

**LEICESTER CITY, LEICESTERSHIRE AND RUTLAND  
LOCAL SAFEGUARDING CHILDREN BOARD**

**EXECUTIVE SUMMARY  
in relation to  
LG**

**November 2006**

**Revised June 2007**

## **1. Introduction**

1.1 Leicestershire and Rutland Local Safeguarding Children Board will always conduct a case review where a child dies and abuse or neglect are known or suspected to be a factor in the death. (Ch 17.5 2006 LSCB Procedures).

1.2 The purpose of a serious case review is to establish whether there are lessons to be learned from the case about how local professionals and agencies worked together, to identify clearly those lessons and how they will be acted upon, and to improve inter-agency working to optimise the safeguarding of children.

1.3 At its meeting on 19th June 2006, the Leicestershire and Rutland Serious Case Review Subcommittee learned that NG, the father of LG who had died in January aged 3 months, had been charged with manslaughter. Both LG's parents, NG and LW, were known drug users and early indicators were that LG had ingested a prescribed drug.

1.4 Each key agency undertook an internal management review and the Case Review Subcommittee made an examination of the occasions when contact with agencies occurred.

1.5 Leicestershire and Rutland's Case Review Subcommittee of the Local Safeguarding Children Board then completed an Overview Report, bringing together and analysing the findings of individual agencies.

1.6 This report summarises the overview report.

## **2. Case Summary**

2.1 Social Care (formerly social services) were first involved with this case for a pre-birth conference on the half sister of LG, in 1996, when there were concerns about the home environment and drug usage of both parents (DB and LW). An assessment then found no cause for concern.

2.2 There were disputes about the care of the two older children, following their parents' separation in 1997, which resulted in involvement with private law family court processes in 2000/2001 and again in 2005. At this time, the care of the children was assessed as satisfactory. They were reported to be fully attached to both parents and did not want to choose between them.

2.3 In August 2005, the Family Court ordered that the two children would reside with their father during the week and there would be staying contact with their mother at weekends.

2.4 In relation to the birth of LG the health visitor, drugs counsellor and social worker visited regularly in October, November and December 2005 with

no concerns recorded. The case was closed by children's social care in December 2005 when the family court process was completed. The health visitor and drugs counsellor continued to visit the family at home on a regular basis.

2.5 LG died on 15th January 2006 having ingested prescribed drugs, and at the criminal trial in April 2007, NG was found guilty of deliberately administering the drugs to LG.

### **3. Conclusion**

3.1 LG's parents both abused illicit drugs and prescribed medication. This gave rise to the need to assess their ability to care for children. This was done on a number of occasions. Each time the standard of care was considered satisfactory.

3.2 No one had any reason to suspect that either parent or anyone else was deliberately administering a prescribed medications to LG and although advice was given in line with local protocols on safe storage and appropriate use, specific information on not administering methadone/ diazepam/ nitrazepam to babies was not provided. During the course of this review it has been suggested that there may be a view amongst some drug users that this practice of giving drugs to babies to calm them down is appropriate and possibly widespread. It is therefore vital that this is both made known to professionals so that advice can be given and that clear information is provided to drug abusing parents of the dangers inherent in this practice.

3.3 The death of LG could not have been foreseen and professionals working with the family acted appropriately.

3.4 Better information sharing between the professionals involved with the family with a clear focus and lead, might have provided a clearer picture of the level and impact of drug misuse, though it would not have prevented the direct administration of the drugs to LG.

### **4. Recommendations**

#### **4.1 Inter-Agency**

4.1.1 In guidance prepared by Community Drugs Teams and provided by other professionals to parents or carers who use drugs there should be a clear statement that drugs should not be given to babies or children and that this could kill them, and for the agency to consider asking parents to sign to say they have read and understood the information on the leaflet

4.1.2 In cases where there are one or more parents who give cause for concern in view of their substance or alcohol abuse caring for children, all professionals should bear in mind the need for a joint risk assessment to be undertaken which should then be shared with all relevant professionals.

## 4.2 Health

4.2.1 A reminder to be sent to health visitors that all documentation must be signed and dated to give context and meaning to the information.

4.2.2 The use of illegal drugs together with the usual household medicines should be discussed in the antenatal or neonatal period with all parents, whether drug users or not.