SUMMARY

FATAL ACCIDENT INQUIRY INTO THE DEATH OF DECLAN HUGH HAINEY

Paisley Sheriff Court

3 September 2014

Sheriff Ruth Anderson QC

Sheriff's Determination

1. Declan Hugh Hainey (Date of Birth 17 April 2008) died at 45 Bruce Road Paisley between 1 July 2009 and 31 August 2009. The precise date of his death is not known.

2. The cause of death is unascertained. However the prolonged neglect of Declan Hugh Hainey by his mother and sole carer Kimberley Mary Hainey was at least a contributory factor in his death.

3. Declan's death might have been avoided had the agencies involved in the information gathering process pre-birth and post- birth obtained all the information which was available to them (including medical records), assessed the risk factors realistically, and put in place Child Protection measures which would have resulted in continued monitoring and assessment over a longer period of time. This would have included inter agency assessment in the period from the move from the protective environment of 38 Friendship Way Renfrew to the isolated and potentially problematic situation at 45 Bruce Road Paisley. Further it would have resulted in the case being subject to regular inter-agency review and closer scrutiny by both Social Workers and Health Visitors. The case would not have been closed subsequently without a formal inter-agency review.

4. Declan's death might have been avoided:-

   (a) if there had been comprehensive communication of reports, assessment forms and minutes of the various meetings which took place both pre and post birth to the other agencies involved in the case after it was closed to the Social Work team at Royal Alexandra Hospital. In particular Health Visitors and Family Matters should have been provided with all the information available on Kim Hainey and Declan. Had they been so, then the Health Visitors would have categorized the case as one requiring 'intensive' as opposed to 'additional' support, and would have called for more intensive social work involvement. Family Matters in turn would have referred the case to the Area Team of the

Social Work Department prior to Declan's first birthday with a view to Child Protection measures being taken and /or a referral to the Reporter being made.

(b) if the medical information relating to Kim Hainey's long history of drug and alcohol abuse, together with details of her psychiatric history and inpatient stays at Dykebar Hospital had been gathered by Social Work at the Royal Alexandra Hospital in early 2008, and passed to all social work and health staff who had continuing responsibility for Declan. Had the available information been obtained, it would have contributed in April 2008 to a more realistic assessment of the risks which existed in relation to Kim Hainey's ability to care for her son and would have continued to be an important factor in any continuing assessment process. This information on its own is likely to have led to a difference in approach by Family Matters as is noted above, and to the Health Visitors re-categorising the case to 'intensive' in around March 2009.

(c) if there had been proper, professional inter-agency and intra-agency communication among social work and health staff responsible for the case. It is fundamental that those responsible for the safety of any child must communicate intelligibly and comprehensively with one another by asking simple basic questions and noting the answers. In this way, information necessary for each worker to carry out his/her responsibilities is obtained. It is only by inter-agency communication that a bigger picture of what is or is not happening can be obtained. Without that bigger picture in this case agencies proceeded along parallel lines. When there is comprehensive intra-agency communication then informed decisions can be taken by those in senior positions and action plans produced which have meaning, clarity, and detail, including instructions as to individual responsibility and clear timetabling.

5. Having determined that on a balance of probabilities neglect was a contributory factor the following defects in the system contributed to Declan's death:-

(a) There was no system in place whereby one of the agencies responsible for Declan's well-being was in overall charge and there was no system whereby one named individual was responsible for coordinating all available information. This defect resulted in no formal inter-agency meetings taken place, especially in the period from February 2009. Had such systems existed then those responsible for the care of Declan would have been aware of all that was happening and all that was not happening and steps would have been taken to protect him from the risks resulting from Kim Hainey's inability to take proper care of her son.

(b) There was no system in place in relation to obtaining medical information. There was a fundamental lack of knowledge by Social Work staff at the Royal Alexandra Hospital as to what information they were entitled and how they might

obtain it. As has been determined above, had such information been available, there would have been a material difference in approach to the case by both Family Matters and Health Visitors and decisions taken in the initial assessment process would have resulted in more protection for Declan.

Background

Declan Hugh Hainey was around 15 months old when he died. His body was not discovered until 7 months later. The Sheriff was unable to determine the cause or precise date of his death. During the Inquiry, it was submitted on behalf of Kim Hainey that she had been a loving mother until she suffered a severe breakdown when Declan died and as part of that breakdown she denied Declan's death to the world. The Sheriff rejected that and found that Kim Hainey had a history of lying and manipulation. Kim Hainey was convicted of Declan's murder on 15 December 2011. She appealed and on 17 April 2013 her conviction was quashed. No motion was made for a retrial.

Findings in Fact

The period prior to Declan's birth on 17 April 2008

Kim Hainey was born on 22 May 1974. Her father moved to England soon after her birth. She was brought up by her mother and an aunt. Kim worked in Glasgow and bought her own flat. However after her uncle died in 1999, she became depressed and started drinking heavily. From 2005 she started to abuse drugs including heroin. She lost her job and her flat. Between 2001 and 2007 she was admitted to Dykebar psychiatric hospital on 3 occasions. She led a chaotic life.

Kim met Declan's father in Dykebar hospital where they were both inpatients. They had a short lived relationship. Declan was conceived in the summer of 2007 but his father never saw him.

On 6 September 2007 Kim consulted a GP regarding her pregnancy but failed to attend pre-natal appointments. In January 2008 Kim fell out with her mother and step- father after they found her with a man they didn't know and evidence of drug abuse. Kim was put out of their house and did not see her mother again until Declan's birth.

In January 2008 Kim arrived at A&E at the Royal Alexandra Hospital in Paisley ("RAH"). She was suffering from drug withdrawal symptoms. She was seen by "SNIPS" (Special Needs in Pregnancy) which was a midwife led unit attached to RAH. SNIPS sent a Notification of Concerns about Kim to the Renfrewshire Council

Social Work Department at RAH. New Expectations was part of the SWD at RAH. They supplied intensive support to pregnant women misusing drugs.

Hazel M, a drug worker from New Expectations, took Kim to the Family Matters Clinic in Paisley which provides early intervention for families where there is a history of addiction and a child under the age of 3. Kim was put on a methadone programme by the GP led Renfrewshire Drugs Service ("RDS") and moved to temporary accommodation. She made no effort to prepare for the birth or find permanent accommodation. By February 2008, Kim's hospital records were available to RDS but they were not discussed with Hazel M so she was ignorant of Kim's mental health history.

On 15 February a meeting about Kim took place. The allocated social worker Hugh M had just returned from long term sick leave and his senior Helen M had no recent child protection experience. No GPs, health visitors or anyone from SNIPS was there. Hugh M was told to prepare an assessment (a "Getting Our Priorities Right" or GOPR document) in accordance with the local authority's protocol for children affected by drug or alcohol abuse and obtain Kim's medical records. The records were not requested. Later that month Kim cancelled a planned home visit by Hugh M.

A pre-birth meeting took place on 17 March. The pre-birth report prepared by Hugh M was not sufficiently detailed to enable a proper assessment of any risks to the baby. He had not obtained Kim's medical records. Eight significant concerns were identified in relation to Kim's ability to care for her unborn child. Despite this the meeting concluded there were no significant child protection concerns. The Sheriff said this was a "wholly unrealistic" assessment of the situation.

The period from Declan's birth on 17 April 2008 until 30 September 2008

Kim gave birth to Declan on 17 April. He was a healthy child. On 21 April a post-birth meeting took place. Hazel M was not present. The meeting decided there were no child protection concerns.

After the birth Kim and Declan lived with her mother and step- father at Friendship Way, Renfrew. Irene C, a health visitor, tested Kim for post natal depression (EPNDS). She scored 5 which meant no further action was required. Irene C should have repeated the EPNDS 3 months later but didn't. Kim got the tenancy of a property at Bruce Road, Paisley and moved there in September 2008.

In June Kim had gone for a night out and returned home drunk and acting aggressively. She tried to leave the house with Declan and assaulted her mother and step- father. The Police were called and she was arrested. However no further action was taken. Hugh M visited 3 days later to investigate. His manager Helen M said she would speak to Kim and see Declan to ascertain if there were grounds for

child protection procedures but she didn't. Neither Hugh M nor Helen M spoke to the health visitor Irene C about the incident. When Irene C visited, she only spoke to Kim. She did not speak to Family Matters and incomplete information was given to Hazel M. The Sheriff said that the 3 agencies failed to communicate effectively with each other.

In July 2008 Helen M decided to close Kim's case. Hazel M was not involved in that decision.

From the end of September 2008 until Christmas 2008

Between September and Christmas 2008 Kim began to withdraw contact between her family and Declan and also with New Expectations, Hazel M and the health visitors. Hazel M had difficulty contacting Kim by phone and no access was obtained to Bruce Road by Hazel M or Irene C on 3 separate pre-arranged occasions.

Eventually on 21 November Hazel M visited Kim and found nothing to concern her. However after that Hazel M again experienced difficulties in making contact with Kim. On 11 December Declan was seen by a GP for the one and only time in his life.

From 1 January 2009 until Declan's first birthday on 17 April 2009

On 19 January 2009 Kim's case was passed from Hazel M to Jill S, a drug worker from Family Matters. Hazel M did not transfer the case papers to Jill S. Family Matters lacked basic information such as the level of Kim's history of failed appointments.

Kim failed to attend her first appointment with Jill S who told her supervisor Gillian T. She classed Kim's case as low priority despite the lack of information and not reading Kim's records. Supervision of the case should have taken place every 6 weeks but in fact only one further meeting took place. On 19 February Jill S went to Bruce Road for a planned visit but didn't get access. On 24 February Kim cancelled another appointment with Jill S. Kim stopped taking Declan with her to the pharmacy for her daily methadone. Her appearance had deteriorated and she smelled of stale alcohol.

On 27 February Kim phoned Jill S to cancel an appointment. She was tearful. Jill S carried out another EPNDS which returned a score of 23, suggesting professional health was required. The Sheriff said that the as the test was done over the phone and Jill S was not qualified to carry it out, the score could not be relied upon.

On 6 March Irene C visited Bruce Road for the only time. Kim said she was depressed but Irene C did not carry out an EPNDS. Declan was struggling to sit,

even although he was 11 months old; he had nappy rash and sores on his scrotum. Irene C arranged a prescription. She did not see Declan again.

On 10 March Kim attended a counselling service arranged by Jill S. She failed to attend her second appointment and the service closed the file. Kim lied to Jill S and said she was still attending the service. On 25 March Kim attended the RDS clinic smelling of alcohol. Jill S told Irene C. The Sheriff said that Irene C should have recategorised Kim's case as "intensive" at that stage but she did not do so. If she had, contact with Declan would have increased and there would have been a case discussion between the 3 agencies involved.

On 26 March a GP from RDS told Jill S about Kim's previous contact with Dykebar hospital. This was the first time the content of the records had been discussed with anyone. RDS wrote to Kim's GP Dr P with concerns about her alcohol consumption but Dr P did not pass these on to Irene C. Elizabeth C, a senior social worker told Jill S to carry out an unplanned visit to Bruce Road. By this time Family Matters were aware of Kim's mental health history. They had evidence of her excessive drinking and had assessed her as a liar. However they did not arrange a multi-disciplinary meeting or carry out a child protection investigation.

By the end of March Jill S had attempted an unplanned visit but didn't get access. She knew Irene C was shortly to be leaving and phoned Dr P to say that Kim's case should be passed to another health visitor quickly. However Dr P did not discuss Kim with Irene C. Irene C was not replaced until August 2009 when Linda F took up her post. Irene C didn't discuss her cases with anyone before leaving.

On 3, 8 and 15 April Kim cancelled three visits with Jill S and told her she was staying with her mother. Jill S told her supervisor and was instructed to keep trying to get access to Bruce Road. The options of a multi-disciplinary meeting or child protection investigation were neither discussed nor instructed. Jill S asked for a health visitor to go to Bruce Road but this didn't happen. A fourth visit scheduled for 20 April was also cancelled by Kim.

On 17 April Kim's family went out for a meal to celebrate Declan's first birthday. That was the last time anyone in his family ever saw him. Although Kim continued to visit her mother during 2009 Declan was never with her and she lied to her mother about where he was.

The period from 17 April 2009 until 17 August 2009

In late April 2009 Jill S told Dr P and health visitor Ruth W about her concerns. Jill S tried to visit Bruce Road but didn't get access. She phoned Kim's mother who lied and said Kim and Declan had stayed with her for 2 weeks at Easter.

On 22 April Jill S and a colleague got access to Bruce Road for the only time. During the visit Kim got angry and aggressive and paid no attention to Declan.

Another visit was arranged for 1 May but Family Matters cancelled it. Jill S was told that Irene C would visit Bruce Road on 24 April then on 1 May but she didn't. On 22 and 23 April Kim visited the pharmacy with Declan but he was never seen there again as on all later visits Kim left him at home. Jill S phoned Kim three times in May/June but could not get access to Bruce Road.

In May 2009 Gillian T left Family Matters and her workload was taken over by Elizabeth C. She had no time to supervise any cases including Declan's. She closed the case on 13 August despite having had no involvement with it. At no time did Jill S seek to discuss the case with Elizabeth C.

In May, Declan missed three immunisation appointments. Kim had told Irene C this was because Declan was unwell but Irene C did not check to see if the final appointment had been attended. Family Matters were not informed.

During the summer, Kim was often observed in neighbours' houses drinking without Declan. In May and June Declan was heard crying for periods of between 4 to 5 hours on a daily basis and most evenings. Kim would stay overnight with a man with whom she had a short lived relationship. She told him Declan was being looked after by her family. Around the end of June Kim spent 2 nights with the man leaving Declan alone for up to 48 hours. She lied to neighbours saying that Declan was at her aunt's, mother's or a playgroup, to explain his absences. He was in fact at none of those places. At the beginning of July, Kim left Declan with another neighbour for an hour and returned under the influence of something. This was the last time Declan was seen alive.

On 19 June, the health visitor Ruth W had taken over Declan's case but at no time did she look at his file. Health visitors were so understaffed they could not even provide base-line cover. In August she was seconded to another clinic and Linda F became responsible for 300 cases.

At a meeting on 13 August Elizabeth C of Family Matters decided to close the case. Despite her concerns and the fact that at least one further visit should have taken place in May, Jill S had not seen Kim or Declan since 22 April. There was no discussion with others and inadequate notes were put on the file.

On 17 and 19 August Linda F visited Bruce Road but didn't get access. Kim phoned her to say she had no worries about Declan who was now walking and had a good appetite. When Kim visited her mother alone she would tell her Declan was at nursery.

On 6 November Kim went to the pharmacy and asked for nappy rash cream. She told a friend Declan was at nursery and she had a job at a garage. The friend visited the garage but no one there knew Kim. On 17 December Linda F visited Bruce Road

and didn't get access. Kim told her that on the phone that she and Declan were going to visit her father in England.

2010

In January 2010, Linda F asked a colleague to phone Kim to arrange an appointment. Kim told the clinic over the phone that she and Declan were in England visiting her father.

On 2 February 2010 Linda F visited Bruce Road but didn't get access. By this time Kim's mother had told Linda F that Kim had lied about visiting her father. On 5 March Linda F raised concerns at a health visitor meeting with GPs and was told to contact the SWD. She called at Bruce Road that day and got no access. She made a Notification of Concern to the SWD on 8 March. A planned home visit for 9 March was cancelled as no social worker was available. Visits were made on 16, 17 and 24 March but no access was gained.

On 30 March the SWD spoke to Kim's mother and told her they were considering reporting Kim and Declan as missing. That evening Kim's mother, step-father and aunt visited Bruce Road. The flat was in a squalid condition and there was no power. Kim's step-father found Declan's body in his cot. The Sheriff found that he had died there. Declan was taken for post mortem examination but the cause of his death could not be ascertained.

The Sheriff said that there is a risk of dehydration and malnourishment if a child is left without food and fluids for prolonged periods. Blood sugar levels will drop which can result in convulsions which can cause brain damage and unconsciousness. She explained that dehydration places the body systems under strain and if a child is left unattended for up to 48 hours death is a real possibility.

The Sheriff also said that if a child is regularly left unattended for long periods that child will lie in cold wet and soiled nappies and be at risk of hypoglycaemia and hypothermia.

Note

The Sheriff said that although Declan's life was short, during it he came into contact with a number of family members, neighbours at Bruce Road, and a variety of workers from health and social work agencies. The Inquiry heard from 8 neighbours and friends who saw both Kim and Declan at various times from September 2008 until the summer of 2009, from 9 employees of Renfrewshire Council's SWD, 5 of whom had direct contact with Kim and Declan, and 4 of whom were line mangers for those with direct contact, 2 GPs from the surgery where Kim and Declan were

patients, 1 doctor from RDS who had no direct contact with them, and 4 health visitors who each at certain times 'held' Declan's case.

Despite the involvement of all those individuals and others, two things were able to happen: firstly, Declan disappeared from early July 2009, and secondly his body was not discovered until 30th March 2010, at least 7 months after his death.

The Sheriff also noted that various neighbours at Bruce Road gave evidence about their concerns that in 2009 Kim never seemed to have her son with her when she was out and about. They also realised that on occasions she had left him alone when she was visiting neighbouring houses to drink. He was also heard crying for lengthy and regular periods of time. The Sheriff said that child protection is not just a matter for parents, family or the various agencies which have statutory duties to meet but that it is the responsibility of us all.

Significant Case Review and Role of the Care Inspectorate

In 2010 Renfrewshire Council commissioned an independent significant case review (SCR). It made 16 recommendations which are set out in Appendix 1. In 2012 the Care Inspectorate reviewed the progress made in relation to the recommendations of the SCR. The CI concluded:-

'Chief Officers, RCPC and staff across services have taken the recommendations from the SCR very seriously. They have turned the recommendations into a comprehensive and realistic action plan which targets systems and processes used by staff across services. Chief Officers and RCPC monitor the actions closely to ensure progress is made. Most actions to meet the recommendations are progressing well although some are at an early stage of implementation. As a result, it is too soon to measure fully the impact these actions will have on children and their families.

Leaders have demonstrated, by their willingness to support and empower their staff, that they have a good understanding of the complexities involved in working with children affected by parental substance misuses. As a result they have increased resources, provided appropriate training, reviewed practice and procedures effectively and involved staff well in taking forward the action plan. Staff have demonstrated that they know their practice requires to be continually reviewed to ensure they are using best practice when working with children and families. They have responded well to taking forward changes to practice as a result of the implementation of the action plan. As a result inspectors are confident that actions to meet the recommendations will continue to be progressed and reviewed for effectiveness.'

The Sheriff also made 4 further recommendations of her own:-

1. Management must ensure that there is regular and on-going assessment of the staffing levels necessary to achieve at all times best practice in relation to the needs of the service which is provided.

2. Where a Notification of Concern in relation to an 'unseen child' is made to any social work department, such notification should be treated as deserving of the utmost priority and resources put in place immediately to assess the situation and take all necessary steps to locate and protect such a child.

3. General Practitioners should ensure that all relevant medical information on a substance misusing parent or carer is collated and provided timeously to social work and health staff involved in decision-making in relation to child protection/supervision. This recommendation endorses recommendation 8 of the SCR and is made to emphasise its importance.

4. It should be mandatory for all staff, whether social work or health professionals involved in the care of the children of substance misusing parents to be trained in the latest guidance and protocols concerning child protection. This recommendation repeats recommendation 9 of the SCR because the Inquiry heard that it was not yet mandatory for general practitioners to undergo such training, though many did on a discretionary basis.

1. When a substance misusing mother-to-be is being referred to maternity services this should be done using a pro forma which includes information on their substance misuse and any other relevant issues.

2. There should be an initial child protection case conference arranged in all cases of children being born to drug-using parents.

3. A health Visitor or School Nurse from the GP practice should be invited to all meetings concerning substance abusing parents and their child (ren).

4. The GOPR care plan should include specific reference to the level of direct contact to take place with the child(ren), who is responsible for maintaining this contact, and , in the event of any significant variation from the programme of planned contact, the requirement for an urgent review be arranged.

5. NHS GGC should introduce an unseen Child protocol in conjunction with it partner Local authorities.

6. Cases coming under the GOPR umbrella should be the subject of regular review and should not be closed or transferred without such a review taking place, including updating the parental Substance Misuse Report.

7. There should be put in place a monitoring system, such as exists in respect of Child Protection, to ensure that the process of completing GOPR Full Assessment Reports and conducting reviews can be tracked, and speedy action taken where there is significant variation from the prescribed timescale.

8. Given that GP records are likely to be the most accurate and comprehensive source of the medical history of a substance-misusing parent it is recommended that it be made the responsibility of the GP to ensure that such information is made available to case discussions either by direct presentation by her/himself, or a representative of the practice e.g. a health visitor, or by the provision of a written report.

9. It should be mandatory for all staff and managers involved in this area of work, either directly or indirectly, including GPs, and consultants within the RDS, to undergo GOPR training, and each agency should maintain a GOPR training record, either on a stand-alone basis, or as part of any existing training record.

10. A simple paper or electronic form of communication should be introduced to ensure that there is clarity of language and intent when staff from one agency are asking staff from another agency to carry out a specific task.

11. There should be a review of guidance for Health Visitors on inter-agency working, including their responsibilities under recommendation 7, and

consideration of a short period of “shadowing” as part of the induction programme for new staff.

12. Guidance should be introduced for Health Visitors on case handover practice, including an entry in the patient record, at least in all “additional” and “intensive” cases, of key issues and the date of handover.

13. There should be a review of clinical and management supervision arrangements for health Visitors with reference to frequency, recording of content and formalising sessions for all staff.

14. There should be a review of the nurse management structure to ensure that health visitors and other nursing staff receive appropriate support and supervision.

15. Steps should be taken to ensure that GPs are familiar with RCGP/SG guidance on the management of substance abusers.

16. Management of Social Work child care practice within the RAH should sit within Child Care rather than Community Care.