Report of a serious case review regarding Child H

Oxfordshire Safeguarding Children Board today publishes the report of a serious case review following an incident in which Child H (then aged 21 months) ingested a prescribed opiate based medication.

Emergency services were called to the home of Child H in September 2013. Child H had reportedly took the prescribed opiate based medication out of the mothers bag and appeared to have drunk from it. The mother delayed calling the emergency services for approximately 1.5 hours.

In the ambulance, Child H stopped breathing and needed resuscitating. Upon arrival at hospital, the child was admitted, required intensive care treatment and subsequently made a full recovery.

The report details the extensive contact that the mother had with agencies before and after the birth of Child H in an attempt to mitigate the impact of her substance abuse and chaotic life on her child.

The report highlights the difficulties agencies face when dealing with children living in families with substance abuse and concludes:

“Though accidents such as ingestion of methadone were to some *very* limited extent ‘predictable’, it cannot reasonably be claimed to have been ‘preventable’ by decisions or actions available to the professionals working with the family.”

Although a great deal of work was done to try to support the mother and safeguard the child, drug dependency was not in itself regarded as grounds for removing Child H, who was initially the subject of a child protection plan.

“Panel members’ collective experience and consideration of this case prompted the observation that there exists a ‘societal ambivalence’ about substance misusing parents. There is no assumption in law nor amongst the Judiciary or a proportion of professionals that a child raised by a drug-dependent parent is necessarily being exposed to an unacceptable level of risk to safety, health or emotional wellbeing.”

Numerous attempts were made to provide support to mother and baby, and the report provides an account of offers of advice and support frequently being turned down with many missed appointments with agencies involved.

These include appointments with drugs workers, health services and social workers, and a failure to attend court appearances. Reluctance of some agencies to share information that could have improved understanding of the risks to Child H was also highlighted.

Maggie Blyth, Independent chair of the Oxfordshire Safeguarding Children Board, said:

“This was a case that could have had a tragic outcome but fortunately the life of Child H was saved by hospital doctors and the ambulance service.

It is clear from the serious case review that the mother put her own drug dependency before the needs of her baby, and this meant that Child H grew up in a chaotic household which had a real impact on the child's development and life chances.

However the reality is that it is not practical to remove every child growing up in a home with a parent or carer who is dependent on drugs. This case raises important questions about the extent to which drug dependency in itself should be seen as a major risk to children, and how those risks should be managed.

The serious case review concludes the incident was not preventable by agencies working together. However it identifies lessons to be learnt for all agencies involved covering policing and criminal justice, social services and the health service. In particular, it concludes that agencies did not see the numerous missed appointments as an opportunity to understand the life of Child H.

The mother of Child H was convicted of neglect.

The report makes a number of recommendations for all agencies involved and the Oxfordshire Safeguarding Children Board itself, and I am confident that action has already started to reduce the chances of this kind of thing happening again."

Other issues raised in the serious case review include:

- There was a widespread tendency to focus narrowly on a particular or central role of each agency
- There were a number of examples where professionals made unjustified presumptions about what colleagues in other agencies would / should do
- There was insufficient exploration or appreciation of the day to day experiences of Child H and the likely impact of those experiences on the child's development and life chances.

The following agencies had involvement with Child H and the family:

- NHS England Thames Valley / Oxfordshire Clinical Commissioning Group in relation to GP services
  Media contact for NHS England:
  Katie Breeze 0113 824 9727 or email katie.breeze@nhs.net
  Media contact for Oxfordshire Clinical Commissioning Group:
  Sarah Rayner-Osbon 01865 334640 or email cscsu.media-team@nhs.net

- Oxfordshire Clinical Commissioning Group in relation to GP services
  Contact: Annie Tysom/Sarah Rayner-Osbon
  T: 01865 334626
  s.rayner-osbon@nhs.net

- Oxford Health NHS Foundation Trust - in relation to providing health visiting and drug and alcohol services
  Contact: Alistair Duncan, 01865 782195

- Oxfordshire University Hospital NHS Trust
  Contact: Susan Brown, 01865 231471

- Oxfordshire County Council
  Paul.Smith2@Oxfordshire.gov.uk 01865 810256

- Thames Valley Police
  Contact: Michelle Campbell 01865 846699

About the serious case review

When a child dies from abuse or neglect, Oxfordshire Safeguarding Children Board will decide whether to conduct a serious case review to identify how local professionals and organisations can improve the way they work together.

Serious case reviews are also carried out if a child is seriously harmed and there are concerns about how organisations or professionals worked together to protect the child.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf