect on a parent’s mental state and judgement ability or indirectly through the parent’s lifestyle or the adverse environment in which they live, for example dealing drugs from the family home. The impact of drugs or alcohol also varies in relation to the parent’s current mental state, experience and or tolerance of the drugs used, expectations, personality and the quantity and combination of the drugs taken was not fully assessed in this case as no referral for a multi-agency core assessment was made.

10. THEMATIC ANALYSIS OF PROFESSIONAL INVOLVEMENT
10.1 Key Themes emerging:

Clinical Governance
10.2 A number of IMRs did not address the role of quality assurance processes within their recommendations and action plans. Monitoring arrangements should be effective and used systematically to strengthen services especially when joint working may be a common way forward.

10.3 Thresholds for service access including referrals into CSC did not appear to be clearly recognised by the professionals involved, or the requirement to follow policies and procedures. The CAF was not used to provide support to the family and there are no examples of its use within any agency involved. Although health professionals considered a pre CAF and CAF, neither was actioned.

10.4 The health trusts involved have identified difficulties with staff using more than one recording system either electronically or paper copies. Although these have been appropriately addressed within the IMRs, these should be monitored and supported by each organisation.

10.5 Multi-agency working
IMRs demonstrate that partnership working was not clearly embedded, for example not inviting CSC or the GP to the multi-agency meeting and the police not recognising the risks to unborn BDS when they gave Mother notice to move on when she was seen with a group of problem drinkers.

10.6 Practice
10.7 Professionals did not undertake comprehensive and robust risk assessments of the nuclear or extended family. In addition, a number of professionals did not appear to demonstrate sufficient knowledge when undertaking interventions with the family and others had not attended relevant safeguarding training at the required level or discussed the family in supervision.

10.8 On a number of occasions there were missed opportunities to share information, complete a CAF, make safeguarding referrals, invite CSC to multi agency meetings or convene a discharge planning meeting. There is no evidence that professionals raised concerns by escalating these to their managers when they discovered that actions had not taken place or when they felt decisions were inappropriate.

10.9 Recording systems
10.10 Information within GP practice systems for example ‘flagging systems’ to identify high risk families, children in need, children and young people with protection plans or families requiring extra support should also ensure that family members are linked. For a short period of time all the family members in this case were registered at the same GP practice, but there appeared no linking of Father, Mother and BDS.

10.11 Despite Father’s illnesses, at no time was he asked about any caring responsibilities or how his illness or the challenge of living with a substance dependent partner, impacted on family life. A similar situation was duplicated in relation to Mother’s substance misuse with the GPs tending to only discuss the presenting illness when seeing her, leaving the substance misuse issues to the experts.

10.12 There were a number of concerns expressed within individual management reviews about recording systems.
10.13 **Domestic Abuse**

10.14 The issue of domestic abuse was mentioned by professionals and by Mother on several occasions. There was some indication that the nature of this abuse was control by Father and possibly giving Mother funds to buy drugs in exchange for sex, although Mother and Father have denied this. There is insufficient information to come to a conclusion on this but the subject of domestic abuse was not sufficiently explored by health professionals to inform a view and address the issues.

10.15 The National Health Service has introduced specific training and guidance (2005) for health professionals, to assist them to take a more pro-active approach to the problem. Starting with midwives (following prima facia evidence that pregnant women and their unborn child are at increased risk), the aim was to raise awareness throughout primary and secondary care about the true extent and cost of domestic violence, including asking routine questions regardless of whether or not there are signs of abuse, or whether domestic violence is suspected. There is evidence and guidance that repeated enquiry at various intervals increases the 'likelihood of disclosure'. This did not happen in this case and as previously stated there was a lost opportunity to ask questions and document responses in order to inform all future assessment and plans.

10.16 **Communication**

10.17 A number of difficulties were identified around communication between individual services, for example GP and health visitor, health visitor and midwife and between agencies.

10.18 There was no formal communication process for transfer / handover of care from the midwifery service to the health visiting service to ensure the inclusion of all family members, social history and minimum data collection.

10.19 Midwives did not have protected time to meet on a regular basis with Health Visitors and GPs to promote more effective information sharing.

10.20 Professionals did not ensure that when they undertook the management of Mother, they had read all her previous records and were aware of all relevant issues.

10.21 **Training**

10.22 The content of and attendance at appropriate professional training varied. All professionals should be supported and developed by in-house and multi-agency training programmes including adult risk issues, parenting assessments, recording and the communication of concerns, working with parents who substance misuse and minimum data collection on all family members, especially fathers.

10.23 Not all staff working with parents who misuse substances had been trained to Level 3 training and the course does not sufficiently address the recognition and impact of parental substance misuse on parenting capacity and the capacity for manipulative and dangerous behaviour.

10.24 Safeguarding training was insufficiently developed for medical staff to reinforce their role as gate keepers of information and that they need to take a holistic view of patients who are parents and assess any risk they may pose to their children.

10.25 Safeguarding Training was not completed by a number of key staff involved with
the family, whilst others had attended training at the required level but not in parental substance misuse, although working with such parents.

10.26 There was insufficient training for professionals working with pregnant women in respect of vulnerable mothers, the risks to unborn babies, effective pre-birth assessments and the thresholds for referral to Children’s Social Care.

10.27 Culture
10.28 The culture around safeguarding referrals was not assessed within any individual management review. At the Drug Treatment Clinic this appeared to be dependent on individuals rather than the team, with for example a GP with specialist interest deferring to the Specialist Midwife whether a referral was made or not. Evidence was provided by Derbyshire Children’s Social Care that no referrals had been made to their service by the clinic within the last 12 months. Unfortunately although asked for similar data, this was not available from Derby City Children’s Social Care Services.

10.29 With the exception of the Health Overview Report, the issue of the cultural context within which the family lived was also not fully explored by IMR authors and appeared not well understood or considered by professionals. Other issues not fully explored include the extended family’s attitude to substance use and misuse and the level of tolerance or intolerance to this by universal and specialist services.

11. The Key Questions
11.1 There are a number of questions identified by the SCR in this particular case and which the report and SCR panel was not able to answer. Various scenarios as to how the death of BDS occurred have been put forward but the SCR is unable to confirm with certainty the absolute circumstances.

11.2 The criminal trial of Mother and Father judged that both were responsible for the manslaughter of BDS, and Mother was additionally convicted of cruelty to a child in respect of BDS. The specific circumstances which led to the manslaughter conviction remain unknown to the criminal trial and the SCR panel.

12. CONCLUSION
12.1 The death of any child is a profound tragedy for any family and creates distress for the professionals involved. This Serious Case Review has identified some sound professional practice including the provision of care and advice to BDS’s mother however, despite the known risks to children of substance misusing parents, there were some significant failings. These included:

- The failure to take into consideration the history of both parents, their relationship with each other and their close, extended family to inform a sound assessment of risk to their child.

- A lack of compliance with DSCB Multi-agency Child Protection Procedures and refer the family to CSC in light of the risk factors that were known before BDS was born and before he was discharged home.

- Some professionals thinking that a referral to CSC would be a failure in their practice and their support to the family.

- The failure of drug treatment professionals to:
- Prioritise the safety of BDS over the needs of his mother by considering and comparing her reports of her illicit drug use,
- Robustly risk assess Mother as to her suitability for having methadone in the home where she had the care of a very young child, and to review this as circumstances changed or incidents occurred, sharing information with other professionals as necessary. However drug treatment is not time limited and ‘sufficient change’ is difficult to define.
- Reflect on chronological evidence, to identify that her intention to becoming drug free was not resulting in sufficient change.

- An over reliance on Mother’s apparent ‘engagement’ with services as evidence that she was compliant with the advice given and a lack of professional challenge and cynicism.
- The lack of focus on Father, the impact of his health problems, history, relationship with Mother and any support needs he may have had in relation to living with a substance misuser.
- Poor information sharing between health professionals
- An over reliance by universal health services on specialist health professionals to inform them of concerns, instead of seeking information for themselves.
- A lack of effective recording systems that would have enabled information to be shared and accessed.
- Professional supervision that depended on the supervisee identifying safeguarding concerns and raising cases, rather than this being guided by the organisation.
- Some agencies not being sufficiently vigilant about the attendance of their staff at appropriate training.
- Some professionals being unaware of the findings of the previous SCR in respect of Child M, other SCRs and research.

12.2 The issue of whether the death of BDS could have been predicted and/or prevented is a challenging question. At one level there were many indicators that Mother and Father cared well for him, followed advice and engaged in the services that were offered, despite these at times being a demanding number and range for any parents. They did not avoid contact with agencies or their son being seen by professionals. They had the support of their family and appeared to have developed a good relationship with each other. At times Mother made progress on reducing her use of methadone, itself an indicator that her intention to become drug free was being achieved but this was not consistently sustained.

12.3 It is unlikely that unannounced home visits would, on their own, have identified that Mother was, as has been suggested, devious, giving her child illicit drugs and her own methadone, obtaining and providing drug free urine samples from another person to ensure her urine tests were negative so that she could continue to be prescribed methadone and selling her methadone to fund the purchase of illicit drugs. However, there were sufficient known risk factors in both parents’ past and a significant amount of research and professional guidance to warrant professional concern and for them to refer the family to CSC. Had this happened
and a robust comprehensive assessment had taken place, BDS would in all probability have become the subject of a Child Protection Plan. This would have resulted in clear expectations of the parents, together with clear consequences if they failed to comply. The plan could also have included rigorous monitoring through testing BDS for the presence of substances or alcohol.

12.4 If the parents had failed to comply with a Child Protection Plan consideration would have been given to implementing Care Proceedings and seeking BDS’s removal. However, some children on child protection plans are harmed by their parents and some die despite the best efforts of professional agencies. We cannot say with all certainty that if BDS had been referred to CSC, he would be alive today but my view is that this should have happened, it would have increased his safeguarding and protection and would probably, but not certainly, have prevented his untimely death.

13. **Recommendations**

13.1 These recommendations are in addition to those made by each agency and are directed at DCSB which should:

- Ensure that in updating the Inter-agency Child Protection Procedures requirements in relation:
  - a) to the protection of children whose parents use substances or alcohol;
  - b) unborn babies, and
  - c) domestic abuse
    are fit for purpose.

- Ascertain whether there is a systemic culture of resistance, by agencies, to making referrals to Children’s Social Care and if so, address this.

- Explore the feasibility of commissioning tests on all children who are the subject of Child Protection Plans and whose parent/s are known substance users.

- Receive reports from all agencies represented on the board in relation to compliance with their agency training requirements.

- Receive reports from all agencies represented on the board in relation to effective supervision arrangements including the consideration of all cases that involve vulnerable children.

- Conduct regular audits to monitor the effectiveness of multi-agency working including the use of the Common Assessment Framework (CAF).

- Ensure that the CAF process should be further embedded in practice to ensure a ‘Think Family’ or ‘team around the child’ approach.

- Consider a public and professional awareness raising campaign in relation to the risks to children of substance and alcohol misusing parents to increase vigilance and reporting by all parties.

- Co-ordinate a multi-agency, cross-organisation work stream to develop an overarching strategy for professionals in Derbyshire who work with substance misusing parents or their children. It should be accessible to all
organisations and provide specific guidance which includes the issues highlighted in the recommendation at the end of the report. Work streams to be developed, to include senior and operational level managers from health organisations involved in this review and children’s social care and police.

- Ensure that all providers of substance misuse services in Derbyshire undertake a review of the arrangements for the prescription and monitoring of methadone for parents with children under 5 years of age. This should include:
  - A review of prescribing guidelines (including policies and procedures).
  - A review of those guidelines for parents with children under 5 years of age.
  - An explicit identification of risks and steps taken to mitigate such risks with related action plans.

To ensure compliance with;
- the required risk assessment,
- guidance to parents,
- ‘Think family’ standards, and the
distribution of safe storage box facilities for all service users who have children under 5 years of age.

Furthermore, the database should be shared with both Health and Social Care Providers across Derby and Derbyshire.

**In relation to health agencies:**
- A pathway should be developed to ensure a multi-agency assessment is always undertaken, led by a prescriber from the drug services, or prescribing GP, before methadone is taken home when children and young people under the age of 18, reside at the house or visit it.

- Prescribers should regularly ask their patients about their contact with any children and review the prescription in the light of this or new information; and

- All prescribing services should always consider the role and capability of non-drug abusing partners and ensure that they are seen alone and if appropriate, referred to services that can support them in their safeguarding role.

- Electronic Systems should be developed to ensure that all drug using adults who may present risks to children are flagged accordingly.

**In making the above recommendations it is assumed that DSCB will:**
- Monitor the implementation of all the individual agency recommendations that follow from this review and previous SCRs and included below

- Will disseminate the learning from these reviews;

- Seek evidence that the learning has been applied in practice and has improved the safeguarding and protection of children; and
- Will address the learning that has emerged about the DSCB SCR process, in particular the competencies of staff to carry out individual management reviews and the issue of accessing parent's medical information.