



MEDICATIONS IN DRUG
TREATMENT: TACKLING
THE RISKS TO CHILDREN



Adfam

Families, drugs and alcohol

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Foreword

This report examines cases where children have died or come to harm from ingesting Opioid Substitution Treatment (OST) medicines prescribed to help people overcome drug addiction. There have been 17 Serious Case Reviews involving the ingestion of OST drugs by children in the last five years alone, plus potentially more incidents that don't reach that level of inquiry. The information we present in this report highlights that not only are such events not isolated, but that they have happened with quite depressing regularity. Each one of these incidents is a tragedy, but with so many, it could start to look like something even more worrisome: a pattern. We need to stop the continuing occurrence of these cases and make sustainable changes to practice on a national scale to make children safer.

OST is an extremely valuable tool in the fight against drug addiction, and we are clear that the evidence base supports its part in our treatment system. The overwhelming majority of the people who need and use OST do so safely. However, we also must recognise that the drugs used – especially methadone – are toxic, powerful and a clear danger to children when stored or used incorrectly by their parents and carers. Although the risks are minimal when taken in the context of drug treatment overall, just one of these cases is one case too many. Incidents where children accidentally ingest these drugs – or worse, are actively given them by their parents – appear to be both frequent and similar enough to merit a more open and honest debate about the risks, particularly amongst frontline professionals. It's

clear that more could be done on a national level to share the learning from each local case and take coordinated action to minimise risks.

Tragedies occur, and we can never eliminate risks completely. But in conducting this research our thinking has always been: on a systemic level, are we doing all that we can to make sure these incidents don't keep happening? And based on our findings, the answer, so far, is no. Whilst this is a very complex area of practice, our central conclusion is extremely simple: these incidents are happening too often. Not enough is being done on a practical level to make sure that children are protected, and parents and the professionals working with them are sometimes taking insufficient safeguards. We can't just accept that 'these things happen' and we must be louder and more challenging.

We think it is possible to make these incidents less likely. What learning there has been from these cases has been isolated and localised, so we've gathered together the best and broadest evidence we can to improve practice on a national level. By doing this, we hope to stimulate debate around the issue and consequently encourage positive changes in practice.

Vivienne Evans OBE

Chief Executive, Adfam

Adfam is the national umbrella organisation working to improve the quality of life for families affected by drugs and alcohol.

Introduction

Background

Since the publication of *Hidden Harm* by the Advisory Council on the Misuse of Drugs in 2003, the needs of children of problem drug users have received much greater attention in policy and practice, both in drug treatment and in the wider children and families agenda. Agencies have significantly improved their practice in terms of recognising and responding to children affected by parental substance use, and there is a greater emphasis on child protection in clinical guidelines.¹

However, whilst the general or overall impacts of parental substance use are now widely recognised, there are some gaps in knowledge and learning on specific risks, such as those posed by the use and storage of Opioid Substitution Treatment (OST) medicines in the home. This review explores these particular risks to children whose parents or carers are in receipt of OST, and gives recommendations on what can be done to improve practice and policy responses.

OST is a medical intervention whereby long-acting and less euphoric opioid medications (primarily methadone or buprenorphine) are prescribed in replacement of illegal opioid drugs (heroin). The aim of OST is to reduce opioid dependence over time so that the user can eventually overcome their addiction, whilst allowing them to begin their recovery journey without illegal drugs, away

from crime, and with the support of treatment services. It is a widespread practice, supported by the Government's 2010 Drug Strategy, which states that 'substitute prescribing [has] a role to play in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification'. Evidence shows that it is an effective treatment across a number of measures including continued engagement in treatment and reductions in crime, the transmission of blood-borne viruses, and risk of death.² Service users and professionals alike have also asserted that it can be a positive facilitator for a normal family life.³

Whilst the National Institute for Health and Care Excellence (NICE) and the Department of Health have acknowledged the possible dangers to children and safety measures are recognised as important, there is still limited policy and practice guidance available on the front line.

Findings from a study of Serious Case Reviews (SCRs) from the last decade revealed a significant number of cases of where children had died or been hospitalised after ingesting OST drugs, and further research is merited. Adfam's focus on the impact of substance misuse on the family means that we are keen to highlight the learning and recommendations that emerge from these tragic events in order to minimise risks to other children in the future.

¹ See Department of Health (2007) *Drug Misuse and Dependence: UK Guidelines on Clinical Management*

² NTA (2012) *Medications in recovery: Re-orientating drug dependence treatment*

³ Chandler et al (2013) 'Substance, structure and stigma: parents in the UK accounting for opioid substitution therapy during the antenatal and postnatal periods' 24(6) *Int J Drug Pol.*

Scale

In 2011-12, it was recorded that 60,596 adults in treatment had parental responsibility, an opiate problem, and were receiving a prescribing intervention; with a further 5,193 in treatment whose parental status was not captured.⁴ In 2003, it was estimated that between 250,000 and 350,000 children in the UK were affected by parental drug use,⁵ and in 2009, a reported 120,000 children were living with a parent currently engaged in treatment.⁶ A review of the available SCRs in the last 10 years revealed that there have been 17 fatalities and six non-fatal ingestions of OST medications by children during this period, not accounting for the number of 'near misses' or incidents that failed to culminate in an SCR, for which there is no data publicly available. Figures are not readily available on the number of child ingestions or child deaths related to OST drugs in the UK, nor is the data on the number of parents in receipt of 'take-home' doses. The true scope of the problem is therefore difficult to ascertain. Indeed, it is possible that given the current absence of a clear picture of this risk, the issue is failing to receive the policy attention it requires.

With these figures in mind, it is important to remember that OST is an approved intervention which is used widely in evidence-based drug treatment. OST can be, and often is, a protective factor for children, allowing patients to gain or regain control and stability in their lives, and improve their relationships with family and friends.

In addition, it improves both the financial situation of the family when money is not being spent on illegal drugs, and allows more time for parents to spend with their children rather than being spent out of the family home procuring drugs.⁷ The provision of OST also fits with the Government's view that 'the capacity to be an effective and caring parent' is a key outcome in a recovery-orientated treatment system.⁸

Aims

This review aims to assess how dangers to children can be minimised during the provision of Opioid Substitution Treatment (OST) to their parents and carers, through analysis of available literature, study of known cases where children have died or been harmed through ingesting OST drugs, and interviews and focus groups with practitioners and policy experts. This review does **not** seek to analyse or criticise the use of OST generally as a method of treating addiction.⁹

OST medicines are not the only substances prescribed to adults which can pose a risk to children. However, Adfam's organisational focus is on the impact of substance use on the family, and this review is strictly limited to cases relating to OST drugs. We have not undertaken analysis of cases where children have come to harm from the misuse of prescription drugs not used in drug treatment (for example, anti-depressants) and over-the-counter medicines like paracetamol. Such cases were outside the scope of this study.

⁴ HC Deb 29 October 2013, vol 569, cols 439-440

⁵ ACMD (2003) *Hidden Harm: Responding to the needs of children of problem drug users*

⁶ NTA (2009) *Moves to provide greater protection for children living with drug addicts (Media release)*

⁷ Chandler et al (2013) 'Substance, structure and stigma: parents in the UK accounting for opioid substitution therapy during the antenatal and postnatal periods' 24(6) *Int J Drug Pol.*

⁸ HM Government (2010) *Drug Strategy 2010: Reducing demand, restricting supply, building recovery*

⁹ For discussion of this issue see: NTA (2012) *Medications in Recovery: Re-orientating drug dependence treatment*

Methodology

The research was split into four parts:

- A **literature review** to analyse current policy, practice and clinical guidelines, national and international academic commentary and case studies
- A review of **media coverage** of cases of child ingestions of OST drugs
- A study of all **Serious Case Reviews (SCRs)** conducted in England and Wales in the last 10 years (2003-13), where OST medications were involved in harm to a child
- **Semi-structured interviews, focus groups and a roundtable discussion** with frontline practitioners, service managers and policy experts working in the fields of families, drugs and alcohol

Limitations

Specific research on this subject is lacking, and relevant data – for example the number of children’s hospital admissions resulting from ingesting OST drugs – is not available. In addition, the research that has been conducted is largely from other countries and was undertaken some time ago. This makes estimating the exact scale of the problem difficult, although correcting this is one of this report’s recommendations.

Our analysis of Serious Case Reviews was limited by the lack of available overview reports. Consequently there was a reliance on executive summaries, which can lack the detailed information required for full analysis. Most of the reviews in this study were undertaken according to an old version of the statutory guidance *Working Together to Safeguard Children* which did not mandate the publication of overview reports, therefore Local Safeguarding Children Boards (LSCBs) contacted declined to make them available to Adfam. Overview reports must now also be published, but this rule only applies to reviews initiated on or after 10 June 2010.

“This review does not seek to analyse or criticise the use of OST generally as a method of treating addiction.”

Key statistics

- An estimated **250,000 - 350,000 children are affected by parental substance use** in the UK
- Over **50% of all adults in treatment in England in 2011-12 were either parents or had children living with them**
- In 2011-12, **60,596 adults in drug treatment had parental responsibility**, an opiate problem, and were receiving a prescribing intervention. A further 5,193 were receiving OST but their parental status is not known
- In 2012, **2.7 million items of methadone were dispensed in the community in England, and 909,000 items of buprenorphine-based medication**
- **Methadone accounts for 5% of opioid exposures** in children under 6 in the US. **Buprenorphine accounts for 2%**
- An estimated **120,000 children were living with a parent engaged in treatment** in 2009
- In the UK, **1% of babies born each year are to women with drug problems** and 14% of children under one are living with a parent who is defined as a substance misuser
- There were **414 Methadone-related deaths amongst adults in 2012**, compared with 269 in 2000; in 2012 there were eight buprenorphine-related deaths
- A study sample of 247 cases identified parental drug/alcohol misuse as a contributing factor in **60.9% of care applications**
- Parental substance misuse was evident in **42% of the 184 Serious Case Reviews** conducted between 2009 and 2011.

Serious Case Review Findings

- Between 2003 and 2013, there were **20 Serious Case Reviews which implicated OST drugs**
- These reviews involved **23 children**, of whom **17 died**
- 18 of the reviews involved **methadone**, while buprenorphine was involved in one review
- The median age of the children was **two years old**
- In five of the cases, the **parents had intentionally administered the drug to the child**; in a further six cases, it was not determined how the child came to ingest the substance
- The OST drugs implicated were most commonly **prescribed to the child's mother** (eight cases).

Part one: Literature review

Part one: Literature review

Introduction

In conducting a review of the literature, we analysed the following sources were analysed:

- National and international academic commentary in journal articles and research papers
- National and international case studies
- Existing practice and clinical guidelines
- Other publications by relevant bodies

A crucial preliminary point to note is that whilst the evidence gathered suggests that safeguarding children from the dangers of OST requires greater attention, OST is an effective treatment in opioid dependence, and is viewed by a significant proportion of both professionals and patients as a positive facilitator for normal family life, allowing the patient to regain control of their life and improve their relationships.¹⁰ OST can be conducive to parenthood as well as improving the financial situation of the family, enabling parents to spend more time with their children rather than spending time procuring illicit drugs or money for them. In this sense, OST can represent a protective factor for the child. The possible risks to children must therefore be set against this background of OST as a tool for implementing positive change in which the children would undoubtedly benefit.¹¹

Background

Figures from the National Drug Treatment Monitoring System (NDTMS) show that 60,596 adults in drug treatment in England in 2011-12 were recorded as having parental responsibility, an opiate problem and were in receipt of a prescribing intervention. A further 5,193 adults had an opiate problem and were in receipt of a prescribing intervention, but their parental status was not recorded.¹² Updated figures from NDTMS supplied by Public Health England (PHE) show that in 2012-13, 61,928 adults in treatment had parental responsibility and were receiving OST, and there were 4,102 more receiving a prescribing intervention with unknown parental status.

The number of children living or in contact with these adults is not known, but it has been estimated that at least 120,000 children are living with parents in drug treatment,¹³ and over half of people newly presenting to treatment in 2011-12 either had children living with them, or were parents themselves,¹⁴ this figure was 55% in 2012-13.¹⁵ More generally, it has been reported that 1% of babies are born each year to women with drug problems,¹⁶ and 14% of children under one in the UK are living with a parent who is defined as a substance misuser.¹⁷

¹⁰ Chandler et al (2013) 'Substance, structure and stigma: parents in the UK accounting for opioid substitution therapy during the antenatal and postnatal periods' 24(6) *Int J Drug Pol.*

¹¹ *Ibid*

¹² *HC Deb* 29 October 2013, vol 569, cols 439-440

¹³ NTA (2009) *Moves to provide greater protection for children living with drug addicts* (Media release)

¹⁴ NDTMS (2012) *Statistics for drug treatment activity in England – parents and people who live with children under 18 in 2011/2012*

¹⁵ Figures from NDTMS supplied by Public Health England

¹⁶ ACMD (2003) *Hidden Harm: Responding to the needs of children of problem drug users*

¹⁷ Manning (2011) *Estimates of the number of infants (under the age of one year) living with substance misusing parents*

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In 2012, over 2.7 million items of methadone were dispensed in England, and just over 900,000 items of buprenorphine-based medicines.¹⁸ Methadone is presented in liquid form,¹⁹ and buprenorphine is offered as a tablet for dissolving under the tongue.²⁰ Whilst data is centrally collected by the National Drug Treatment Monitoring System on patients receiving prescribing interventions, which drug they are prescribed is not recorded: thus, we do not know the respective numbers of people in receipt of methadone and buprenorphine prescriptions.²¹

NICE states that the decision about which drug to use should be made on a case by case basis, but if both drugs are equally suitable, methadone should be prescribed as the first choice because it is cheaper.²² However, it also states that there are ‘risks of diversion of [OST] drugs to non-drug-users, especially children’, and a ‘high mortality risk associated with methadone in opioid-naïve people’. In making a decision, the clinician should ‘estimate the benefits of prescribing methadone or buprenorphine, taking account of the person’s lifestyle and family situation (for example, whether they are considered chaotic and might put children and other opioid-naïve individuals living with them at risk).²³ This information is presented in a NICE Technology Appraisal, which means the NHS is

legally obliged to fund and resource the medicines and treatments recommended²⁴; directions issued by the Secretary of State for Health also make it a statutory obligation for commissioners to make funding available within three months for medicines that have been recommended by NICE.²⁵ This makes Technology Appraisals different from guidelines, which are there to assist clinical decisions but do not carry the same obligations on implementation.

In 2012 there were 414 adult deaths involving methadone, representing 15.9% of all drug poisoning deaths.²⁶ This compares to eight deaths attributed to buprenorphine,²⁷ which has less risk of overdose, mainly because of its ‘ceiling effect’ on respiratory depression and its ‘blocking effect’ on the body’s opiate receptors.²⁸ When swallowed, buprenorphine is also only partially absorbed.²⁹ There is no central record of OST ingestions by children, for example through A&E records; as such, it is difficult to identify with certainty the true scope of the problem. However, it should be noted that OST-related deaths in children are rare and episodic,³⁰ and they are responsible for a fraction of child deaths overall: 3,857 child death reviews were completed in 2012-13, but information on substance misuse and poisoning deaths is not analysed due to insufficient numbers.³¹

¹⁸ Health and Social Care Information Centre (2013) *Prescriptions Dispensed in the Community: England 2002-12*

¹⁹ MHRA, *Methadone 1mg/ml oral solution* (pdf)

²⁰ MHRA, *Buprenorphine 0.4mg/2mg/8mg sublingual tablets* (pdf)

²¹ HL Deb 31 March 2014, vol 753, cols WA150-WA151

²² NICE (2007) *Methadone and buprenorphine for the management of opioid dependence*

²³ *Ibid*

²⁴ NICE, *About technology appraisals* (web resource)

²⁵ NICE (2014) *Developing and updating local formularies*

²⁶ Office for National Statistics (2013) *Deaths related to drug poisoning in England and Wales, 2012*

²⁷ St George’s University of London (2013) *Drug-related deaths in the UK: January-December 2012* (pdf)

²⁸ Boyer et al (2010) ‘Methadone and Buprenorphine toxicity in children’ 19 *Am. J. Addiction*

²⁹ Welsh & Valadez-Meltzer (2005) *Buprenorphine: A (relatively) New Treatment For Opioid Dependence*, *Psychiatry (Edgmont)* 2(12)

³⁰ Winstock & Lea (2007) *Safe storage of Methadone takeaway doses – a survey of patient practice* 31(6) *Aust N Z J Pub Health*

³¹ Department for Education (2013) *Child death reviews: year ending 31 March 2013*

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The risks posed to children by the drugs used in Opioid Substitution Treatment (OST) are characterised so far by a lack of research, awareness and understanding. The most important figures collected – the number of parents in receipt of OST – were the result of a highly specific Parliamentary question and an individual request to PHE, and are not available from other sources like annual data releases.

Also, much of the research studied below dates back a number of years and some was undertaken in the US rather than the UK; whilst the learning is often transferable, it is worth noting that British debate on OST is dominated by methadone, whereas American research was more informative when looking at buprenorphine. In the US, methadone is prescribed only in government-approved Opioid Treatment Programmes (OTPs) and patients are required to take the medication at the clinic, on a daily basis.³² Take-home doses are only allowed for patients who have been on the programme for an extended period of time. Conversely, FDA approval in 2002 allows for dispensing of buprenorphine in treatment settings other than OTPs, including in office-based settings.³³ Once a stable dose has been reached and toxicology samples are free from illicit opioids, the physician ‘may determine that less frequent visits (biweekly or longer, up to 30 days) are acceptable.’³⁴

Understanding the risks to children

Some academics have asserted that the risk of accidental ingestion of OST drugs by children has been apparent for quite some time, yet continues to be a significant problem.³⁵ Safety issues surrounding the storage of methadone in particular have long been documented,³⁶ but Boyer et.al., in their American study, argue that its increased use in the treatment of opioid dependence resulted in a substantial risk of harm to children, and tripled the number of exposures in children under six – a ‘greatly underemphasised’ fact in medicine.³⁷

Indeed, significant increases in hospital admissions for exposure to both methadone and buprenorphine have been documented.³⁸ In Utah, between 2002 and 2011 there were 462 recorded exposures to buprenorphine, of which children under five accounted for 39% and people aged 6-19 accounted for 7%.³⁹ In the US between 2010 and 2011, there were 68 recorded cases of buprenorphine ingestion by children under six, with 77% aged between one and two.⁴⁰ The same study found that ingestion of buprenorphine/naloxone (another OST drug, branded as Suboxone) caused 9.5% of emergent hospitalizations for drug ingestion by children aged under six years – a greater proportion than

³² SAMHSA (2013) *Trends in the use of methadone and buprenorphine at substance abuse treatment facilities:2003 to 2011*

³³ Center for Substance Abuse Treatment (2004) *Clinical Guidelines for the use of Buprenorphine in the treatment of opioid addiction. Treatment Improvement Protocol (TIP) Series 40. (pdf)*

³⁴ *Ibid*

³⁵ Martin & Rocque (2011) ‘Accidental and Non-Accidental Ingestion of Methadone and Buprenorphine in Childhood: A Single Center Experience, 1999-2009’ 6 *Current Drug Safety*

³⁶ Bloor et al (2005) ‘Safe storage of Methadone in the home – an audit of the effectiveness of safety information giving’ 2 *Harm Reduction J*

³⁷ Boyer et al (2010) ‘Methadone and Buprenorphine toxicity in children’ 19 *Am. J. Addiction*

³⁸ Martin & Rocque (2011) ‘Accidental and Non-Accidental Ingestion of Methadone and Buprenorphine in Childhood: A Single Center Experience, 1999-2009’ 6 *Current Drug Safety*

³⁹ CDC (2012) ‘Buprenorphine Prescribing Practices and Exposures Reported to a Poison Center – Utah, 2002–2011’ 61(49) *MMWR*

⁴⁰ CDC (2013) ‘Notes from the field: Emergency department visits and hospitalizations for Buprenorphine ingestion by children – United States 2010-2011’ 62(3) *MMWR*

⁴¹ *Ibid*

any other single medication.⁴¹ A comparison of the two found that methadone accounts for 5% of opioid exposures in children under six in America, whilst buprenorphine accounts for 2%; however, methadone exposures are more likely to be fatal.⁴² In Europe, it has been similarly asserted that whilst buprenorphine ingestions are more frequent in children than methadone, they are also less severe.⁴³

Data from the American Association of Poison Control Centres showed that between 2000 and 2008, 20 children under the age of six died following exposure to methadone.⁴⁴ Whilst we do not have a comparable comprehensive statistical picture of the number of OST exposures in the UK, a review of 20 SCRs involving 23 children found there have been at least 17 fatalities and eight non-fatal exposures to OST drugs in the last 10 years (see *Part Three*). The median age of the children involved in the SCRs was two years old, mirroring previous research which approximated the average age of children accidentally having ingested methadone at 34 months.⁴⁵ More generally, parental substance misuse was found to be a factor in 57% of Serious Case Reviews conducted between 2003 and 2005, and in a third of cases involving serious injury or death, parental drug or alcohol misuse was identified.⁴⁶

Understanding of the dangers of OST drugs may be patchy, and a lack of patient safety awareness has been documented in research.⁴⁷ Calman's 1996 study, for example, found that much greater precautions were taken with the storage of illicit drugs, perhaps signifying a lack of appreciation that OST drugs pose an equally dangerous risk.⁴⁸ Similarly, Li's finding that methadone had been ingested whilst dissolved in orange juice that had been left in an unsafe place by adults in the household in three of the four cases he investigated, led to his assertion that methadone users are often unaware of the dangers presented by 'careless storage' since they are able to tolerate large doses, and consequently underestimate the toxicity of the drug to children.⁴⁹ Although 82% of patients in Bloor's study agreed that methadone is dangerous, and the author concluded that levels of awareness of the risks to children and non-drug using adults were high⁵⁰, the minority of the treatment population who do not understand the risk still present a significant danger.

There are different ways of disseminating information on the dangers of OST: some local services display posters warning of the risks,⁵¹ and the continuous provision of written information, or 'information

⁴² Martin & Rocque (2011) 'Accidental and Non-Accidental Ingestion of Methadone and Buprenorphine in Childhood: A Single Center Experience, 1999-2009' 6 *Current Drug Safety*

⁴³ *Ibid*

⁴⁴ Boyer et al (2010) 'Methadone and Buprenorphine toxicity in children' 19 *Am. J. Addiction*; Marcus (2011) 'Accidental death from take home methadone maintenance doses: A report of a case and suggestions for prevention' 35 *Child Abuse and Neglect* See also; Forrester (2000) 'Parental substance misuse and child protection in a British sample. A survey of children on the child protection register in an inner London district office' 9(4) *Child Abuse*; where substance misuse was identified as a factor in 52% of a sample of 50 families.

⁴⁵ Binchy et al (1994) 'Accidental ingestion of Methadone by children in Merseyside' 308 *BMJ*

⁴⁶ DCSF (2008) 'Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of Serious Case Reviews 2003-2005' DCSF

⁴⁷ Gibson (2010) 'Accidental Methadone poisoning in children: A call for Canadian research action' 34(8) *Child Abuse & Neglect*

⁴⁸ Calman et al (1996) 'Methadone Treatment. Only half of patients store methadone in a safe place' 313(7070) *BMJ*

⁴⁹ Li et al (2000) 'Fatal Methadone poisoning in children: Maryland 1992-1996' 35(9) *Substance use & misuse*

⁵⁰ *Ibid*

⁵¹ Binchy et al (1994) 'Accidental ingestion of Methadone by children in Merseyside' 308 *BMJ*

prescriptions’, has been called for.⁵² Written information alone may be insufficient however, and whilst 64 of the 87 patients in Calman’s study remembered seeing posters in drug agencies warning of the dangers, only 25 recalled someone having actually spoken to them about the dangers of methadone – although this was twice as likely amongst patients with parental responsibility. Bloor’s study also found that only 31% had been given safety advice on methadone;⁵³ this lack of awareness has led some local assessment tools to incorporate questions on whether parents are aware of the dangers of children accessing their medication as an attempt to build these discussions into everyday practice.⁵⁴ In an Australian study conducted in New South Wales by Winstock and Lea, 87% of participants confirmed that the issue of safe storage had been discussed with them, and 97% said they stored their methadone in a lockable place or out of the reach of children – statistics more favourable to those results from comparable studies conducted in the UK.⁵⁵

Safety measures

The debate about protecting children from ingestion of OST medications has often been dominated by discussion of safe storage methods as the best or easiest way to make service users aware of the dangers of OST medication and the need to keep it well out of children’s reach. The majority of reported

cases of child ingestion of OST drugs have occurred as a result of accidental ingestion of methadone liquid solutions, or less commonly pills, which had been prescribed to the parent or relative,⁵⁶ and it is also known that the vast majority of exposures occur within the child’s home.⁵⁷ Some have suggested that the national provision of lockable storage boxes to every patient in treatment is the answer, both in research⁵⁸ and in Serious Case Reviews.

Marcus has suggested that an approach of ‘engineering in safety’ should be adopted, with a system whereby the client would be required to bring a lock box with their empty daily dose containers to the treatment centre, to exchange dosage containers and ensure the use of the lock box.⁵⁹ Current clinical guidance states that ‘risks to children of ingesting prescribed medication and the importance of safe storage must be emphasised at the first appointment [with a clinician] and repeatedly thereafter’, and DrugScope’s resource guide for professionals advises people in treatment be told:

‘Put your drugs away as soon as you bring them home and every time after you use/take them. Always keep them out of sight and out of reach. Keep them in a high cupboard that can be locked or high up in a locked wardrobe.’⁶⁰

⁵² Bloor et al (2005) ‘Safe storage of Methadone in the home – an audit of the effectiveness of safety information giving’ 2 Harm Reduction J; Boyer et al (2010) ‘Methadone and Buprenorphine toxicity in children’ 19 Am. J. Addiction

⁵³ Bloor et al (2005) ‘Safe storage of Methadone in the home – an audit of the effectiveness of safety information giving’ 2 Harm Reduction J

⁵⁴ Nottingham City Safeguarding Children Board (2009) ‘Safeguarding Children with Drug and Alcohol Using Parents: Practice Guidance for all agencies’

⁵⁵ Winstock & Lea (2007) ‘Safe storage of Methadone takeaway doses – a survey of patient practice’ 31(6) Aust N Z J Pub Health

⁵⁶ Palmiere et al (2010) ‘Parental substance abuse and accidental death in children’ 55(3) J Forensic Sci

⁵⁷ Zosel et al (2013) ‘Characterization of adolescent prescription drug abuse and misuse using the researched abuse diversion and addiction-related surveillance’ 52(2) J Am Academy Child and Adolescent Psychiatry

⁵⁸ Boyer et al (2010) ‘Methadone and Buprenorphine toxicity in children’ 19 Am. J. Addiction

⁵⁹ Marcus (2011) ‘Accidental death from take home methadone maintenance doses: A report of a case and suggestions for prevention’ 35 Child Abuse and Neglect

⁶⁰ Drugscope (2011) The Essential Guide to Problem Substance Use during Pregnancy: A resource book for professionals

Harm Reduction J; Boyer et al (2010) ‘Methadone and Buprenorphine toxicity in children’ 19 Am. J. Addiction

Some research has aimed to shed light on the reality of storage practices in the home. In 1996 Calman conducted a study of 87 patients, 40 of whom had parental responsibility.⁶¹ Of the 87, 43 were considered to be storing their methadone safely, with the majority storing the medication in a cupboard or drawer. Others reported leaving the methadone by the bed or in the fridge, and five patients with parental responsibility admitted to leaving the methadone 'lying around' the home. A more recent study by Bloor in 2005 found that the vast majority of patients did not store their methadone in a locked cupboard or other secure location, with more common answers being in the fridge or the wardrobe.⁶²

Limited compliance with safe storage messages and the continued ingestion of OST drugs by children would suggest that the provision of child resistant containers is not enough in isolation to prevent these incidents from happening. Such measures must be accompanied by frequent reinforcement, evidence collection on compliance, and assessment of attitudes and practice,⁶³ and systems should be in place to check that the equipment is in fact being utilised by the patient, and that this is recorded in the patient's notes.⁶⁴

Where service users were given information on safe storage, the source has been shown to vary: service

users discussed the matter with the methadone clinic (42%), the local drug agency (27%) and the pharmacist (21%).⁶⁵ Whilst indications by Ofsted show that drugs workers are now much better at understanding and addressing safeguarding risks to children⁶⁶, non-drug staff can still be reluctant to address these issues with clients: prescribing pharmacists perceive verbal advice to be risky, and a preference for 'non-confrontational' written information on storage and measuring has been expressed.⁶⁷ The matter becomes ever more taboo in view of the cases of intentional administration of OST medications to a child (see below), and in explaining the toxicity of methadone to children even at very small doses.

As well as lockable storage boxes, other countermeasures to the unsafe use and storage of OST drugs have been proposed. Harkin's study of storage practices in 1999 found that 48 of 186 patients had used a baby's bottle to measure methadone, and a further seven had used it to store the medication;⁶⁸ of those who had used a baby's bottle, almost half had children under the age of 14 living with them. Bloor also found that 25% of patients in Dublin had used babies' bottles for storing and measuring their methadone.⁶⁹ Calls have therefore been made for the free provision of measuring devices with each instalment prescribed.⁷⁰

⁶¹ Calman et al (1996) 'Methadone Treatment. Only half of patients store methadone in a safe place' 313(7070) *BMJ*

⁶² Bloor et al (2005) 'Safe storage of Methadone in the home - an audit of the effectiveness of safety information giving' 2 *Harm Reduction J*

⁶³ *Ibid*

⁶⁴ Department of Health (2007) *Drug Misuse and Dependence: UK Guidelines on Clinical Management*

⁶⁵ Bloor et al (2005) 'Safe storage of Methadone in the home - an audit of the effectiveness of safety information giving' 2 *Harm Reduction J*

⁶⁶ Ofsted (2013) *What about the children? Joint-working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems*

⁶⁷ Bloor et al (2005) 'Safe storage of Methadone in the home - an audit of the effectiveness of safety information giving' 2 *Harm Reduction J*

⁶⁸ Harkin et al (1999) 'Storing Methadone in babies' bottles puts young children at risk' 318(7179) *BMJ*

⁶⁹ Bloor et al (2005) 'Safe storage of Methadone in the home - an audit of the effectiveness of safety information giving' 2 *Harm Reduction J*

⁷⁰ *Ibid*

Attention has also been drawn to methadone's presentation as a liquid, with one author commenting that its placement in a solution is an 'accident waiting to happen' and an 'absurd' form to use in the home;⁷¹ perhaps exacerbated by the fact that it is sweetened and often brightly coloured.⁷² Binchy has therefore made a case for changing the taste from a sweet to a bitter-tasting liquid, in order to discourage children from swallowing large amounts.⁷³

Intentional Administration of OST

Recommendations on the safe storage of OST drugs are generally designed to avoid accidental instances of children finding and ingesting them without knowing the dangers. However, such recommendations are rendered useless if the parent is *deliberately* administering the drug to the child.

Relatively little is recorded in the literature about the deliberate administration of OST medications to a child, making it difficult to ascertain the scale of its incidence. There are reports where the cause of intoxication was homicide by the parents,⁷⁴ and analyses of individual cases where parents have used methadone as a means of sedating or pacifying the child do exist;^{75, 76} such cases have also

been divulged in a number of Serious Case Reviews and related media coverage. Toxicology reports in these cases can detect exposure to methadone and other drugs over long periods of time, and this has led to criminal proceedings against the parent(s) for neglect, cruelty to children, and manslaughter. However, at present even dedicated guides for parents on caring for a baby with drug withdrawal symptoms do not directly address the issue of administering drugs to pacify them, despite discussing the parenting challenges presented by the baby's irritability or sleeping difficulties.⁷⁷

Determining whether a child came to ingest drugs accidentally or by design is difficult to identify through toxicology tests,⁷⁸ so ascertaining how widespread the practice of intentional administration is poses a significant challenge. It is also controversial, and analysing the context of this practice should not be ignored in favour of 'scapegoating' OST drugs themselves.⁷⁹

Prescribing and dispensing

As well as examining the safe storage of OST drugs, some research also examines how prescribing practices can influence risks to children. In particular, the risks and benefits of take-home

⁷¹ Marcus (2011) 'Accidental death from take home methadone maintenance doses: A report of a case and suggestions for prevention' 35 *Child Abuse and Neglect*

⁷² Rosemont Pharmaceuticals (2013) Patient Information Leaflet: Methadone Hydrochloride DTF 1mg/1ml Oral Solution

⁷³ Binchy et al (1994) 'Accidental ingestion of Methadone by children in Merseyside' 308 *BMJ*

⁷⁴ Glatstein et al (2009) 'Accidental methadone ingestion in an infant: case report and review of the literature' 25(2) *Pediatr Emerg Care*

⁷⁵ Kintz et al (2005) 'Methadone as a chemical weapon: two fatal cases involving babies' 27(6) *Ther Drug Monit*

⁷⁶ Siew et al (2012) 'Respiratory failure caused by a suspicious white powder: a case report of intentional methadone poisoning in an infant' 28(9) *Pediatr Emerg Care*

⁷⁷ DrugScope (2011) *The Essential Guide to Problem Substance Use during Pregnancy: A resource book for professionals*

⁷⁸ See: Kintz et al (2010) 'Interpretation of hair findings in children after Methadone poisoning' 196(1-3) *Forensic International Journal*

⁷⁹ Trujols et al (2006) 'Contextualising methadone-related deaths: Failure to contextualise may be considered a weapon against public health' 28(5) *Ther Drug Monit*.

This is a response to Kintz et al (2005) cited above.

OST prescriptions versus mandatory supervised consumption on pharmacy premises have come under scrutiny.

UK clinical guidelines stipulate that methadone and buprenorphine should be administered daily and under supervision for at least the first three months of treatment, with supervision being relaxed only once the patient's compliance with the regime is assured.⁸⁰ It is known that supervision is a key factor in reducing methadone-related deaths for adults.⁸¹ The relaxation of supervised consumption should be a 'stepped' process, in which the patient stops taking doses observed by a professional but remains on daily dispensing. After further progress, the frequency of dispensing can be gradually reduced, meaning that larger quantities are taken home.⁸² Service users have generally acknowledged the importance of supervised consumption, with the majority agreeing that everyone should be on supervised consumption at first.⁸³ However, it has been noted that moves towards unsupervised consumption have been driven by pressure to expand treatment whilst reducing costs, and some international jurisdictions have relaxed their requirements for attendance and monitoring relating to OST.⁸⁴

Safeguarding issues are meant to be taken into consideration in the creation of a treatment plan, including the dispensing frequency of medications, with take-home doses being refused if there are

concerns over storage safety or risks to children.⁸⁵ The Department of Health states that patients must be made fully aware of the importance of protecting children from accidental ingestion, that prescribing arrangements should aim to reduce the risks to children, and that supervised consumption is the 'best guarantee' the medicine is used as directed; take-home doses should not be prescribed where there are concerns about the safety of medications stored at home and potential risks to children.⁸⁶ Similarly, Public Health England released guidance as recently as January 2014, stating that clinical decisions to relax, drop or reinstate supervised consumption should be regularly reviewed and take into account levels of risk, especially to children.⁸⁷

Levels of adherence to this clinical guidance, however, are more difficult to ascertain. Although figures on the number of drug treatment clients with parental responsibility and a prescription for OST are available, which of these people are on supervised consumption or on take-home regimes is not known. The exact numbers of those in OST who are prescribed take-home doses, and how often they pick up their medicine (daily, weekly or anywhere in between) are unavailable; therefore it is not known, on a national level, if parents are more likely to be put on supervised consumption than people without contact with children.⁸⁸ Equally problematic is the fact that practice amongst prescribers and clinicians can vary considerably, in both the dose prescribed

⁸⁰ NICE (2007) *Methadone and buprenorphine for the management of opioid dependence*

⁸¹ NTA (2007) *Supervised Methadone in Staffordshire and Shropshire: A study of factors associated with key outcome variables*

⁸² Department of Health (2007) *Drug Misuse and Dependence: UK Guidelines on Clinical Management*

⁸³ NTA (2007) *Supervised Methadone in Staffordshire and Shropshire: A study of factors associated with key outcome variables*

⁸⁴ NTA (2012) *Medications in recovery: re-orientating drug dependence treatment (Appendix C)*

⁸⁵ Department of Health (2007) *Drug Misuse and Dependence: UK Guidelines on Clinical Management*

⁸⁶ *Ibid*

⁸⁷ Public Health England (2014) *Optimising opioid substitution treatment*

⁸⁸ *HC Deb* 29 October 2013, vol 569, cols 439-440

and volume of take-home use.⁸⁹ Bloor's sample of 185 patients attending an NHS prescribing service in 2005 showed that 63% were on a daily pick-up regime, 34% picked up every two days, 2% twice per week, and less than 1% collected their methadone on a weekly basis.⁹⁰ These numbers can vary enormously depending on the location, amongst numerous other factors; for example in Dublin, at one point over 50% of patients collected their methadone on a weekly basis.⁹¹ Bloor also found a link between weekly pick-up regimes and the use of babies' bottles as measurement devices to get the correct daily dose,⁹² suggesting that larger quantities of OST drugs in the home is correlated with increased risks to children.

There is also a lack of clarity in guidance on what exactly would constitute a violation of protocol in relation to OST dangers, and the measures which should be taken on the back of this. Guidelines on points to consider and 'red flags' to be aware of when making clinical judgments on prescribing regimes, outside relatively simply questions on safe storage, were not available. Triggers for putting or keeping parents on supervised consumption could therefore vary from area to area, service to service, and even worker to worker, according to their own judgment or differences in local policy.

Although supervised consumption would remove the presence of OST drugs in the home and therefore risks to children – including teenagers who deliberately misuse methadone or use it in suicide attempts⁹³ – a number of drawbacks to such policies are identified in the literature.

On a practical level, it is harder for parents of young children to attend a pharmacy every day to take their medication. Daily travel to the pharmacy can conflict with the pursuit of other interests such as gainful employment;⁹⁴ it can be especially inconvenient for those with childcare responsibilities,⁹⁵ so safeguarding and risk are considered alongside other factors like maintaining positive engagement in treatment when making dispensing decisions.

As well as practical considerations, drug treatment clients have also reported feeling ashamed having to take their children to collect their methadone, and have complained about the lack of a private place in which to consume it.⁹⁶ Users with children may feel stigmatised and would therefore prefer to be able to collect methadone every few days, rather than being supervised daily.⁹⁷ In the same vein, the Department of Health states that efforts must be made to stop supervised consumption being viewed as a punishment.⁹⁸

89 Bloor et al (2005) 'Safe storage of Methadone in the home – an audit of the effectiveness of safety information giving' 2 *Harm Reduction J*

90 Binchy et al (1994) 'Accidental ingestion of Methadone by children in Merseyside' 308 *BMJ*

91 *Ibid*

92 Bloor et al (2005) 'Safe storage of Methadone in the home – an audit of the effectiveness of safety information giving' 2 *Harm Reduction J*

93 Martin & Rocque (2011) 'Accidental and Non-Accidental Ingestion of Methadone and Buprenorphine in Childhood: A Single Center Experience, 1999-2009' 6 *Current Drug Safety*

94 Department of Health (2007) *Drug Misuse and Dependence: UK Guidelines on Clinical Management*

95 NICE (2007) *Methadone and buprenorphine for the management of opioid dependence*

96 NTA (2007) *Supervised Methadone in Staffordshire and Shropshire: A study of factors associated with key outcome variables*

97 *Ibid*

98 Department of Health (2007) *Drug Misuse and Dependence: UK Guidelines on Clinical Management*

In an American study evaluating patient preferences in dosing regimes for buprenorphine, 91% of patients participating rated three-day take-home as the preferred schedule.⁹⁹ Overall findings revealed that reducing the regularity of clinic attendance actually *improved* medication compliance and increased patient satisfaction, highlighting a potential conflict between the goals of maximising the parents' engagement with treatment and minimising the presence of OST drugs in the home.

Initiatives whereby a maximum number of take-home doses per week is allowed could be helpful in addressing risks, but whilst this reduces the frequency of the presence of methadone in the home, it falls short of reassuring us that the risk to children is a thing of the past.¹⁰⁰

Professional Practice

As well as practice recommendations like restricting take-home OST drugs for parents of young children or making the provision of locked boxes compulsory, the literature also examines the need for improvements in professional practice and the 'human element' of decision making on risk.

Professional Curiosity

The term 'professional curiosity' embodies the notion that practitioners must retain a level of healthy scepticism when dealing with clients,

remembering to ask questions and comment on anything that may be a cause for concern. This 'respectful uncertainty' does not require the constant interrogation of clients by services, but does mean that information should be evaluated critically.¹⁰¹ The *Munro Review of Child Protection* strongly champions the development of professional judgement and confidence in working with challenging clients, and having the confidence to act on professional intuition.¹⁰² Parental resistance is a key feature of many cases in which children come to harm: Brandon's study of child deaths and serious injury revealed that parental hostility towards agencies can commonly result in workers being left afraid of visiting the family home,¹⁰³ and parents often made it difficult for professionals to see the children, directing attention to other matters and leaving the child unseen and unheard.¹⁰⁴ This was also a common thread in the Serious Case Reviews studied for this review.

Stigma

Many clients in treatment have commented on how they have experienced stigmatic attitudes in dealing with services: in one 2012 study, some professionals were described as discriminatory and incompetent in their work with mothers accessing treatment.¹⁰⁵ Drug treatment clients have also identified a desire for the better training of pharmacists around methadone users, in order to combat stigma.¹⁰⁶

⁹⁹ Amass et al (2001) 'Thrice weekly supervised dosing with the combination Buprenorphine-naloxone tablet is preferred to daily supervised dosing by opioid-dependent humans' 61(2) *Drug and Alcohol Dependence*

¹⁰⁰ Winstock & Lea (2007) 'Safe storage of Methadone takeaway doses – a survey of patient practice' 31(6) *Aust N Z J Pub Health*

¹⁰¹ Lord Laming (2003) *The Victoria Climbié Inquiry Report*

¹⁰² Professor Eileen Munro (2011) *Munro Review of Child Protection: A child-centred system*

¹⁰³ DCSF (2008) 'Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of Serious Case Reviews 2003-2005'

¹⁰⁴ *Ibid*

¹⁰⁵ Silva et al (2012) 'Balancing motherhood and drug addiction: The transition to parenthood of addicted mothers' 18(3) *JHP*

¹⁰⁶ NTA (2007) *Supervised Methadone in Staffordshire and Shropshire: A study of factors associated with key outcome variables*

Parents experiencing problems with drugs may fear that revealing their struggles will lead to punitive reactions by services, so it is important that practitioners work with delicacy to ensure they do not alienate parents, and that they are sensitive to parents' reactions so they can be both supportive and robust in the messages they give.¹⁰⁷

Accountability, joint working and information sharing

The delivery of OST can involve a number of professionals who – ideally – should be aware of the same risk factors when prescribing or dispensing drugs. In particular, clinical guidelines stipulate that the relationship between the prescriber and the dispensing pharmacist is important and they should liaise if concerns such as non-attendance or intoxication are identified; there should be systems in place to ensure information about parents can be fed to and from the prescriber and keyworker.¹⁰⁸

What is less clear from guidance, however, is how the flow of information in terms of OST works in practice, especially when considering take-home medication. Whilst clinical guidelines state that compliance with safety measures should form part of the decision-making process concerning dispensing and supervision arrangements,¹⁰⁹ how prescribers might have access to such information is unclear, and it would have to come from someone who had visited the house, such as a drug worker

undertaking a home visit. The lines of accountability in terms of who is acting on what information, and when, is not clear, and of course may vary according to local systems; but as the Munro Review has stated, given recent reforms to public services, it is ever more important to clarify roles and responsibilities, with clear and unambiguous lines of accountability in child protection.¹¹⁰

Whilst some research is available on joint work involving drug services, unsurprisingly it lacks focus on OST. Ofsted have recently commended drug practitioners for their understanding of the needs of children, and their appreciation of their responsibility to work closely with children's services. In the majority of the assessments they undertook, drug services and children's social care staff were collaborating well, and had succeeded in honing a good understanding of parental substance misuse and its impact on children.¹¹¹ It is not known whether improvements in the recognition that safeguarding is 'everyone's responsibility' is mirrored in an appreciation that minimising the risks of OST to children is also something which applies to a range of professionals.

Training

Pharmacists have reported feeling in need of more training on OST; 60% expressed a desire to be better trained in relation to the children of drug users, and in particular, to be better informed on prescribers

¹⁰⁷ Cleaver et al (2011) 'Children's Needs – Parenting Capacity (Second Edition) Child abuse: Parental mental illness, learning disability, substance misuse, and domestic violence'

¹⁰⁸ Department of Health (2007) *Drug Misuse and Dependence: UK Guidelines on Clinical Management*

¹⁰⁹ *Ibid*

¹¹⁰ Professor Eileen Munro (2011) *Munro Review of Child Protection: A child-centred system*

¹¹¹ Ofsted (2013) *What about the children? Joint-working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems*

and the guidelines they implement.¹¹² The NTA has encouraged pharmacists to undergo further training, which is available from the Centre for Pharmacy Postgraduate Education (CPPE) in England¹¹³ – but these modules are not compulsory. This belief was not unique to pharmacists however; 90% of the specialist providers and half of responding GPs said they need more training, including an ‘ABC of methadone.’¹¹⁴

In 2003 the ACMD found that a third of social services surveyed for the *Hidden Harm* report did not offer training on protecting the children of drug users, reflecting the lack of professional awareness around parental substance misuse generally, and subsequently around OST.¹¹⁵ A decade later, doubts remain amongst professionals that much has changed in this respect¹¹⁶: a 2013 study found that education on alcohol and other drugs is an ‘inconsistent and variable’ element of qualifying social work education, and the priority given to this area was considered to be too low.¹¹⁷ However, in a study sample of 247 care applications, 60.9% identified parental drug or alcohol misuse as a contributing factor to the application¹¹⁸, showing that social workers are extremely likely to be working with this group. It has been recommended that all frontline staff undergo training on issues of parental substance misuse, and the NTA encouraged training on an inter-professional basis where

possible, to endorse shared understanding of professional skills.¹¹⁹ This presents an opportunity for the inclusion of some OST-related content.

Conclusions

Although this literature review is only part of Adfam’s research into the risks to children from OST medications, and further detailed analysis of individual cases and professional opinion is to follow, it does provide some indication of the current situation, together with some positive learning points on what can be done to effectively safeguard children at risk.

Understanding the dangers of OST medications

is at the heart of any measures intended to reduce the risk of children ingesting OST, but the available literature illustrates a lack of consistency in both practitioners’ and service users’ knowledge of OST drugs. In order to implement risk minimisation measures effectively, there must be clear recognition of the reasons behind them: that OST drugs can be dangerous, and that methadone in particular poses a significant risk to children and other ‘opioid naïve’ people. Professionals must understand this rationale, and be able to transmit the message to clients in a clear but sensitive way; this can be supported by clear literature and information in drug agencies and pharmacies.

¹¹² (2007) *Supervised Methadone in Staffordshire and Shropshire: A study of factors associated with key outcome variables*

¹¹³ NTA (2006) *Best practice guidance for commissioners and providers of pharmaceutical services*

¹¹⁴ NTA (2007) *Supervised Methadone in Staffordshire and Shropshire: A study of factors associated with key outcome variables*

¹¹⁵ ACMD (2003) *Hidden Harm: Responding to the needs of children of problem drug users*

¹¹⁶ Adfam (2013) *Parental substance use: through the eyes of the worker*

¹¹⁷ Galvani & Allnock (2013) *Substance use in social work education: a national survey of social work qualifying programmes in England*

¹¹⁸ CAFCASS (2012) *Three weeks in November...Three years on...Cafcass care application study (pdf)*

¹¹⁹ *Ibid*



Whilst **safe storage** measures like the provision of free, lockable boxes to all service users can potentially reduce the risks of children accidentally ingesting OST drugs, the coverage of such policies is not known, and where it has been analysed, doubts have been raised about the levels of compliance amongst treatment clients. The importance of discussing safe storage with clients has also been highlighted, but again there can be inconsistency in the level and regularity of these discussions, and unclear accountability over whose role it is to address these issues with service users. Individual measures such as lockable boxes are not solutions in isolation, and are particularly ill-suited to preventing the **intentional administration of OST drugs to children by their parents**, which is not fully analysed in the literature outside discussion of individual cases; we therefore know little of the prevalence of this dangerous practice. This is discussed in more detail in the Serious Case Reviews analysis, where a number of cases are highlighted.

Clinicians are meant to take children into account when making decisions on **prescribing and dispensing regimes** for treatment clients who have contact with children. Assessing consistency in the application of such guidance is extremely difficult however, and a number of different systems will be in operation around the country. To introduce a policy whereby all those who have children or close contact with children are placed on a supervised consumption regime would be extremely challenging, given a number of practical

and therapeutic concerns about compatibility with childcare responsibilities, stigmatisation and potential negative impacts on engagement with treatment.

The literature suggests that some parents can be resistant to helping agencies, being uncooperative and directing attention away from the child.

Professional curiosity and challenge is extremely important in assessing risk to children: this applies to effective practice generally, but is also highly relevant to practitioners who may be reluctant to address matters like the safe storage of OST medications. Training to develop the application of professional curiosity is essential, especially in working with resistant families; but this must be considerate of the importance of developing and maintaining a trusting, open and positive relationship with the client.

Of course, families where a parent has a substance dependency may face a number of challenges other than the risk of OST ingestion by children. They may also be in contact with a number of different services working with the adult, the child(ren) or both, across a number of different – and sometimes competing – needs. This means that just as with parental substance use generally, **effective joint working and information sharing** is necessary to minimise the risks of OST ingestion by children. Specifically, GPs and prescribers need to be aware of children in the home and services working with the family must inform prescribers of any concerns

identified, so that parents are put on appropriate prescribing and dispensing regimes. Practitioners like doctors and pharmacists, who have direct involvement in OST decisions, should be given training on the dangers it can pose to children; and other professionals in contact with the family (for example, social workers or health visitors who go into the family home) should also be aware of the risks, be able to undertake safe storage checks, and see this as part of their overall safeguarding role.

What also emerges from the literature is a **lack of clear guidance on what good practice looks like on the frontline**. Although NICE and clinical guidelines do recognise the possible dangers to children and the need for practitioners to bear them in mind when making decisions, there is little detail on how this would be implemented in practice. In terms of prescribing and dispensing, which professionals should be acting on what information and when is unclear; for example what sort of event or discovery would trigger a return to supervised consumption, and how this information would be shared between different services in contact with the family.

Clarifying lines of accountability would also be useful here, given the absence of a clear driver of good practice.

In order to implement risk minimisation measures effectively, there must be clear recognition of the reasons behind them: that OST drugs can be dangerous, and that methadone in particular poses a significant risk to children

Part two: Media analysis

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The research involved a review of local and national media reporting of cases of OST ingestion by children. Some reports were sourced relating to the cases studied for the Serious Case Reviews research, as well as further incidents in Scotland or involving young people over 18. However they provided a somewhat incomplete picture, giving brief facts, occasionally an outline of SCR findings, and usually focusing on criminal proceedings brought against the parents.¹²⁰ A deeper analysis or debate around the policy and practice considerations of OST directly is absent.

A search for press releases and media responses to these cases by major organisations in the families, drugs and alcohol fields was also undertaken, which yielded very few results. None made proactive comment on cases of children ingesting OST drugs and these organisations were not quoted in any related media coverage. It does not appear that the risks posed by OST drugs to children have been recognised by major children's charities in their media work, and the issue has not been widely addressed by organisations in the drug sector – at least in public.

Attempts to cover this issue specifically or in depth were few and far between, and only two examples were located. One came from The Centre for Social Justice, a thinktank which often campaigns on drug policy issues. It highlighted several cases where children had died from methadone overdoses and recommended that the Government take steps to

‘ensure that methadone is taken for as short a time as possible, under proper supervision, and that parents receive proper rehabilitation to lead drug-free lives’.¹²¹ However, this was posted on the organisation's website and it is not clear what efforts had been made to draw attention to the issue in the wider media. In this example, cases of methadone ingestion by children are primarily used as an argument against the use of OST generally, and safety measures and related practice are not explored.

There was one other relevant analysis of the risks posed to children by OST in a specialist publication, *Druglink* magazine. Taking three cases of children ingesting methadone, it explored some of the issues covered in this research, including notes on safe storage of medication, lockable boxes, messages on the dangers of OST drugs and effective work with mothers whose babies are withdrawing from drugs after exposure during pregnancy.¹²²

Though some coverage of individual OST cases was found, its punitive or alarmist tone obscured more productive discussion of OST drugs and their dangers to children on a wider scale. The lack of deeper analysis also means that the issue is unlikely to be familiar to the majority of the general public. Although significant in number, the cases discovered during this research have not led to the level of public debate or changes in practice that other high profile Serious Case Reviews have caused.

¹²⁰ See, for example: *Daily Mirror* (Sep 04 2012) *Left to die at hands of his junkie parents: Baby who died from methadone overdose should have been in care, report reveals*; *BBC News* (13 December 2013) *Riley Pettipierre methadone death preventable, report finds*; or *Daily Mail* (20 July 2010) *Heroin addict couple jailed for regularly giving baby methadone before she died to 'soothe her'*

¹²¹ Centre for Social Justice (2013) *How many more tragedies until we get to grips with Methadone crisis*

¹²² Rebecca Lees (2013) 'Mother's Milk' (pdf) 28(1) *Druglink*

Part three: Serious Case Reviews

Part three: Serious Case Reviews

Introduction

For this part of the research, Adfam set out to find all Serious Case Reviews which implicated OST drugs in harm to a child during the period 2003-13. This period was chosen because *Hidden Harm*, the report from the Advisory Council on the Misuse of Drugs which first shone a light on the impact of parental substance use, was published in 2003, and this provides a neat 10-year timespan to study.

Serious Case Reviews are local enquiries, published by Local Safeguarding Children Boards (LSCBs), into the death or serious injury of a child where abuse or neglect are known or suspected. They examine whether lessons can be learned and how local organisations involved in child protection can improve partnership practices to prevent future episodes. SCRs are not inquiries into how exactly a child died or was seriously harmed, or into who is culpable: these are matters for coroners and criminal courts.

In the period 2009-11, 184 Serious Case Reviews were undertaken, of which 42% involved parental substance use.¹²³ The number of child deaths due to maltreatment or violence is estimated at 85 per year.¹²⁴

Publication

The production and publication of Serious Case Reviews fall under the statutory guidance *Working Together to Safeguard Children*. Until 2010, only executive summaries were made available for public consumption, and ‘neither the SCR overview report nor the Individual Management Reviews [undertaken internally by services involved with the family, and then submitted to inform the final overview report] should be made publicly available’.¹²⁵ This policy was changed by the Secretary of State for Children and Families in 2010, who declared that for all SCRs initiated on or after June 10 2010, overview reports should be published.¹²⁶ This requirement was restated in an updated version of *Working Together to Safeguard Children* published in 2013, which requires that ‘final SCR reports should be suitable for publication without needing to be amended or redacted’, and ‘must be published, including the LSCB’s response to the review findings, in order to achieve transparency’.¹²⁷

The majority of the reviews discussed in this study were conducted under the old guidance. Therefore, the LSCBs declined to make full overview reports available, and this research is based largely on executive summaries. These are intended to reflect the full overview report and are based on the same information, but they contain less specific detail.

¹²³ Department for Education (2012) *New Learning from Serious Case Reviews: a two-year report from 2009-11*

¹²⁴ *Ibid*

¹²⁵ DCSF (2010) *Working together to Safeguard Children (pdf)*

¹²⁶ Department for Education (2010) *Publication of Serious Case Review Overview Reports and Munro Review of Child Protection (pdf)*, Letter from Tim Loughton MP to LSCB Chairs and Directors of Children’s Services

¹²⁷ Department for Education (2013) *Working Together to Safeguard Children*

Learning from Serious Case Reviews

National Government bodies are responsible for identifying and disseminating common themes and trends across Serious Case Reviews, and acting on lessons for policy and practice. As Governments have redrawn departmental responsibilities, this has encompassed the Department for Education and Skills, then the Department for Children, Schools and Families, and now the Department for Education. A report published by the Department for Education in 2010 concluded that ‘potential learning opportunities provided by Serious Case Reviews are not being fully realised at either local or national level’.¹²⁸

No national analysis of Serious Case Reviews involving OST medications has been published to date. One biennial analysis of SCRs noted that ‘a number of [Serious Case Review] recommendations sought the development of guidance or protocols (at a regional or national level) to cover specific circumstances...[including] for example, the prescribing and safe storage of methadone’, but this is the only mention.

It is Adfam’s view that the seriousness of these incidents, and the clear similarities between them, mean that more in-depth research is merited. With such a specific risk in mind, there is no credible reason why a lesson learned in one area of the country cannot also be learned in another.

Criticism of the SCR system

There has been ‘considerable criticism of the current SCR methods’, and ‘too much emphasis on getting the process right, rather than on improving outcomes for children’.¹²⁹ Some reviews have also been criticised for concluding that harm to children was not predictable despite otherwise obvious warning signs.¹³⁰

For the purposes of this research, the primary role of Serious Case Reviews is simply as sources of reliable information on incidents of children ingesting OST medications. It is not the aim of this review to assess the quality of individual Serious Case Reviews or comment on the efficacy of the system overall.

Sourcing the reviews

This review is largely sourced from executive summaries, being the only publicly available documents. This was primarily done through the NSPCC library and online searches.

Once the cases had been identified, each relevant LSCB was contacted but overview reports were not made available in the majority of cases. This was generally because under previous statutory guidance (as explained above) overview reports did not have to be written with a view to publication, so they are not sufficiently anonymised for public consumption. Given the significant extra detail found in the few overview reports which were sourced (Bristol, Child K; Southampton, Child F;

¹²⁸ Department for Education (2010) *Learning from serious case reviews: Report of a research study on the methods of learning nationally from serious case reviews*

¹²⁹ Professor Eileen Munro (2011) *Munro Review of Child Protection: A child-centred system*

¹³⁰ See, for example, *The Guardian* (November 13th 2013) ‘Hamzah Khan: Minister has ‘deep concerns’ over review findings’ (web resource)

and Derbyshire, BDS), over and above what could generally be found in the executive summaries, it is likely that the full overview reports contain important learning which is effectively hidden from public view. Executive summaries were as short as six pages (Plymouth), compared with full overview reports over 80 pages (Bristol, Child K); a discrepancy in the amount of detail given was obvious. As well as being an unfortunate gap in this research, the unavailability of the overview reports also points to a blockage in terms of sharing learning outside the Local Authority which published the reviews.]

Serious Case Reviews involving OST drugs

According to the available evidence, in the last decade there have been 20 Serious Case Reviews involving the ingestion of OST drugs by children. These cases involved 23 children, and there were 17 fatalities. 15 deaths were due to methadone, which was mentioned in 19 of the reviews. One case involved death due to buprenorphine toxicity, and the final case heroin ‘and other drugs’; it contains recommendations on the storage of methadone, so it is inferred that it was relevant to the case. Below is a summary of reviews studied for this research, broken down by year and local area, alongside other pieces of information relevant to the analysis.

A full summary of each case is provided as Appendix I.

Serious Case Reviews: Summary

LSCB	Year	Case	Age	Drug(s) involved	Severity	Type of ingestion	Drug prescribed to
'Area A'	2012	Child B	6	Methadone	Non-fatal	Parental	Mother
Birmingham	2009	Case 11	2 and 3*	Methadone	1 fatal, 1 non-fatal	Accidental	Father
Bradford	2009	Child HD	2	Methadone	Fatal	Parental	Mother
Bridgend	2010	Child K	2	Methadone	Fatal	Accidental	Mother and father
Bristol	2009	Baby Z	1	Methadone	Fatal	Unclear	Mother
Bristol	2011	Child K	1	Methadone	Fatal	Parental	Mother and father
Buckinghamshire	2009	Child A	2	Methadone	Fatal	Unclear	Unclear
Camden	2003	Child B	2	Methadone	Fatal	Unclear	Mother
Ceredigion	2012	Child V	15	Methadone	Fatal	Intentional	Father*
Ceredigion	2012	Child Z	17	Heroin and other drugs	Fatal	Intentional	Unclear
Cumbria	2010	Child E	17	Buprenorphine	Fatal	Unclear	Unclear
Derbyshire	2013	Child BDS12	2	Methadone	Fatal	Accidental	Mother
Gloucestershire	2010	0109	1 and 3	Methadone	1 fatal, 1 non-fatal	Parental	Mother
Gwynedd and Anglesey	2010	Child 2	6 months	Methadone	Non-fatal	Parental	Unclear
North Yorkshire	2005	SNM	1	Methadone	Fatal	Unclear	Unclear
Nottingham City	2008	'Thomas'	1	Methadone	Non-fatal	Accidental	Mother's partner
Plymouth	2006	LB	Unclear	Methadone	Non-fatal	Unclear	Unclear
Reading	2009 (republished)	Child T	3	Methadone	Fatal	Parental	Mother
Southampton	2012	Child F	2	Methadone	Fatal	Accidental	Mother
Staffordshire	2010	C1 and C2	14 and 14	Methadone	1 fatal, 1 non-fatal	Intentional	Father
Staffordshire	2008	Child aged 3	3	Methadone	Fatal	Accidental	Mother

*from media reports
 †Multi-Agency Case Review

Other reviews

There was also a Serious Case Review published by Sheffield Local Safeguarding Children Board in 2002 on Child AC. This was another case of methadone ingestion by a small child, but falls outside the 2003-13 time limit of this review.

Scotland has not been included in this analysis. Adfam does not have a history of working in Scotland, the Significant Case Review system works under different guidance, and there is a separate Government drug strategy. But according to a review of Significant Case Reviews in Scotland (the equivalent of Serious Case Reviews), there were 6 non-fatal cases of ‘ingestion of methadone, heroin or other opiates’ between 2007 and 2012, and 5 fatal cases of ‘overdose/drug intoxication’.¹³¹ Media reports are also available on some specific cases.^{132, 133}

Other cases

Serious Case Reviews are only undertaken when a child dies or is seriously harmed, and abuse or neglect are suspected to be factors in the incident. Although parental substance use is commonly associated with neglect, it should not be generalised that all parents who use drugs are a risk to their

children. This is especially true of parents engaged in treatment, which is known to be a protective factor for children.¹³⁴ There are other cases involving ingestions of OST drugs which do not qualify for Serious Case Review consideration, for example: Jasmin Melia in Grimsby. Aged 16, she died after taking methadone and sleeping tablets prescribed for her father and his partner. There was an inquest but not a Serious Case Review, so this is not included in this analysis. Media reports are available on this case.¹³⁵

Louis Wainwright and Nick Smith in Scunthorpe. Aged 18 and 19, they both died from ingesting methadone; Serious Case Reviews are not undertaken for those over 18. It is not clear from media reports how they sourced the drug. It was originally reported in the press that they had died after taking mephedrone, which at the time was a ‘legal high’ and the subject of intense media and political attention.¹³⁶

Just prior to the publication of this research, another incident of methadone ingestion by a small child occurred in Blackpool. Criminal investigations are ongoing at the time of publication.¹³⁷

¹³¹ University of Wolverhampton/IRISS (2012) *Audit and analysis of significant case reviews* (pdf)

¹³² Daily Record (23 April 2013) ‘Edinburgh couple found guilty of killing their toddler son in a Tenerife hotel room after giving him methadone and diazepam’ (web resource)

¹³³ BBC News (5 March 2006) ‘Dead toddler had drunk methadone’ (web resource).

¹³⁴ NTA (2012) *Parents with Drug Problems: How Treatment Helps Families* (pdf)

¹³⁵ BBC News (28 January 2011) ‘Grimsby family’s fear after methadone death’ (web resource)

¹³⁶ BBC News (25 January 2011) ‘Scunthorpe community ‘awash with methadone’ (web resource)

¹³⁷ BBC News (7 March 2014) ‘Blackpool toddler death: Sophie Jones ingested methadone’ (web resource)

Multi-Agency Case Reviews

Adfam was also provided with a Multi-Agency Case Review on one case in which a young child had been administered methadone by his parents. The child survived. The case was similar to the Serious Case Reviews studied in many respects including the circumstances of the incident, the lessons learned, key messages and recommendations for practice; the reasons it was not deemed worthy of a Serious Case Review are not known, given that other SCRs have been conducted for some non-fatal incidents. We have, however, included this review in the analysis which follows. This is because:

- it adds to the evidence base on children who have come to harm from OST medicines;
- it was conducted using the same processes as a Serious Case Review, so fits with the research methodology;
- it demonstrates that there are other reviews of cases of children ingesting OST medicines which fall beneath the threshold for Serious Case Reviews, which are therefore unknown in number and in content.

This review was sourced on an individual basis from a local area which has not undertaken any Serious Case Reviews for children ingesting OST medicine. It is referred to in this report as Area A.

Analysis

Each review was studied in detail to examine, as far as possible, the background of the case; the circumstances of the event of ingestion; key messages and ‘lessons learned’; and recommendations.

Each case is referred to by the name of the LSCB which published it, and where an LSCB has produced more than one SCR studied in this review, they are distinguished by the anonymised name of the child in the case (Bristol Child K and Bristol Child Z, for example).

Context of the cases

There were found to be several different types of case involving OST, which influenced the scope of the recommendations and key learning points.

When did the incident happen?

17 of the 20 cases are from the second half of the 2003-13 timeframe. It is important to note that the use of OST in drug treatment has risen over the last decade, so it stands to reason that more incidents of accident and misuse may happen, involving both adults and their children.

How old were the children?

There is a clear age bias towards very young children in the Serious Case Reviews: 17 of the 23 children involved in the reviews were known to be three or under, compared with five children 14 and over. The median age was two.

How was the drug ingested?

Administered by parents: it has been known for parents to administer methadone to very young

children, with the aim of sedating or pacifying them. These cases may involve criminal proceedings against parents, and toxicology tests may show exposure to drugs over a period of time.

This is a very dangerous practice, as illustrated in this review. Parents may have a number of ill-informed or incorrect motivations or beliefs relating to this practice, for example that children can cope with smaller doses of a prescribed medication which is used widely and safely by adults; that babies may already have been exposed in the womb and are therefore 'resistant' to it, especially if they were born with neonatal withdrawal symptoms; and that it is a similar principle to other poor parenting practices which use substances to pacify children, like dipping a baby's dummy in whisky to help them sleep.

Cases of parental administration: 6

Taken accidentally: some children may ingest methadone if it is left in an accessible place or receptacle, without knowing what it is. Questions have been raised about its 'attractiveness to children' (Camden), and some cases have involved methadone stored in toddler's beakers or other unsuitable containers. Very small doses can be lethal, which highlights the risks of unsafe methadone storage and disposal – in one case, a parent argued that the child had ingested the remnants of an 'empty' bottle after it had been inadequately disposed of (Southampton).

Cases of accidental ingestion: 6

Taken intentionally: some teenagers ingested methadone deliberately, either as a drug of abuse or in attempted suicides.

Cases of intentional ingestion: 3

Unclear: not all Serious Case Reviews go into detail about the incident in question. How the child came to access the OST drugs may be unknown or disputed, or the report may not address this question.

Unclear: 6

Who was it prescribed for?

The source of the OST drug (which family member it was prescribed to, or whether it was obtained illicitly) could have implications for practice, so this was also investigated.

Prescribed for the mother: 9 cases

Prescribed for the father or mother's partner: 4 cases

Prescribed for both parents: 2 cases

Unclear: 6 cases

The fact that the majority of cases gave prescription details means that the families were in regular contact with a variety of professionals about their OST medication, including drug services, GPs and pharmacists. It is also worth noting which member of the family it was prescribed to; for example, a lack of focus on the safeguarding role of fathers in the family unit has been cited as a common fault in Serious Case Reviews.¹³⁸

¹³⁸ Department of Health (2002) *Learning lessons from past experience: a review of serious case reviews*

Key messages, lessons learned and recommendations

The purpose of Serious Case Reviews is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children.¹³⁹ Serious Case Reviews aim to identify the lessons learned from a particular case, and make recommendations for action which would prevent a similar event from occurring in the future. Many of the reviews contain similar messages and recommendations across a number of themes, depending on the particulars of the case. These are presented below.

Safe storage

In cases of accidental ingestion, methadone may have been stored within reach of children (Bridgend) or in inappropriate containers like baby beakers (Derbyshire, Nottingham). In the cases involving teenagers, OST medicines may not have been stored securely enough to prevent them from accessing it (Ceredigion, Staffordshire). Such incidents reflect insufficient awareness on the part of both parents and professionals of the risks posed by OST in the home.

Several reviews make recommendations about ensuring that prescribed drugs are stored safely, and that service users and professionals are aware of the risk of harm to the child from accessing drugs (Area A). Practice measures like the provision of free, lockable boxes could be accompanied by discussions

of the risks of OST medication with the service user, or messages to professionals that it is reasonable for them to ask to see the storage arrangements if children are present in the house (Gloucestershire).

Associated recommendations

- Discussing safe storage with service users (Bristol Baby Z, Nottingham, Southampton, Gloucestershire, North Yorkshire); and recording these conversations as part of routine data collection (Bradford, Gloucestershire)
- Providing lockable boxes to service users for storing methadone safely at home (Gloucestershire, Bristol Child K)
- A safety plan for the storage of methadone should be agreed with the service user and entered into the risk management plan, and a copy given to the service user and to other agencies working with the family, subject to the appropriate consent (Bristol Baby Z)
- Professional checks and awareness on safe storage (Nottingham, Staffordshire, Southampton, Ceredigion, Area A)

One review mentioned that there was a local system in place whereby lockable boxes were available, in part because a previous inter-agency management review had highlighted this as a need (Derbyshire). The system was sufficiently detailed that parents in the case also signed a document to say they understood the dangers of methadone to children. Given that there was a subsequent incident of this kind in which a child died, this suggests that

¹³⁹ Department for Children, Schools and Families (2010) *Working together to Safeguard Children Chapter 8: Serious Case Reviews*

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guidance on the safe storage of methadone and the provision of lockable boxes are not in themselves sufficient to prevent children from ingesting it.

Professional awareness

Aside from noting a general lack of professional expertise in working with problematic substance users amongst non-drug service staff, several reviews comment on their inexperience around the particular risks and challenges of OST. Parents receiving OST are likely to be in touch with a number of other agencies, including GPs, health visitors and social workers, and these professionals also have a stake in reducing the risk of harm to children.

Reviews noted the need to ensure that professionals working with substance misusers are aware of storage and toxicity issues in relation to methadone and other drugs where children are involved (Gloucestershire). Risks could be missed if professionals were insufficiently aware of the dangers of OST medicines: one review found that neither police nor social workers identified methadone as a significant risk, despite discussion of an incident where police officers undertaking a drug warrant had seen a cup of methadone next to the child's bed (Area A).

Other reviews noted a lack of clarity amongst workers visiting the family's home about what methadone looked like and arrangements for storage and disposal (Southampton). In Derbyshire this issue had been specifically addressed: a previous, similar interagency management review had apparently recommended that health visitors

check on safe storage boxes when undertaking home visits, but 'this information had not been widely disseminated to all relevant health professionals and therefore was not common practice'. The conclusion was that checking on safe storage is a collective professional responsibility, and not one that should be left to an individual service.

Associated recommendations

- Pharmacists to receive training on the signs and symptoms of methadone ingestion in children (Bristol Child K)
- There should be clear guidelines for midwives and health visitors when working with substance misusing parents...[which] address the issues of safe storage of drugs at appropriate developmental stages throughout the child's life (North Yorkshire)
- Any professional working with children and families where substance use is a known risk factor should understand prescribing options and be able to identify prescribed methadone (Southampton)
- GPs should have specific discussions with patients about safe storage and undertake risk assessments (Staffordshire C1 and C2)

The deliberate administration of methadone to children

This is undoubtedly a controversial topic. Millions of doses of OST drugs are given out every year safely and in the context of a drug treatment system which allows people with substance misuse problems to pursue their recovery without illicit drugs and all the

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dangers they entail. OST has a rightful and valuable place in drug treatment.

However, the findings of the Serious Case Reviews analysed suggest, firstly, that the deliberate administration of methadone by parents to young children does sometimes happen; and secondly, that professionals involved with the family are unlikely to account for this possibility.

For example: ‘whilst all agencies were vigilant in monitoring for neglect or harm in respect of the child, no assessment had been carried out to mitigate the risk of him actively being given prescription drugs’ (Bradford); and ‘none of the professionals involved with the family had foreseen the possibility of either child being given methadone by one or other of their parents’ (Bristol Child K). It is therefore suggested that practitioners acknowledge to themselves and service users that there are occasions when parents deliberately administer drugs, including methadone, to their children (Bristol Child K). The mother in one case indicated that she believed the practice of administering methadone to small children was not uncommon amongst some substance-misusing parents (Gloucestershire). Some reviews explicitly note that there is a need for further research and guidance around the dangers of parents giving drugs to their children (Bradford, Camden, Birmingham).

Details of interviews with the mother and father are presented in one overview report. They said they had never given any drugs to the child and

were apparently shocked to learn that some people did this, despite toxicology and hair tests showing that the child had been exposed to cannabis, crack cocaine, heroin, diamorphine and alcohol over a number of months prior to his death. Evidence was also presented during criminal prosecutions indicating that the child had ingested methadone a number of times, ‘in all probability’ as a result of being given it by one or both parents (Derbyshire). The deliberate administration of methadone to the child is also quoted as a possible reason for non-engagement with services: fear of detection may lead parents to avoid contact with services (Gwynedd and Anglesey) and this may be behind resistance to health and welfare checks on the child (Reading).

Associated recommendations

- The Health Board, in conjunction with substance misuse service and primary care staff, should consider developing a survey to determine whether the activity of administering small amounts of methadone to babies is commonplace in the community (Gwynedd and Anglesey)
- There should be local and/or social media campaigns highlighting the dangers of this practice (Bradford, Bristol Child K)
- LSCB substance misuse training should address the risk of drug using parents actively giving drugs to their children (Bradford)
- Specific recorded reference should be made on all case-notes about the toxicity and possible fatal consequences of administering methadone to children (Gloucestershire)

Drug testing for children

Some reviews mention the possibility of children being tested for drugs – again, this may be a controversial suggestion. For example, one case notes that if the child had been on a Child Protection Plan in response to the identified risks, this ‘could have included rigorous monitoring through testing [the child] for the presence of substances or alcohol’ (Derbyshire).

These suggestions may be aimed at identifying cases of accidental ingestion more swiftly when they present to health professionals: in one case, a child’s life was saved because a doctor recognised the signs of methadone intoxication despite the initial report from a paramedic (and originally from the parents) that the child had swallowed Germolene and bubble bath (Staffordshire). It may also be a way of detecting parental administration of methadone in reviews which conclude that professionals may not be able – or in a position to – tell that the child is under the influence of drugs (Bradford). In a different case, a child aged five was placed in foster care and was disruptive and unable to sleep, eat or drink; this aroused suspicions that the child was experiencing withdrawal symptoms from drugs administered by the parents. Hair tests confirmed the presence of methadone in the child’s body, but who exactly acted on these suspicions first is not clear (Area A).

Associated recommendations

- Doctors should consider a toxicology urine test as part of routine investigations included for a child’s admission when a child of parents who are known to be or have been drug users, is admitted to hospital with an acute illness. The number of tests taken and the number of positive results should be collated and reported to the LSCB after 12 months (Gwynedd and Anglesey)
- When A&E responds to reports that a child may have ingested methadone or another noxious substance, as a matter of routine other children in the household should be taken into hospital to be checked (Birmingham)
- A ‘control/monitoring’ measure for testing babies and young children for the presence of controlled drugs in high risk categories should be considered (Bristol Child K)
- Give consideration to the possible drug testing of young children (Bradford)
- Explore the feasibility of commissioning tests on all children who are the subject of Child Protection Plans and whose parents are known substance users (Derbyshire).

Prescribing and dispensing

Several reviews made reference to the impact of prescribing decisions on the case, or suggested amendments to local practices to minimise the risks of OST drugs to children. As an overall point, it was suggested that the quantity of methadone in any household with children should be reduced to a minimum (Bristol Child K).

At the discretion of the prescriber, OST drugs are available in 'take-home' dosages. This is generally (but not always, as evidenced in some reviews) contingent on positive engagement with treatment and consideration of safeguarding concerns. This can help people in recovery pursue other activities, interests and responsibilities, including employment and childcare, without having to attend a pharmacy every day to take their medicine under the supervision of a pharmacist. If there are concerns about safe storage, risks to children, 'diversion' of drugs into the illicit market or continued and unstable drug misuse, supervised consumption in the pharmacy is generally advised; this is also good practice for the first three months of OST treatment. It is noteworthy that when there are concerns about children, 'take-home doses may be permitted but the dose taken home limited by frequent dispensing'.¹⁴⁰

Although OST drugs can be diverted into the black market, none of the SCRs overtly suggest that the drug ingested by the children was present in the household without a prescription; cases involved OST drugs prescribed to the mother, the father (or her partner) and both. In a few cases the prescription details are unknown or not given, including a case of ingestion at a grandparent's house (Buckinghamshire). Some reviews potentially concerning prescription arrangements, including one where the mother and her partner had been able to collect each other's methadone (Bristol Child K); and another where the mother's prescription was

split between supervised consumption and take-home doses, but 'no mention of the rationale for splitting the dose was documented and there is no record of safe storage being discussed' (Derbyshire). One review concludes that if supervised consumption is required for one parent in a family, then it should apply to all members of the household (Bristol Child K).

Associated recommendations

- Review dispensing regimes for parents generally, those with children under a certain age or 'high risk individuals' (Birmingham, Bradford, Bristol Child K, Camden, Derbyshire)
- Review take-home prescriptions for parents every three months (Staffordshire 2008)
- There should be regular and systematic review of patients' intake of methadone assessed against their prescribed dosage (Staffordshire C1 and C2)
- Prescribers should regularly ask their patients about their contact with any children and review the prescription in the light of this or new information (Derbyshire)
- Review or develop the guidance for pharmacists and specialist workers who are prescribing drugs for adults who care for children or live in the same household as children. This should include the need for safe storage and ensuring that there is a valid script in place before prescribing drugs to those who misuse substances (Nottingham).

¹⁴⁰ Department of Health (2007) *Drug Misuse and Dependence: UK Guidelines on Clinical Management*

Parental substance use

The risks posed by OST are not singular in households where parents use drugs; they form part of a wider web of vulnerabilities for the children. In a number of reviews, a lack of perception of risk around methadone was just part of a more general lack of awareness of the risks presented by parental substance use (Bridgend, Gloucestershire, North Yorkshire, Plymouth, Reading). A lack of understanding of the risks presented by parental substance use could in turn contribute to another hallmark of Serious Case Reviews – a focus on the needs of the parents rather than those of the children (Southampton, Staffordshire 2008). SCRs concluded that ‘the impact of two drug abusing parents caring for children was completely missed’ (Birmingham), and said that professional focus was all too often on the immediate needs of the adults and not on the impact the adults’ behaviour was having on the children (Gloucestershire). If parents are not in treatment then risks to children can be heightened, as recognised by the suggestion that non-compliance of parents with drug treatment programmes could have been set as a measure to re-refer the child to social services after the case had previously been closed (Nottingham).

As well as professionals being more considerate of serious risks to children when parents use drugs, there was also a stated need to undertake assessments of children living with drug using parents even where the significant harm threshold does not appear to be met (Staffordshire C1 and

C2). This risk awareness can extend beyond the child’s birth parents: one child ingested methadone at their grandmother’s house, and the review found that risks presented by contact with extended family members was not taken into account by professionals (Buckinghamshire).

Associated recommendations

- Children’s services should review training provided on the impact on children of parental substance misuse, particularly in respect of lifestyle issues (Bradford)
- The Drug and Alcohol Action Team and Safeguarding Children Board to commission training for professionals in recognising drug use by both parents/carers and the impact on their children (Birmingham)
- Social Services review their inter-agency approach to drug misusing parents who are considered to be neglecting their children, and provide further training for professionals involved in the inter-agency network (Camden)
- The child protection committee to review procedures relating to substance misusing parents and the impact on children, and review training available on these (North Yorkshire)
- The revision of Hidden Harm guidance becomes a strategic priority for the LSCB (Staffordshire C1 and C2)
- Police should participate in agency training/awareness raising about parents who misuse drugs and the risk to children (Southampton)



- Team Managers need to ensure that assessments undertaken in relation to drug using parents have allowed sufficient exploration of the potential risks to children (Bristol Baby Z)
- Designated staff from Adult Health Services, Vulnerable Children’s Division and Police have access to relevant, targeted training on domestic abuse and substance misuse and the safeguarding consequences for children, as this case demonstrated a lack of practice knowledge in these areas (Staffordshire 2008).

There was also some evidence of good practice in this area. In one review, it was noted that a substance misuse worker proactively challenged the mother about her children’s whereabouts when she used drugs (Derbyshire); and treatment staff picked up the child and held her on their knees when she was brought into the service by the mother, to check on weight and wellbeing (Reading).

Professional curiosity and challenge

In some cases, risks to children could be both magnified and extended by a lack of professional recognition that parents were not making progress in improving the safety of their children: practitioners could demonstrate a level of optimism that was not reflected in significant positive changes in the family situation or for the children (Bristol).

There could be a reliance on self-reported information from the parents which obscured the real problems (Bridgend, Derbyshire), ‘disguised compliance’ with services and a willingness to accept parents’ ‘reassurances and excuses’ (Birmingham). Misplaced belief that the mother was ‘clean’ from illegal drugs erased questions about the impact of substance use on parenting (Gwynedd and Anglesey), and risk factors were minimised as time went on rather than remaining a consistent thread in the case (Buckinghamshire). Concerns raised by extended family members and friends about the parents’ ability to safeguard children may not be acted upon, and agencies may have been aware for several years of the nature of the parents’ drug misuse (Plymouth). The terms of reference for one review made explicit reference to this issue, in aiming to investigate ‘the extent to which work with adults in the household was conducted in a sufficiently challenging way’ (Reading); another review noted that practitioners need to improve their ability to challenge families and challenge each other in multi-agency settings (Bristol Child K).

In response, reviews spoke of the need to guard against the ‘rule of optimism’ on the part of professionals (Bristol Baby Z, Gwynedd and Anglesey); to treat information given by drug misusing parents with caution (Camden); and for practitioners to be prepared to ‘think the

unthinkable', ie that the child could be given drugs by their parents (Bradford). One SCR noted that 'professionals not routinely asking parents who misuse substances if they have ever given their children illicit substances' was a common finding of similar case reviews (Derbyshire).

As well as general comments about over-optimism on the part of professionals, there were also cases of insufficiently robust reactions to clear risk factors: no agency took action over hazards in the home such as dirty needles, unknown visitors or drug dealing in the house (Bridgend); and 'professionals failed to...take effective action and this meant the response to the obvious risks posed to the children was completely inadequate' (Birmingham). More specifically relating to OST, one review stated that the parents had to be given 'numerous reminders' by professionals to obtain a lockable box for methadone, apparently without the failure to act resulting in any sanction or change in dispensing arrangements (Bristol Child K); and in another area, there were concerns from early on by professionals visiting the home that the mother was not sufficiently safety conscious, yet the incident in the SCR suggests that sufficient safeguards were not ensured despite the assurances of the mother (Camden). As well as not challenging the accounts of parents, there were also cases where a lack of cooperation with services generally did not lead to attempts to safeguard the child, and they were left in an 'abusive situation' longer than necessary (Area A).

Associated recommendations

Though optimism and lack of professional challenge were themes common to a number of the reviews, they was not represented as frequently in concrete recommendations.

- The DAAT should work with treatment providers to ensure staff are offered regular and challenging supervision which will enable them to develop their interview skills in relation to asking challenging or difficult questions (Southampton).

There were, however, a number of recommendations concerning the effective engagement of families who are actively resistant to support from local services. For example:

- Guidance on working with highly resistant families should be developed (Staffordshire)
- There should be training opportunities for practitioners and managers/supervisors in partner agencies about how best to work with avoidant and resistant families and which provides an understanding of barriers to parental engagement (Area A).

Information sharing and partnership work

'Working together' is a central feature of all Serious Case Reviews, regardless of how the child has come to harm. Cases involving OST are no different in this respect, and common failings relating to partnership work and information sharing were widely noted. There were many cases where safeguarding

information relevant to OST prescriptions was not passed on, and take-home prescriptions continued to be given in ignorance of key pieces of information. In one case, the father in the home had previously been found to be 'hoarding' methadone, but the GP was unaware of this and continued to prescribe take-home doses (Staffordshire); in another, the mother's partner died of a methadone overdose just weeks before the child, but this information was not acted upon (Southampton); and in another, GPs interviewed for the SCR expressed 'surprise' that the mother was allowed to take home her methadone, having assumed that it was being taken under supervision at the pharmacy (Derbyshire). More generally, several cases noted that substance misuse expertise was missed by other professionals due to poor attendance at multi-agency meetings and child protection conferences (Bradford, Bristol Child K, Camden, Nottingham, Derbyshire, Reading).

Associated recommendations

As with the lack of professional challenge (see above), this issue was a feature common to many reviews without necessarily being converted into recommendations. This may be because these issues are matters of professional skills and organisational culture, so are difficult to target with specific, individual actions or measures like the introduction of new protocols.

- Substance use professionals must identify those adults who are parents, or who have regular care giving access to children, and share the information with Children's Social Care as early as possible (Buckinghamshire)

- The LSCB should audit the participation of all relevant child protection agencies and consider how to ensure meaningful collaboration and joint working with families where parental substance misuse is an issue (Reading).

National policy

Some reviews recognised that the incident they investigated was not necessarily isolated, and noted that action outside the local area may be appropriate. Investigations as part of the Bristol Child K review found that between 2003 and 2011, five children were admitted to hospital in Bristol after ingesting methadone; and another child's death was classed as 'not completely unpredictable, as children elsewhere have previously died from methadone overdoses in similar circumstances' (Camden). One review in particular – the most recent studied during this research, in Derbyshire – even included a summary of similar case reviews as part of its terms of reference; a 'paucity of such research' was found on this 'growing and important significant risk indicator for children'. As this research demonstrates, rare incidents at the local level can represent a much more noticeable pattern when seen from a national standpoint.

Associated recommendations

- Department for Children, Schools and Families to commission a study of the risk to children of parents/carers who ingest methadone and to circulate an analysis of Serious Case Review findings where this has been a feature (Birmingham)



- The LSCB to write to central Government regarding the apparent need for further research and guidance around the dangers of parents giving drugs to their children (Bradford)
- The Department of Health is invited to review the safety of the presentation of methadone for home prescription, bearing in mind the safety of children (Camden).

A low priority for OST learning

It is important to note that Serious Case Reviews do not always aim to discuss the specifics of a single event in which a child has come to harm: they investigate the context of professional engagement with the family, with a view to discovering what could be done better and preventing similar episodes in the future. Indeed, previous research undertaken by the Government has found that ‘local overview reports often provided insufficient information to achieve a clear understanding of the case and the incident which led to the children being harmed or killed’.¹⁴¹ Some of the cases in this research fit this description, and spend little time analysing the ingestion incident itself. In many cases it did not appear that drug treatment services had been asked to contribute to the findings of the review, nor were they represented on Review Panels. Consequently, low priority was sometimes given to the OST-specific elements of the cases.

For example: ‘it is not the role of the review to investigate the circumstances under which the child was able to access the contents of the container

in which the methadone was stored’ (Bridgend). The author goes on to state that ‘this has already led to changes being implemented immediately in order to prevent a repetition of a similar incident occurring’; however, no detail is given on what these changes are or what actions have been taken. The conclusion is that ‘the responsibility for ensuring the methadone was adequately secure and not accessible to a young and unsupervised child in the home lay with the parents’; this sentiment probably explains why the review does not put forward any ‘lessons learned’ or recommendations relating specifically to OST. In this particular case, media reports show that police found 76 bottles of methadone in the home, of which 42 were determined to be within reach of children, and 25 empty.

In another case, a child died after ingesting methadone at his maternal grandmother’s house. A ‘rigorous’ police investigation followed, but could not conclude how the child had ingested the methadone. Despite over 40 recommendations being listed, none concern OST specifically (Buckinghamshire).

Similarly, a case in Ceredigion (Child V) centred on a 15 year-old boy who took a fatal overdose of methadone. With little information forthcoming from the Serious Case Review, news reports were sourced which revealed that it was his father’s methadone which was not being stored securely. The Serious Case Review ‘endorses the recommendations made

¹⁴¹ DCSF (2008) *Understanding Serious Case Reviews and their Impact: a biennial analysis of serious case reviews between 2005 and 2007*

by the agencies in their individual management reports' (the reviews from individual agencies which feed into the Serious Case Review) but does not state what these are, or whether they address the OST issue. In another Ceredigion case (Child Z), a 17 year-old girl's cause of death was due to inhaling vomit after taking 'heroin and other drugs'. It is not specified what these drugs were, but the safer storage of methadone in supported housing is one of the report's recommendations, indicating that it was a concern. But no other mention of OST drugs is made in the report, and it is not clear in what way they were involved in the death.

Recommendations: summary of themes

- Providing lockable storage boxes for methadone, monitoring their use, and undertaking and recording safe storage discussions with service users
- Reviewing or restricting the availability of take-home OST for parents
- Investigating and counteracting the practice of parents deliberately giving young children methadone as a soother
- Performing toxicology tests on the children of substance users, either when admitted to hospital or as a routine practice
- Training for practitioners including pharmacists, midwives and health visitors on OST, safe storage and signs of ingestion in children
- Requesting further research on the extent and nature of these cases by central Government

Conclusions

Though the cases share a common risk factor in the form of OST drugs, there are differences between many of them which prevent any one 'eureka' conclusion about managing the risks of OST drugs to children. SCR conclusions range from barely addressing the OST ingestion incident at all, through to a complete overhaul of the local prescribing system and the implementation of numerous new measures. It is hard to say whether any one change would have prevented each incident from happening: however, there are some overall points of learning.

In each case, either **parents, professionals or both were insufficiently aware of the dangers that OST drugs pose to children**, especially those of a very young age; or if they were aware, they did not implement sufficient safeguards to ensure that children were not exposed. Messages on the dangers of OST medications weren't transmitted, didn't get through, or were ignored. **This is especially true of methadone**, which was responsible for the vast majority of the cases, all of those involving very young children, and all of those involving the intentional administration of drugs to children.

Particular attention should be paid to areas which supposedly had safety measures already in place, but which were not complied with. Many of the reviews mention the known dangers of OST drugs, or reference local systems already in place to manage risk, such as discussions over safe storage or the provision of lockable boxes. However, such measures were clearly insufficient in themselves to



stop the incidents from happening. In turn, this calls into question **whether the measures proposed in each Serious Case Review to stop future incidents from happening will be effective.** Whether local changes have had the desired effect is difficult to ascertain, given that incidents are rare in the first place, and identifying ‘near misses’ or non-events is naturally problematic. Many recommendations would constitute ‘new’ practice in each area, but the SCRs showed **little reference to existing national guidance** (including NICE), which already explains the responsibilities of professionals to recognise the dangers to children when working with OST clients.

The fact that many ‘lessons learned’ and recommendations are mirrored across different areas and different years **brings into question the extent to which these cases have been learned from on a national level.** For instance, both the earliest and most recent cases examined for this research (Camden, 2003 and Derbyshire, 2013) recommend a review of the arrangements for take-home prescriptions for parents of young children, as do several more reviews in between. Promoting national rather than purely local learning in relation to the specific risk factors of OST could help prevent future incidents.

More alarmingly, there is also evidence that even **local learning has been lacking in relation to OST cases,** given that several of the reviews mention previous, similar incidents. The Derbyshire review for Child BDS makes reference to a previous Interagency Management Review, apparently on a similar case; Bristol produced two reviews in the space of four years (Baby Z and Child K), both of which involved the ingestion of methadone by young

children; and Staffordshire also undertook two Serious Case Reviews involving methadone, in 2008 and 2010. Despite the very specific cause of harm or death, **input from drug treatment services or experts in the field was not consistently sought** in conducting the reviews.

Given the specific nature of the cause of harm, **any one of these cases could have triggered a national review.** In fact several of the SCRs called for this, apparently to no avail. With 17 Serious Case Reviews in the last five years, the need for such a review is overwhelmingly demonstrated. Learning from Serious Case Reviews involving OST medications is arguably more transferable than other SCRs which do not share such an individual, identifiable cause of harm or death, and are focused on more broad or nebulous failures like ‘breakdowns in communication’ or ‘partnership work’.

Whilst this review has aimed to provide as much detail as possible, **it is unfortunate that full overview reports are not available:** the move to mandate their publication is to be welcomed and will support learning on both national and local scales. Hopefully this will go some way in correcting one of the frustrations of this research, which was that some Serious Case Reviews covering incidents of OST ingestion by children spend next to no time discussing its dangers or making relevant recommendations (at least in their executive summary versions). Publishing overview reports should mean that they make a real contribution to awareness and knowledge of the risks of OST, and can be recognised and debated by a wider audience.

Part four: Interviews, focus groups and roundtable discussion

Part four: Interviews, focus groups and roundtable discussion

Eleven semi-structured telephone interviews were conducted with a range of experts including representatives from drugs services, family services, GP surgeries, pharmacies, Local Safeguarding Children Boards and others. Each interviewee was asked similar questions (included in the prompt sheet in Appendix II), but the interviews were also dynamic, responding to the issues and discussions raised by the interviewee. Many of the interviewees had been involved in incidents of children being exposed to OST medications, either as a provider of services or within an SCR process.

Two focus groups were conducted in different areas of the country with 15 practitioners and managers based in drug services. Participants were asked to comment on their understanding of, and experience with, the issues surrounding OST drugs and the safeguarding implications for children (the discussion prompts are also included in Appendix II). Finally a roundtable discussion with 11 policy experts, service user representatives, regional managers and health service representatives was held.

All interviews and group discussions were recorded, transcribed and analysed thematically to identify common themes. To protect anonymity, interviews and group participants are not identified by name. The findings are presented below.

Safe storage

Many of the interviewees discussed the provision of lockable boxes to store prescribed medication. Although this wasn't a consistent approach identified by everyone, some interviewees mentioned Local Authorities or service providers which had made the provision of safe storage boxes mandatory for all clients prescribed OST medications.

Practitioners in both focus groups adhered to a protocol of the free, blanket provision of lockable boxes for clients with children; this was set at a central level by their employer, a large treatment provider. The provision of the lockable boxes was accompanied by a number of complementary practices, including discussions and the provision of leaflets about the need for safe storage, and home visits for parents with children under five to check compliance. These measures all formed part of the organisation's internal database system, which also recorded what medications a client was prescribed and in what instalments. As one practitioner remarked:

"It's not just a case of you give [the medication] to them. They need to understand why, what the storage is... so, they are spoken to about where they store [the drugs]. There's a form that they sign, so they agree that they understand what we are talking about."



Being rooted in an organisational policy, based on avoiding previous events where children have come to harm, was said to add legitimacy to these conversations and help to explain the worker's duty of care without sounding accusatory or making the parents feel like the assumption was that they'd be unsafe.

The provision of safe storage boxes was seen as a positive basic step in providing parents with the practical tools they needed to ensure their medication was stored securely. However, almost all of the interviewees felt that although this was a very positive action, it was a simplistic answer to an issue which was much more complex:

"I think the focus is often on safe storage of medication but I think that's not particularly nuanced."

"If I had a lockable box I'm sure I would sometimes forget to put [the medication] in. † I think that locked boxes are useful – I am not saying don't do it – but what that family did [in a case they had experience of] † no safeguarding policy would cover that."

"People look for solutions but often the solutions aren't simple."

Interviewees also pointed out that the provision of safe storage boxes was not consistent across all Local Authorities or service providers. In some local areas the provision of boxes was made mandatory following a Serious Case Review recommendation and in others, Local Authorities opted to provide

boxes due to a budget surplus, with no guarantee this would continue as standard practice in the future:

"Both of our services do give out and encourage service users to use the secure storage boxes. In [Town X] that seems to be something they are pretty hot on, and when professionals go out and visit they check on safe storage arrangements, but in [Town Y] they said that actually they only started to get boxes as the Drug and Alcohol Action Team [DAAT] had an underspend. So I said, "are you confident that if the supply ran out of the boxes, could you still go to the DAAT and say we have run out, can we have more money?", and they said they don't know."

The lack of a consistent approach left some interviewees questioning the consensus on providing safe storage boxes and the commitment to this measure in practice. It also meant there was a lack of clarity for service providers as to what the expectations are in their local area. Some interviewees pointed out that if the provision of safe storage boxes was considered a positive or necessary step for clients prescribed OST in one area, it would be reasonable to suggest it would be important in all other Local Authorities too.

"We introduced lockable boxes in [Town A] † and then there was an anxiety that if we had a child ingest methadone in [Town B], that's going to look terrible – why are you giving them out in [Town A] but not [Town B]? You know, so lo and behold, we have spread it across all our services."



Interviewees also raised concerns that the provision of safe storage boxes gave some practitioners and services a false sense of security, a sense that the job of risk management was complete and that the issue had been addressed:

“I think when we focus on the [storage] box to lock it up, we tick a box that makes us feel better but it doesn’t necessarily improve safety for a child.”

One practitioner from a focus group also noted that addressing *disposal* was as important as discussing storage, having seen “[methadone] bottles put under bushes”. Another participant suggested that clients be compelled to return their used bottles to the pharmacy in order to reduce this particular risk. Such comments highlight the possible ‘loopholes’ in simply having a conversation about safe storage and then considering the matter closed.

Interviewees also discussed the impact of the domestic chaos that often comes with drug use and that whilst the provision of a box was seen as preferable, it was not necessarily an indication that it would be used by the client consistently. Some parents in treatment require basic support around their parenting skills and how to develop healthy family functioning prior to any considerations of safe storage of medication being understood. Whilst services can be confident that they can provide the storage box, they cannot be sure that the box is used consistently and the parent is able to assess the risks of not storing their medication appropriately.

“Many service users are known to have chaotic lifestyles. They are probably not going to be the most reliable when storing their drugs in a locked box, making sure it is locked and out of the way of the kids, especially if they have to use it regularly. It’s about organisational practices and if your life is a bit haphazard, remembering to do things like that may not come so easily.”

Prescribing and dispensing

Another popular proposed solution to the problem of children ingesting OST medications has centred on the introduction of mandatory supervised consumption regimes for parents, aiming to eradicate risk by taking OST drugs out of the household entirely.

Interviewees discussed cases where Local Authorities or services had responded to the perceived risks, or to particular cases, by making it mandatory for any parent of a child under five to be prescribed their medication using a supervised consumption regime; one roundtable attendee also came from an area where OST clients with children under five on a Child Protection Plan were not allowed to take OST medication home except where pharmacies were not open seven days a week.

As explained in the Literature Review, clinical guidance states that supervised consumption should apply for the first three months of substitution treatment; this is then subject to review, based on engagement with treatment and identified risk factors (including children in the home). How



effectively this guidance is translated into practice, however, is harder to ascertain, although one worker from a focus group explained that every three months clients are asked questions including ‘do any children visit the house?’ and ‘do you visit any houses where children are present?’.

Some interviewees felt that there was a lack of clear, specific guidance for practitioners to follow on what safe prescribing looks like for parents receiving OST; this could also add to a lack of professional confidence about how to deal with it. There were reported to be inconsistencies in terms of which factors did and did not influence prescribing decisions in a local area: a focus group attendee said, for example, that if a client begins drinking heavily, one organisation’s policy could require they return to a daily pick-up regime, whilst another professional might say, “well, the drugs are being stored safely,” and continue to allow take-home doses. More specific guidance was called for, including examples of good practice, how risks have been minimised, and how compliance with prescribing regimes has been improved.

One practitioner at a focus group said the “default” at the three-month stage is to remove clients from supervised consumption, unless there is a “real safeguarding issue”; accurate assessment of risk is therefore critical. The worker estimated that around 20% of their clients would remain on a supervised

consumption regime, mainly due to safeguarding concerns or mental illness. An audit of 15 cases where it was decided the client should remain on a supervised plan revealed that four were due to safeguarding concerns; but as is often the case in this complex area, applying such judgement consistently and safely on a national scale would seem very difficult.

Opinions on the use of stricter supervision regimes were somewhat mixed amongst the interviewees. In practical terms, whilst some felt that it would not eliminate risks from illegally acquired OST drugs, it could also offer practitioners and providers some comfort in minimising risks. It could also offer more regular opportunities to engage with the client in pharmacy settings, build a productive relationship and undertake ongoing checks on the general welfare of the child, if they accompanied the parent. However, significant disadvantages were reported, and it was felt that this kind of response could be viewed as draconian for parents who are trying to engage and progress in their recovery:

“That regime could be seen as punitive from a parent’s point of view”

“Supervised consumption may risk the engagement of the client. The progress through the prescribing regime is used as a carrot to encourage progress through treatment into recovery. The people who would drop out of treatment and stopped picking up would be the ones we are most worried about.”

Reactions were similar in the practitioners' focus groups. One worker admitted they would rather no take-home doses be given to clients with children, even where safeguarding risks had been classed as low: in one case, a family were allowed take-home methadone despite using significant amounts of illegal drugs, on the basis that they used an 'injecting room' to use the drugs and stored their prescriptions securely. Another worker admitted feeling conflicted over the issue, saying that to "absolutely prevent" accidental ingestion occurring, it was necessary that parents be put on a supervised consumption plan, but acknowledged the "disengaging effect" this could have on the adult in treatment. Focus group participants were all from areas which had not introduced the practice of mandatory supervised consumption, so it would be interesting to find out whether concerns over engagement have been realised in areas which have tightened their practices.

It is important to note that disengagement from treatment has wider consequences when the service user is a parent. Treatment is a protective factor for clients' children, and parental disengagement can therefore have a detrimental impact on their dependants too. It may be understandable, therefore, for practitioners to be more reluctant to jeopardise their relationships with parents than with other service users. One interviewee recounted

an experience with a client who had experienced some ill-informed and punitive decisions from the agencies she was working with and therefore withdrew from all interactions and disappeared, leaving the child at potentially greater risk.

As well as possible harms to engagement in treatment, more administrative arguments were put forward against the introduction of supervised consumption for parents; these mirrored the drawbacks identified in the *literature review*. Depending on the nature of the local area, it may be difficult to make seven-day dispensing available to all clients who need it, and clients may struggle to attend a pharmacy every day if they are pursuing other recovery goals like job-hunting. Ironically, given the aims of a supervised consumption policy to protect children, parents with very young children may find it more difficult than others to attend a pharmacy daily. Some focus group attendees said this might lead to service users seeking OST drugs on the black market, without any safeguards at all: this would be a significant unintended consequence with precisely the opposite effect from the aim of the original policy.

This issue – and the possible efficacy of supervised consumption regimes overall – was complicated by the consideration of family members other than mothers, to whom safeguarding discussions are often limited. Fathers, partners and wider family members were discussed at the focus groups and



whilst practitioners confirmed that both parents are taken into consideration when looking at the use of supervised consumption, one worker explained that men in services are more “transient”, can move around more and change their relationship status quickly. In such cases, services can be unaware of men’s connections with children:

“...we might assess a man at a point in treatment when he is single, [with] no connection to any women or any children and then, very quickly, he can be in a situation that we would class as a risk, and just as quickly, he can be out of it.”

If the aim of a supervised consumption regime for parents is to eliminate the presence of OST drugs in households where children are present, then it stands to reason that the logic should extend further than just mothers, to anyone else who might use or store such substances at the house (mothers’ partners, for example) or whose houses children are likely to attend (such as grandparents or other extended relatives). Whilst mandatory supervised consumption may look like a simple catch-all policy, such considerations make achieving its aims rather more difficult, and reintroduce questions of professional capacity and nuanced risk assessment.

As with the mandatory supply of lockable boxes, some felt that whilst supervised consumption would potentially be useful in reducing risk, it also attempted to simplify a more complex safeguarding issue: “to me, it’s a very simplistic, reactive way of doing something.” Similarly, it was suggested that

such changes risked removing responsibility from the parent and placing it on the drug treatment system in a way which focused more on compliance with systems than on the needs of the child. By focusing on such practical actions, local areas risked reducing the impetus and confidence of the workforce to be alert to the risks associated with OST.

Intentional administration

Despite generally high levels of professional awareness about the dangers of OST drugs to children and the common measures to protect them from ingesting it, the matter of intentional administration of drugs to children was evidently less familiar to interviewees and the practitioners in the focus groups. Many found the findings from the Serious Case Reviews quite surprising. Deliberate administration was a difficult concept for some to accept and presented much thornier questions for workers in terms of addressing the practice with clients. It was recognised that attempting to eliminate these incidents has different implications for practice from cases of accidental ingestion, and could require a different set of measures to minimise risk.

Some interviewees felt that practitioners struggled to contemplate that their clients would behave in a way so unthinkable to them, and therefore the topic was never addressed directly; one said they “couldn’t have dreamed” their clients would engage in this practice. Discussions about the toxicity of methadone to a child and the use of it as a pacifier were not routinely considered within assessment



or keyworking interventions because practitioners and managers struggled to believe that this practice went on within their client group:

“As a GP I had never thought about it in the 30 years I have been working with drug users. I have never thought about a client using methadone as a soother.”

However, one interviewee had knowledge of a case involving intentional administration, and cited a lack of awareness about the practice:

“There would have been ‘positive regard’ for the client that meant [practitioners] ruled out the unthinkable and it [the incident of OST ingestion] was intentional, so it was even more unthinkable.”

Conversations with service users about intentional administration were reported not to take place, partly because of a belief that clients would already know how dangerous it could be. However, some interviewees and focus group attendees mentioned links to the historic use of unsuitable substances to pacify unsettled children, including whisky and laudanum, and said they’d been thought of as acceptable in the past. One service user representative also noted that opiate users often feel they know more about the use of opiates than practitioners, through their own lived experience: they may feel relatively confident in administering a small amount to a child, and having begun the practice of using it as a pacifier, may become increasingly bold in doing so. Not understanding the risks in reality was mentioned by one practitioner:

“I’m sure it happens – [service users] not understanding that a small amount [of OST medication] can kill, and giving it to children purposefully.”

Low levels of awareness of this practice meant that intentional administration was not covered in information leaflets provided to service users on the dangers of OST to children:

“The safe storage of methadone [information], it doesn’t say ‘and be aware you should never use it as a pacifier,’ you know, in simple straightforward words... it just says ‘always lock your methadone in a safe place,’ but it doesn’t specifically inform or educate the parents or remind them that this is a very dangerous thing to do.”

Addressing this issue in professional practice was subject to some debate. Some interviewees felt that messages about the use of OST drugs as pacifiers required loud, explicit communication from the outset as a warning to parents, but focus group practitioners expressed fears that such candid conversations would be difficult to undertake without sounding accusatory, and could potentially damage the relationship between worker and service user, especially early on:

“When it comes to saying ‘would you deliberately give your child methadone?’ – I think the idea would be abominable to staff and therefore, I don’t think they would be able to resourcefully communicate or raise the question.”

Some practitioners thought that properly conveying messages about the dangers of OST drugs could perform the dual function of ensuring safer storage and also discouraging any deliberate use. Different ways of framing the issue were also put forward, like using an external example from a Serious Case Review to demonstrate the dangers of OST to children rather than presenting it as an identified risk for the individual client. Another indirect way of addressing the issue was to address the motive of the administration, ie to pacify an unsettled child: practitioners could therefore ask about the child's sleeping pattern and how this was affecting the parents, with the aim of identifying any concerns and helping to address them at an early stage in a protective, supportive way.

One interviewee talked about the need for practitioners to have a "personal acceptance of the reality" of the behaviours of their clients and the impact they have on the child. Accepting that poor parenting practices may take place does not equate to breaking down a positive relationship between worker and client, but means that practitioners can be aware of what can happen and work alongside the client to safeguard against risk. By fully appreciating the reality, practitioners are able to approach the issue in a way that isn't punitive but allows a compassionate view which holds both the adult and child in mind when making important decisions.

Professional curiosity and challenge

Reviews of cases where children have ingested OST often find that risk factors over time were missed or minimised by services working with the family; this applies to OST-specific risks like unheeded reminders about safe storage, and more general concerns about the wellbeing of the child or the progress of the parent in caring for them. As a result, a common suggestion is that practitioners need to be more robust and challenging in their work with substance using parents.

Although initiating conversations about giving OST drugs to children could be seen as a bridge too far by practitioners in the focus groups, many of the interviewees commented on the need for the workforce to be inquisitive and challenging with prescribed clients around safeguarding issues. It was felt important for practitioners to consider and ask questions around safe storage, to consider the presentation of the parent and the child, their willingness to review supervision regimes and engage in discussions around risk. Some interviewees remarked that practitioners wanted to see the best in their client and trust what was being reported to them; this was mirrored by focus group attendees, who noted a tendency to "champion" the drug user by believing that "she's such a lovely mum, she loves her kids" and therefore overlooking some potential risks. The same effect was observed where positive progress *in* treatment was taken as an automatic indicator of progress *outside* treatment, and a reduction in safeguarding risks.

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Whilst in the large majority of cases the client may indeed be telling the truth about their circumstances, some felt that practitioners needed to maintain some scepticism in their practice. Many interviewees felt that Lord Laming’s terms ‘healthy scepticism’ and ‘respectful uncertainty’ should be maintained by practitioners in their work with clients.¹⁴² Some Serious Case Reviews illustrate a catalogue of evasive or dishonest behaviours by parents; in the light of this it is important that practitioners keep an open mind and to test out all concerns and explanations given:

“Never believe everything, but that doesn’t mean you don’t give them regard.†‘Healthily sceptical’, we try to promote that, so we’re always are a little bit sceptical, and we try very hard not to collude [with parents].”

“They hide the risks, they minimise them to staff and they tell staff what they think the staff want to hear.”

“The whole quality of keyworking issue, you need therapeutic skills, properly trained staff, because you have to have people who can engage with difficult stuff. Not just the right attitude but the willingness to be sceptical.”

Cultivating professional scepticism in practice is much more difficult than highlighting it as a need, and focus group participants felt that workers – and

new staff in particular – may not want to appear too forceful and risk the disengagement of service users from treatment. One worker said it would require a “significant piece of work” on healthy scepticism to make such challenge commonplace, and to ensure workers could use it in a sensitive manner. Framing questions in the right way was said to be integral to facilitating positive communication: it was suggested, for example, that rather than asking directly to check the storage of OST medicines, or enquiring about the child’s school attendance, it would be preferable to say; “so tell me about your day,” from which point it is the responsibility of the professional to apply their own curiosity and techniques in driving the conversation in the appropriate direction.

“...it is about people trying to dig deeper and break those questions down; trying to get those clients to reflect on where they are at and how substances impact on them.”

Another practitioner agreed that applying ‘professional curiosity’ to the issue of OST was about more than a new set of questions to ask service users:

“I think what we do recognise is that you can have a client, and have a form, and be reading these questions out to a client, and just getting tickbox answers. It’s actually trying to get beneath that, and trying to get people to think in terms of that culture shift of our staff†that it’s not just the adult

¹⁴² Lord Laming (2003) *The Victoria Climbié Inquiry Report*

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you're working with, it's the child. If there's a child around, the child takes priority over the adult. They can choose to walk out and leave treatment, but someone's got to make sure the child is okay."

It was also remarked that:

"I think we make it so complicated and technical and highbrow; pages and pages of data, that actually, what we've done is petrified the workforce. If we take it back to the simplicity of the basic principles: if you see something [concerning], don't sit comfortably silent – talk. If we do that all the time, actually what we've found [is that] safeguarding improves."

General consensus suggested that some workers are comfortable in engaging in these conversations and applying a healthy sense of curiosity and do so regularly, but that this varies and depends on the individual worker. Thus, it is important to ensure staff training and education focuses on building confidence and competency around addressing the issue of child safety, and creating and maintaining an open, direct, and positive relationship with clients.

Seeing the child

Another issue in cases involving OST ingestion is that the welfare of the child can be overlooked by services like drug treatment agencies whose primary function is seen as working with the adult. OST ingestion is a very specific risk, but it also sits

alongside a number of other concerns for child welfare. Treatment workers at the focus groups were aware of the need to view the situation from the child's perspective as well as the parent's.

One interviewee discussed a case where their client had been 'hoarding' methadone but their assessment of that risk had only considered the impact on the adult – ie overdose – and not the risk presented to child in a household containing large quantities of methadone. "Not really thinking about what risk means so far as behaviour and the ability to be safe around children is concerned" could be a problem for practitioners. Being preoccupied with guidelines and written questions can mean the wellbeing of children is not prioritised, and signs that something may be wrong can be missed. As one practitioner explained:

"Quite often when we get into protocols, forms and risk assessments, what we do is stop people thinking and allowing them to do what needs to be done urgently. 'Here's the baby, I've never seen it before, so, rather than asking about hepatitis, I'm going to look at the baby...'"

Several Serious Case Reviews – having found in post-mortems that drugs had been ingested or administered over a period of time – mention the possibility of drug testing children in 'high-risk' categories; it is unclear if any area has actually introduced such a policy, and the ethical drawbacks

are clear. Without testing, the difficulties of recognising the ingestion of drugs by children, rather than just risk in their situation at home, were fully appreciated at the expert roundtable discussion, with one general practitioner saying it is almost impossible to tell, short of examining the child's pupils. However, a number of other ways in which professionals can undertake general welfare checks on the children of drug users were discussed in the interviews, focus groups and roundtable.

Responses to the question of children being allowed on the premises of treatment services were mixed. Practitioners said policies could vary between different services and over time, and that a greater degree of clarity would be welcome. In the interviews, a number of overarching reasons for this were put forward, including insurance issues, the suitability of drug treatment premises (especially needle exchanges) for children, and the lack of available staff to oversee them during parents' assessments. One focus group attendee's service had previously had a crèche but this was underused and not sustained, although such a system was in place successfully at another, women-only service; and another had an agreement with a nearby family support service to look after children during their parents' appointments. When a child is seen at the service, practitioners were expected to carry out visual assessments of wellbeing (judging whether the child is dressed appropriately, for example), but they indicated that staff require better education to know what to look for and how to identify simple signs which may be cause for alarm.

Some practitioners, as dictated by organisational policy, undertook home visits to clients prescribed OST with children under five. These were described as very valuable and enabled rounded assessments of the child's living situation, as well as checking on safe storage arrangements for prescribed drugs; if possible, workers tried to speak to the child independently and observe parent-child interaction. In one worker's experience, clients had been accommodating and open to showing workers their storage arrangements, but another said that some parents can be resistant to letting drug service workers see the child. Fathers were mentioned as particularly challenging in this respect, for example in refusing home visits or preventing drug workers from seeing the child's bedroom: one practitioner said she had experienced such resistance several times in the preceding few weeks.

It was, however, noted that drug services cannot be all things to all people, especially if they operate in the voluntary sector. It was proposed that health visitors be asked specifically to check on safe storage of medications in the home, and having some drugs workers based in GP surgeries had also had a positive impact on engagement with children and communication between professionals.

Assessing 'comfortable' risk

Whilst there has been significant progress in recent years in reducing the risks children face from parental substance use – through improved assessment, regular follow-up and referral – interviewees were keen to suggest that it is not possible to eliminate all risks, including those



presented by OST. The exposure of children to prescribed medication will always be a present and clear risk that prescribers and clinicians need to be aware of, as part of understanding how the safety of the child can be improved; moreover, it may be one of many risks that need to be judged by the professional in a complex and possibly chaotic family environment.

Many of the interviewees suggested that rather than seeking the impossible and attempting to remove *all* risk from the parent-to-child relationship, there is a simpler need to ensure that practitioners and prescribers are alert to all the possible risks prescribed medication may pose in the home. As with the cultivation of ‘healthy scepticism’ in the workforce and the ability to address challenging questions sensitively, there is a need to invest in the skills of clinicians and prescribers so they feel skilled and supported to make subtle and difficult judgements and are able to be comfortable with the associated level of risk:

“We need to take the moral panic out of this issue – it is about living with the risk, not necessarily [being] risk averse but risk sensitive.”

“We have to learn to live and be comfortable with a certain amount of risk. It’s about understanding those risks, thinking it through and dealing with it appropriately.”

This also highlighted the limits of clinical guidance and local protocols in eliminating risk to children from the ingestion of OST medicines in the home:

“You can give out guidelines and training but at the end of the day it’s a clinical decision whether or not they are going to let their client take home a quantity of methadone over the weekend. They can give all the advice they like about how to store it and how to keep the children safe but whether the client will follow† that is a risk that the clinician needs to determine whether or not they are prepared to take.”

However, it was clear from interviewees that accepting *some* risk does not mean accepting *all* risk, and concerns were identified that clinicians, prescribers and practitioners can become desensitized to risks due to the environments and behaviours they are exposed to on a regular basis. Some of the experiences that practitioners hear from their clients can, over time, make them immune to the risks that these behaviours may present, especially when considering their secondary impacts on a child. This sentiment was echoed in the focus groups, where one participant felt that complacency in the workforce could be partially explained by the nature of social work, in that disclosures of risk are so common that workers become “immune” or “less affected” by them. Interviewees suggested that we need to promote “safe care” within the workforce: the idea that workers can provide non-punitive, non-judgemental care to parents whilst still assessing, understanding and addressing the risks they pose to their children:

“It’s about risk judgements as much as anything.”

“It isn’t a science, just general good risk management... and for me, that is a massive cultural

campaign.”

Information sharing

A lack of consistency in the knowledge and involvement of local professionals outside drug treatment agencies in recognising, communicating and acting on the risks of OST was also discussed. In the focus groups, for example, pharmacists were reported to have varying levels of interest in information about OST clients, with some asking for a lot and others nothing; there could also be deficiencies in pharmacies reporting when a drug treatment client had failed to pick up their medication. Home visits could sometimes be undertaken jointly between drug services, health visitors and social workers, but this is not standard practice. GPs could also be differentially aware of the service user’s activities or the arrangements for picking up their medicine. A lack of communication between services around risk factors like non-compliance with pickup regimes or changes in prescribing arrangements could mean that opportunities to review the safety of the situation could be missed. This led to some confusion amongst interviewees about what pieces of information should feed into assessments for treatment clients, and a lack of consistent good practice information was noted in terms of who should act on which pieces of information, and what reasoning, evidence or guidelines should be used to inform decisions.

Learning and development

As well as barriers to safer practice and limitations in national policy development, a number of ways to

improve and develop knowledge and practice around children and OST were discussed with interviewees, focus group practitioners and attendees at the expert roundtable discussion.

Serious Case Reviews

The role of Serious Case Reviews in improving practice and learning from mistakes was debated by a number of practitioners and experts. On the whole, their value was recognised as providing an excellent opportunity for future learning and correcting any mistakes identified; particular examples given included refreshing safeguarding training for people working in substance misuse services.

However, a number of deficiencies were also identified, both in the review process itself and the extent to which learning is truly able to change practice on the ground:

“I mean the recommendations are there and nobody would disagree with them, but it’s the ‘how do we do that?’”

One issue of particular relevance was representation on Serious Case Review panels: practitioners said that even when cases are specifically linked to substance use (if not OST), experts in drugs and alcohol may still not have the opportunity to feed into the review from a central point. This means that points of learning and action for substance misuse services may be lacking.

It was generally agreed at the focus groups that the aftermath of a Serious Case Review was followed by



a period of great activity, but this tended to be short-lived and rarely resulted in lasting learning. Many interviewees had been involved in Serious Case Reviews and were frustrated at the lack of progress following the identification of key practice-based recommendations in their local areas. A member of one Local Safeguarding Children Board commented:

“...what happened was, there was a load of activity after the SCR and then it dropped off, and then staff changed and it was almost like the lessons had to be learned all over again.”

Where incidents had occurred and either been escalated to SCR level or not, interviewees felt that the learning often stayed locally and was confined to the services and practitioners involved in the original ingestion case. Interviewees talked about the possibility of learning from incidents in other areas and seeking to implement those practice changes within their own services or on a national scale. It was suggested that the collation, analysis and dissemination of all of the relevant Serious Case Review recommendations and subsequent practice changes in local areas would be hugely beneficial:

“Why has nobody nationally rounded up the SCRs, and said ‘OK, [methadone ingestion] does seem to be a predictable thing, there’s all these other cases that have happened in fairly similar circumstances, let’s write them up and make them accessible’.”

As well as the lack of a national picture, ascertaining the extent to which SCR recommendations are

implemented locally was also said to be difficult. One roundtable attendee felt there wasn’t a reliable mechanism to find the extent to which recommendations are actually followed through into practice; this was in an area which had previously recommended a review of prescribing arrangements on the back of a methadone case.

Data

National awareness of OST as a risk to children may also be hampered by a lack of consensus on the true scale of the problem. At the roundtable discussion, it was noted that information about cases of ingestion may be limited, patchy or unreliable: exact figures are hard to come by because information on the prescribing regimes of parents in treatment and the number of children attending A&E after ingesting various prescription drugs is not available. This uncertainty over the true scale of the problem was said to harm the chances of an effective and consistent national approach, and make establishing consensus less likely; this would also harm professional awareness and vigilance in professional circles outside of drug treatment. One conclusion was that A&E should routinely collect data on child ingestions of prescribed medications in a systematic manner, capturing all relevant information, including the child’s age.

Peer groups

In terms of transmitting messages to parents, the role of peer education and service user communities was discussed. Some practitioners were of the opinion that peers are in the best position to provide

credible information on challenging topics, and provide an open and non-judgmental forum for discussion; this included stressing the dangers of OST drugs, the importance of storing them safely, and that under no circumstances should methadone be used as a pacifier for children. One Local Authority represented at the roundtable discussion had researched this specifically, and found that circulating messages through peer groups would be the most effective method; however, this was tempered by the point that it is no one person's 'job' to transmit these messages, and the responsibility should not be placed exclusively on the shoulders of peer networks.

Good practice

Interviewees identified the frustration of being unable to source guidance and good practice on how best to assess and minimise the risks posed to children through exposure to OST medicines, which would ideally lead to the widespread adoption of effective practices. They also commented on the lack of sharing of good practice between areas and providers, meaning that changes in practice tended to be reactive rather than proactive:

"I think we need to get better at advertising what success looks like. We are quite good at showing what failure looks like, you know grab people's attention to frighten them, but [we should] utilise that and show what they can do well."

Interviewees commented on the lack of sharing of good practice between areas and providers, meaning that changes in practice tended to be reactive rather than proactive

Conclusions

The interviews and discussions with professionals and experts provided a useful and interesting counterpoint to analysis of the literature and Serious Case Reviews. They were particularly enlightening on the **inconsistent picture of practice** relating to safeguarding and OST, and the **limitations of policy alone** in minimising risks to children. Practitioners did not think there was a simple answer which could immediately make practice safer: although they were supportive of non-intrusive measures like free, lockable boxes for storing medication, such policies only constituted a limited number of the tools available to local areas and services. So whilst a number of risk-reducing activities were identified, there was **an insufficiently clear picture of what good practice looks like** in the protection of children from OST ingestion.

There was also a **low level of awareness of cases where parents have administered medication to their children**; indeed, this may be because they are rare and few practitioners will have involvement with them, but given the numbers identified in the Serious Case Reviews, it seems this is in need of

some attention. Practitioners need to be able to educate and warn parents against this dangerous practice and reiterate that opioids are potentially lethal, even in tiny amounts.

Some of the comments about learning and development are concerning, and suggest that **even when cases of methadone ingestion by children had happened, and were fully investigated, the extent to which they changed frontline practice was doubted**. Loopholes in practice changes were also identified, such as an **insufficient focus on fathers** in conversations about safeguarding generally, and OST specifically. The importance of regularly checking with men whether there have been any changes to their relationship or living status must be recognised, and assumptions about caregiving roles should be challenged.

Discussions tended to move away from catch-all changes in policy and protocol to broader considerations of risk assessment in substance using families, and the **need to build professional confidence and competency in addressing difficult issues**, of which the dangers of OST can be just one in a wider web of challenges for a family with substance dependencies.

Recommendations for best practice

At the conclusion of discussions, practitioners were asked for suggested recommendations to improve practice relating to safeguarding and OST. Contributions included:

- A more prominent role for pharmacists, health visitors, social workers and the police in safeguarding children from the risks of OST ingestion, including the provision of basic training
- Setting a baseline standard for best practice and embedding this amongst frontline staff
- The national provision of free, lockable boxes for the storage of OST medications
- Including safe disposal messages and clear warnings on the fatal risks of administering OST drugs to children alongside existing provision of safe storage information
- Educating treatment staff on physical welfare checks for children, including the signs and symptoms of drug ingestion
- Training for drug treatment workers on professional challenge, respectful curiosity and working with resistant clients
- Mandatory representation of drug and alcohol services on Local Safeguarding Children Boards
- Substance misuse training must incorporate content on OST, saying what exactly it is with a list of clear ‘must do’s’ for professionals
- Bringing drug teams and children’s services closer together, for example through joint home visits to clients.

Conclusions & recommendations

Conclusions and recommendations

This research aimed to examine the risks to children from Opioid Substitution Treatment medications prescribed to their parents, carers or other family members. It is hoped that this report can stimulate productive debate about OST and the implications for safeguarding, and result in meaningful changes in practice. However, in all of these discussions **we must not endanger the rightful place of medications in a recovery-orientated treatment system.** We must strike a balance between emphasising the obvious and particular dangers of OST drugs to children and scaremongering in the ongoing debate over the use of substitute prescribing in the treatment of addictions.

To get as broad a range of evidence and opinion as possible, we looked at a range of sources from academic literature, media coverage, Serious Case Reviews into individual incidents and the views of frontline practitioners, service managers and policy

experts. Whilst this gave a number of different perspectives on safeguarding and OST, some points were highlighted throughout all phases of the research.

It is evident from our review that **the risks to children posed by OST medications are not being sufficiently managed and minimised in practice.**

This is particularly evident in our findings from Serious Case Reviews, illustrating a fairly consistent pattern of incidents and highlighting 17 over the past five years alone – not to mention an unknown number of near-misses or incidents below SCR thresholds. The frequency and similarity of these cases suggest that national learning is not taking place after each incident, and there are currently no mechanisms for monitoring the implementation of the recommendations that result from them.

Recommendation

Full overview reports of Serious Case Reviews involving OST drugs should be republished (in suitably anonymised or redacted forms, where appropriate) or made available to Government-appointed researchers. Further research into these cases and the learning from them – including analysis of what was changed at the local level and how this was evaluated – is warranted.

There should also be a commitment to collect and review any OST cases biennially and examine the key learning points for practitioners, the implementation of new recommendations and any lessons for good practice.

The Department for Education or Ofsted would be best placed to carry out this work.

As well as limited national learning, this research also brings into question **the extent to which Serious Case Reviews result in sustainable local improvements** in the area where the incident took place. Although OST is far from the only risk to children growing up in sometimes chaotic family

environments, and it is valuable to look at a wide range of concerns, it is perverse that some SCRs do not prioritise learning on the specific cause of harm to the child in the incident at the centre of the Review.

Recommendation

A representative from a drug treatment agency should be present on all Local Safeguarding Children Boards, to ensure that lessons relating to parental substance use are properly prioritised locally. Drug treatment services should also be represented on the Review Panel for any Serious Case Reviews where the parents' drug or alcohol use is relevant.

This research highlights a **clear knowledge gap**. Not all cases of children ingesting OST medications result in Serious Case Reviews, therefore the total number of incidents is not known; this could be estimated using figures from hospital admissions, but these are not available. Although the number of parents receiving OST has been found, this is not

broken down into the different types of prescribing and dispensing regimes, meaning that assessing risk on a national level is very difficult. And whilst Serious Case Reviews can shine a light on individual local areas, the picture of practice in places yet to undertake such reviews into these incidents is much less clear.

Recommendation

Data should be collected centrally on:

- The number of parents prescribed different OST drugs, and on which supervision regimes
- The number of under-18s admitted to hospital after ingesting OST drugs
- The number of under-18s who have died after ingesting OST drugs.

It would also be beneficial to analyse whether these cases involved accidental ingestion by the child or deliberate administration by the parent(s).

Collection of this data should be the responsibility of Public Health England (PHE) or the Department of Health.

It is also evident from this research that **service users and professionals are sometimes not fully aware of the dangers that OST drugs can pose to children when not managed correctly.** This is particularly true of the cases involving the use of drugs as soothers for small children, where professionals did not account for the possibility of

this practice, and parents did not fully appreciate its dangers. In ensuring robust safeguards around OST, professionals need support on **assessing risk in families where the parents use substances, and embedding healthy scepticism and professional challenge into their practice.**

Recommendation

Training for drug services, pharmacies and GPs must highlight the dangers of OST medicines to children. Workers should also be able to address the deliberate administration of OST medicines and other drugs to children with service users and take an active role in promoting positive parenting practices. Such developments dovetail with the ongoing focus on healthy scepticism and professional challenge.

Other professionals working with vulnerable families, especially those undertaking home visits, also need to be alert and vigilant about the dangers of OST drugs.

OST medicines appear to present risks to children that other prescription drugs do not. Toxicity in very small doses, possible attractiveness to children, the chance of unsafe storage in chaotic households and the rare but real use as a pacifier form a group of risks specific to methadone, and this must be recognised. OST medications are also very different from illicit drugs, in that (notwithstanding an illegal market) they are controlled in a way in which illegal drugs are not, and therefore the capacity to minimise risks on a systemic level (through improved prescribing practices, for example) is greater. It is also clear **that the vast majority of Serious Case Reviews – and all of those concerning**

very young children – involved methadone and not buprenorphine. Alongside other clinical considerations, this should be taken into account when making and reviewing decisions about the safest form of OST.

Existing clinical guidelines do mention the need to consider the risks to children (alongside other factors like diversion into the illicit market) when making decisions about OST; however, this research suggests that **safeguarding concerns may not be properly prioritised in reality.** There is a need for **more accessible guidance for frontline practitioners and a greater emphasis on implementation at the local level.**



Recommendation

Guidance on the implementation of NICE, specifically Technology Appraisal 114, must reemphasise safeguarding children as a primary factor in making and reviewing decisions about OST, including which drug to prescribe and whether to permit take-home doses.

This would be the responsibility of PHE or the Department of Health. There is also a role for the Secretary of State for Health in ensuring that NICE is implemented at the local level.

A particular challenge is that whilst we must accept that not all risk can be accounted for, we also know

that **single, isolated incidents of OST ingestion can be fatal**. Safety measures should reflect this.

Recommendation

Safe storage boxes should be provided to all treatment clients in receipt of OST, if they ever take any of their prescription home. There must also be consistent checks on storage arrangements, and information about the dangers of OST should be provided on an ongoing basis. Systems should be in place between different local agencies to distribute knowledge of, and responsibility for, monitoring and ensuring safe storage, including the sharing of safety plans agreed with the service user.

This policy may only be a starting point in reducing risks and, as demonstrated in the Serious Case Reviews, incidents occur even in areas with safe storage policies in place. However, it would be a good starting point, and implementing it on a mandatory and nationwide basis would also serve an educational role in highlighting risks to professionals and service users alike.

We do not recommend the uptake of mandatory supervised consumption for parents in treatment. Whilst this would indeed reduce the presence of OST drugs in the home and the associated risks, our research leads us to conclude that such a policy would be a blunt instrument with the capacity to threaten the successes of treatment. The idea that the children of substance users undergo drug testing appears to be a similarly intrusive policy with the potential to alienate the whole population of parents accessing services to support them with drug dependencies.

Final comments

Although this report discusses a limited number of cases, it also highlights an unacceptable number of child deaths which share a single, common risk factor.

It demonstrates that dangers to children are not sufficiently prioritised by practitioners working with people prescribed OST. Clear instructions from NICE are not sufficiently implemented at the local level or accessible enough to frontline practitioners, meaning that these incidents keep occurring.

It is also evident that the learning opportunities presented by each tragic case have not been used to make practice safer. The recommendations presented in this report therefore constitute a call for more coordinated, national action and awareness to stop more children from dying these unnecessary deaths.

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Appendix I: Serious Case Review summaries

This section contains summaries of the individual Serious Case Reviews studied during this research. It complements the analysis presented in Part Three. Where possible, and depending on the information available in the reports, details are included on:

- The age of the child
- The circumstances of the incident
- The substance involved, who it was prescribed to and on what regime
- Any criminal proceedings resulting from the incident
- The family's contact with social services
- The Review's conclusions on whether the incident was preventable or predictable
- Whether drug services and/or pharmacies were represented on the review panel
- Which organisations were asked to submit Individual Management Reviews*
- Relevant key messages
- Relevant recommendations

Where possible, a link to an online version of the report is also provided.

* Individual Management Reviews are provided by the different agencies that had contact with the family involved in the Serious Case Review over a specified time period. Taken together, these reports paint a detailed picture of the family's relationship with services, and are used to create the full Serious Case Review. IMRs may also make their own recommendations for particular services, which can be reproduced in Serious Case Review reports.

Case: 'Area A', Child B Year: 2012 (Multi-Agency Case Review)

Overview

Concerns were raised that Child B, a six year-old, may have been given drugs by his parents after an emergency order was made and he was placed in foster care. As a result of these concerns, a hair strand test was undertaken which revealed that at some point methadone had entered the child's body. It was not possible to ascertain the quantity of methadone absorbed or the period of time over which this happened. It appears that Child B's mother was in receipt of a monthly prescription of methadone issued by a GP in the community to be collected from the surgery on a weekly basis. Child B was the subject of a child protection plan at birth. Several months later the proceedings concluded with a one-year supervision order. When he was four years old he was again put on a child protection plan because of concerns about neglect. There is no indication that any criminal proceedings were brought.

The review found that there were significant failings in professional practice and that Child B was left in an abusive situation for longer than necessary and earlier intervention could have prevented the child being harmed.

Review process

A substance misuse service was represented on the review panel. No IMRs were obtained from either drug services or the pharmacy, although 'acute services' were covered by the Healthcare Trust's IMR.

Key messages

- Professionals must be alert to the risk of harm to the child from accessing drugs and to address issues of safe storage with parents.

Recommendations

- That Area A LSCB asks that all partner agencies assure that all of their staff are cognisant of the impact of substance misuse on parenting and aware of the requirements for safe drug storage.

The review is not available online.

NB This is not a Serious Case Review, it is a Multi-Agency Case Review. However, it followed the same processes as a Serious Case Review.

Case: Birmingham, Case 11 Year: 2009

Overview

In Spring 2008, a two year-old child died after ingesting methadone at their parents' home. Their three year-old sibling also ingested methadone but survived.

The methadone was prescribed for the child's father. The mother was also a user of illicit drugs and used methadone, which she said was supplied by the child's father. The mother stated that an insecure methadone bottle had been left in the kitchen, and the children drank from it. An ambulance was not called until the next day, as the father instead tried to make the children vomit up as much as they could and thought they could 'sleep it off.'

When the child was 7 days old, the baby and older sibling were taken into police protection following an allegation of physical abuse on the older child. A child protection joint investigation ultimately found the injuries to be accidental and the children were soon returned to live with their parents after a brief period in kinship care. Whilst the family was known to local services, the report finds a failure to act on indicators of risk.

After the ingestion incident, the parents were convicted of causing or allowing the child's death and of neglecting the child's sibling, and were both given prison sentences.

The review concluded that the death could have been prevented and the probability of harm to the child and siblings could have been predicted. It found that professionals showed a failure to challenge and a willingness to accept the parents' reassurances and excuses despite repeat incidences of chronic neglect and 'persistent inadequate parenting.' Furthermore, the impact of two drug abusing parents caring for children was 'completely overlooked'. The professionals involved failed to follow procedures, failed to intervene appropriately and failed to take effective action, therefore the response to the obvious risks posed to the children was deemed fundamentally inadequate.

Review process

The lead commissioner for substance misuse was present on the review panel. It is not specified from which organisations IMRs were requested.

Key messages

- There was a failure to recognise that siblings may have ingested methadone when one was taken into hospital.

Recommendations

- The Department for Children, Schools and Families to commission a study of the risk to children of parents/carers who ingest methadone, and to circulate an analysis of Serious Case Review findings where this has been a feature
- Birmingham DAAT to review the management and supply of methadone when there are children in the household under the age of 16 to ensure that the risks to children are evaluated
- When West Midlands Ambulance Service, West Midlands Police and Hospital Accident and Emergency respond to a report that a child may have ingested methadone or other noxious or poisonous substance, as a matter of routine other children in the household should be taken into hospital to be checked.

The report is not available online.

Case: Bradford, Child HD

Year: 2009

Overview

In July 2006, a two-year old child died from cardiac and respiratory arrest. Toxicology results confirmed the presence of methadone and ‘non prescription drugs’ which had been ingested over a prolonged

period of time. The mother was in treatment to help manage drug addiction and it appears the methadone was prescribed to her.

The child’s mother had previously had two children removed into care. HD was placed on the child protection register from birth and remained on that register throughout his life. The mother had a long history of drug abuse and was involved with many drug agencies throughout the child’s life.

The mother pleaded guilty to manslaughter and child cruelty.

The review found that HD’s death was not predictable in that the professionals visiting and observing HD could not reasonably have been expected to recognise that HD was ingesting methadone. This was based on the acceptance that staff did not have the skills to recognise the effects of methadone ingestion on babies. However, the panel considered that HD’s death may have been preventable as there were a number of factors that should have alerted staff that HD was not best placed with his mother.

Review process

The community drug and alcohol team was represented on the panel. IMRs were obtained from substance misuse services, the PCT (GPs and health visiting services), and the Drug Intervention Programme.

Key messages

- Whilst all agencies were vigilant in monitoring for neglect or harm in respect of HD, no assessment had been carried out to mitigate the risk of him actively being given prescription drugs
- The signs of methadone ingestion could not have been spotted by professionals working with the family. For example, the baby showed no withdrawal symptoms when settling into a new foster arrangement and was not seen as drowsy or sedated outside of bedtimes
- Not all meetings where the Child Protection Plan was considered had representation from the full range of agencies working with the mother and child – in particular GPs and drug treatment staff
- There was not a consistent focus on the mother's substance misusing lifestyle and the impact on her ability to parent.

SCR Recommendations

- Establish a working group to include drugs agencies, health agencies and children's social care to identify responses to the issues which come out of the SCR report, and give further consideration to the possibility of drug testing for young children
- The training sub-group of the Local Safeguarding Children Board should ensure that all substance misuse training for frontline staff addresses the risk of drug using parents actively giving drugs (prescription or non-prescription) to their children and develop a publicity campaign to highlight this risk

- The LSCB should work with health agencies to develop a system for identifying high-risk individuals who should have all methadone administered under supervision
- Bradford LSCB to write to central Government regarding the apparent need for further research and guidance around the dangers of parents giving drugs to their children.

IMR Recommendations

- Bradford and Airedale PCT (GP Primary Care): review methadone prescribing and its link to current best practice in respect of daily pick-up and administration
- Substance misuse services:
 - » Improve information to service users regarding the safe storage of medicines and the risks to children of Central Nervous System depressants e.g. best practice leaflet
 - » Explore the use of 'reads codes' for the local database system to indicate that clients have been given information of the dangerousness of medication to children and advice on safe storage
 - » Ensure the reason for change of medication (including dispensing regime) is documented on every occasion; future audit to be undertaken
 - » Mandatory child protection training of all staff in substance misuse services.

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A report is available [online](#). However, this centres on the reconsideration of the original SCR, after it was deemed ‘inadequate’ due to a number of failings. Little information about the incident is given in this report.

Case: Bridgend, Child K
Year: 2010

Overview

A two-year old child died in 2008 after ingesting methadone he found in his parents’ bedroom. Both parents were being prescribed methadone at the time.

Child K’s older sibling was on the child protection register, but Child K was not.

Both parents were sentenced to 12 months in prison after pleading guilty to familial homicide.

The review concluded that the circumstances of Child K’s death could not have been predicted, as the responsibility for ensuring the methadone was adequately secure and not accessible to a young and unsupervised child in the home lay with the parents. Nevertheless, shortcomings were noted in terms of professionals acting on concerns when they were raised, not sharing information effectively, adopting an over-optimistic approach to the family and not recognising the extent and impact of drug taking.

Review process

There was no drug service or pharmacist representation on the review panel, nor was there an IMR obtained from any drug agency.

Key messages

- The circumstances in which the child gained access to the methadone are not investigated, since this had apparently already led to changes to prevent similar incidents from occurring. No information is provided on the nature of these changes.
- Other risk factors were present in the home, such as, dirty needles, unknown visitors and suspected drug dealing in the house. No agency took action over these hazards, nor were these issues addressed with the parents.
- The case provides an important opportunity to improve the procedures described in the health IMR: to apply clearer action in recognising and anticipating risks of injury to children in a household where drugs or their substitutes are stored and used.

Recommendations

There are no recommendations which address the issue of OST.

The executive summary is available [online](#).

Case: Bristol, Baby Z

Year: 2009

Overview

On 21st July 2007, Baby Z died aged 14 months after ingesting methadone whilst in the care of his mother and a friend. The cause of death was recorded as ‘morphine and methadone intoxication’, but it was unclear how the ingestion happened. When police attended the scene they found evidence of drug taking, including spilt methadone. Baby Z had also been born with withdrawal symptoms, and underwent a morphine programme.

At the time of the incident, the mother was on a daily dispensing arrangement for methadone; she had requested this at least in part due to becoming pregnant again and suffering from morning sickness. From the review it is evident that she spent time on both daily pick-up and supervised consumption regimes. She was advised to keep methadone safe at home, but this was not formally entered into a risk management plan or shared with other agencies involved with the family.

The family was known to services, and home visits had been undertaken by children’s social care and a health visitor. However, no immediate concerns for Baby Z’s welfare were identified.

The mother pleaded guilty to manslaughter and was given a five-year prison sentence.

The review panel ultimately found that Baby Z’s death was not predictable, as the mother had been

seen to be caring for him well and staff could not have identified signs of drug ingestion. However, the death may have been preventable as there were sufficient concerns from staff to merit a ‘co-ordinated response to his care,’ and because his mother had been facing considerable stress which was likely to result in relapse.

Review process

Two reviews were conducted after the original was deemed inadequate. In the first review, the Chief Executive of Bristol Drugs Project was present on the panel. In the second review, there was representation by a Young People’s Substance Misuse Manager. A list of agencies submitting IMRs to either review is not given.

Key messages

- Drug workers put their clients’ needs above those of the clients’ children
- In relation to inter-agency practice, it is important that there is an agreed and shared understanding of the risk management plan when several agencies are involved.

Recommendations

- Safer Bristol should conduct a review of child protection knowledge and practices at Bristol Drugs Project and consider how they will change the requirements in their commissioning and monitoring procedures
- Where there are specific risks within an adult care pathway to children in the family (e.g. prescribed methadone stored at home) the risk should be discussed at each care plan review



with the service users, the information shared with other relevant services working with the family, and appropriate written information provided to the service user

- Where a parent is taking prescribed methadone at home, a safety plan for its storage should be agreed with the service user, entered into the risk management plan and a copy given to the service user and to other agencies working with the family (subject to the appropriate consent)
- All service users prescribed methadone should be given appropriate written information in relation to the significant risks to the child of using methadone and storing it in the home
- Team managers need to ensure that assessments undertaken in relation to drug using parents have allowed sufficient exploration of the potential risks to children.

The executive summary is available [online](#).

Case: Bristol, Child K

Year: 2011

Overview

In August 2011, a 23-month old child died after being found by his father unconscious and not breathing. His death was considered to be the result of methadone ingestion over a period of time. Both parents had a long history of drug using and were in receipt of opioid substitution treatment. At the time of Child K's death, the mother was receiving her methadone through daily supervised consumption whereas the father was prescribed

for twice-weekly collection. The review notes that the parents were given advice on safe storage on numerous occasions without acting upon this advice. Nevertheless, the report concluded that advice about safe storage is of limited use when parents are administering methadone to a child deliberately.

Child K was on a child protection plan from birth but the plan was discontinued before Child K reached his first birthday; he was then considered a child in need. However, following the birth of his sibling, both children became the subjects of Child Protection Plans.

The parents were charged with the manslaughter of Child K and causing or allowing the death of a child under 16. Both parents were convicted of offences relating to the child's death.

The review concluded that although the death of Child K could not have been predicted, there were indicators that the long-term outcomes for Child K and his sibling may have been negatively impacted by their parents' lifestyle. The only way the death could have been prevented was if Child K had been taken into care.

Review process

Drug service representatives were not included in the review panel, although IMRs were obtained from both drugs agencies involved with the family and the pharmacy.

Key messages

- Safe storage information is of limited use in cases of deliberate parental administration
- Insistence on daily supervised consumption of OST for all parents would not entirely reduce the risks to children, but would reduce the chances of accidental ingestion. The mother, when interviewed, said that dispensing should be available 7 days per week.

SCR recommendations

- The Local Safeguarding Children Board should explore, with service commissioners and providers of drug and alcohol services, ways in which services for substance using parents have a family focus. This should include consideration of feasibility and efficacy of the restriction of methadone prescriptions to parents of young children to daily supervised consumption
- A control/monitoring measure for testing babies and young children for the presence of controlled drugs in high risk categories should be considered
- Consideration should be given to a short and powerful social media campaign to tackle a culture where administering methadone is perceived as acceptable.

IMR recommendations

- Drug agency A:
 1. Adapt in-house training to include lessons learnt from the death of Child K
 2. Use the expanded risk assessment for all OST patients (already piloted)

- Avon & Wiltshire Mental Health Partnership Trust (AWP), Drug Agency B:

1. A standard care plan should be developed, setting out best practice for safety planning where methadone or other potentially dangerous drugs are taken home. This care plan should include confirmation of parental understanding and actions to demonstrate compliance with their safety plans, the timescales applicable within the care plan and the actions to be taken if safe storage is not achieved. An audit of the full completion and use of the standardised care plan for safety planning when methadone or other potentially dangerous drugs are taken home will be completed. Findings from this will inform further actions to be taken.
2. A Bristol protocol for the prevention of child exposure to synthetic opiates is developed for use in specialist drug maternity services and drug services working with parents covering: safety planning; provision and use of lockable boxes; prescribing and administration of medication; home consumption; drug testing practice; review of risk post birth; identifying and managing uncooperative parents; withdrawal of services from uncooperative parents; thresholds for child protection referral to prevent exposures to synthetic opiates; thresholds for escalation to prevent exposure to synthetic opiates; coordination between adult drug services in the family



- Pharmacy:
 1. Company to review training and guidance and to incorporate specific training relating to children with parents taking drugs/ methadone. This should incorporate the signs and symptoms of methadone ingestion in children and an insight into the life of the child and when to refer or challenge professionally. The review and writing of the guidance to be completed by 31/1/2012. Training of all branch colleagues to be completed in 31/3/2012 and to be confirmed by the completion of a web form monitored by Head Office.
 2. Company to ensure the importance of good inter-agency communication and working is highlighted in the review of the company safeguarding training and guidance. Reference to be made to the importance of discussing the children of parents taking methadone and related medication with the prescriber/community drug teams if appropriate and the importance of appropriately recording any shared information securely in the pharmacy. The updated company safeguarding training and guidance to be completed by 31/1/2012 and to be completed by branch colleagues by 31/1/2012.
- Pharmacy/PCT: to discuss the review of the Level 2 training for pharmacy contractors to incorporate additional information relating to the signs and symptoms of methadone ingestion in a child
- Pharmacy/PCT/Safeguarding/Community

Drug Teams: review policy and procedure documents if appropriate to ensure the male of the household is adequately assessed and to aim to reduce the quantity of methadone in any household with children to a minimum.

- NHS: that there should be a consideration of one drug service for dependent drug using parents. The child's needs are paramount in UK law and must be seen as a priority because they are dependent on the adults they live with. This service should be reviewed within the next 6 months.

The executive summary is available [online](#).

The overview report is also available [online](#).

**Case: Buckinghamshire, Child A
Year: 2009**

Overview

Child A was born drug-dependent in 2005. On 2nd January 2008, an ambulance was called to the maternal grandmother's house where Child A was found asystolic with fixed dilated pupils. Child A later died in hospital and toxicology reports revealed that he had ingested a fatal amount of methadone. A rigorous police investigation followed but was inconclusive as to how the ingestion took place. Details on who the methadone was prescribed to are not given.

Child A was placed on the Buckinghamshire Child Protection Register after his birth and in 2006 he was made the subject of a one-year supervision order.



There is a mention of the child's parents being 'suspects in a continuing police investigation' but no further information related to charges is provided by the review.

In conclusion, it was found that no one significant event or action by any agency was identifiable as one which, if done differently, would have changed the tragedy of Child A's death. It was noted, however, that the purpose of the supervision order was not sufficiently understood by the different agencies.

Review process

The composition of the review panel was not recorded in the executive summary. An IMR was provided by the Residential Drug Rehabilitation Unit.

Key messages

None of the key messages or learning points concern OST.

Recommendations

None of the recommendations, out of over 40 reproduced from the IMRs, are directly related to OST.

The report is not available online.

Case: Camden, Child B
Year: 2003

Overview

Child B was born with drug withdrawal symptoms, and died in 2001 aged 2 after ingesting methadone prescribed to her mother. On weekdays, the

prescription arrangement was supervised consumption but on weekends she was permitted to take it home because the pharmacy was closed and there was no suitable local replacement. How the child came to ingest the methadone is not known, but it is noted in the report that it was questionable as to whether the mother understood safety issues or was diligent about keeping her drugs out of the reach of children.

At the time of Child B's death, her sibling was on the Child Protection Register, but Child B was not. The mother pleaded guilty to 5 counts of child cruelty and neglect and was sentenced to a 2-year Community Rehabilitation Order.

The review concludes that Child B's death could not have been anticipated but conceded that with hindsight, professionals did not pay sufficient attention to Child B's welfare, concentrating instead on her 'more obviously vulnerable' older sibling.

Review process

Membership of the review panel and the agencies submitted IMRs are not disclosed.

Key messages

- Relevant professionals were often missing from child protection conferences and core group meetings were not held
- Information given by drug misusing parents should be treated with caution. If a parent is misusing drugs, it should be assumed that their capacity to parent will be adversely affected, unless it can be proven otherwise. The parents



should be challenged at an early stage about the impact of their drug misuse on their children, and the likelihood of the children being removed from their care

- This was not the first occasion known to Camden where a child had died or been injured by taking a drug dependent parent's prescription. It raises issues of the attractiveness of the substance to a young child, and the safety awareness threshold of parents. From early on there were concerns by professionals visiting the home that the mother was not sufficiently safety-conscious.

Recommendations

- That Camden Area Child Protection Committee and Social Services review their inter-agency approach to drug misusing parents who are considered to be neglecting their children and provide further training for professionals involved in inter-agency work
- The Area Child Protection Committee, Social Services and Council lawyers should engage in a thorough review of a sample of neglect cases on the child protection register, to test whether the case is typical of others. If it is typical, to ensure that staff receive guidance on the thresholds of child neglect and parental behaviour that should not be tolerated
- In the light of this case the Area Child Protection Committee should review and revise its guidance and procedures on child neglect where there is parental drug misuse and arrange appropriate training
- In conjunction with the Area Child Protection Committee, the Drug Dependency Unit should

review its policy and practice of allowing parents with young children to take their methadone prescriptions in the family home

- The Department of Health is invited to review the safety of the presentation of methadone for home prescription, bearing in mind the safety of children.

The executive summary is available online.

Case: Ceredigion, Child V

Year: 2012

Overview

In 2009, Child V died at the age of 15 after overdosing on methadone. How the methadone came to be ingested, and who it prescribed for, are not deducible from the report.

Child V was considered to have been involved in offending behaviour and substance misuse prior to his death, but it appears that formal child protection procedures were not implemented.

No mention of criminal proceedings is made in the report.

The review concluded that no agencies or individual professionals could have prevented Child V's death given the circumstances of his life at the time, and the nature of the circumstances of his death. It was further noted that Child V was a 'difficult young man to engage' and whose behaviour and attitudes were 'entrenched.'

Review process

An IMR was not sought from drug services and review panel membership is unknown.

Key messages and recommendations

There are no recommendations relating to the issue of OST. The report states that it endorses the recommendations made in the IMRs, but these are not republished and no clue is given as to what they are.

The report is not available online.

NB Due to the lack of information given in the SCR, other sources of information were sought to fill in the gaps. Media reports on a case involving a child of the same age, in the same location, apparently reveal that Child V ingested methadone prescribed to his father which had not been stored securely.

Case: Ceredigion, Child Z **Year: 2012**

Overview

In April 2009, Child Z died aged 17 in the bedroom of a 30-year old man in supported accommodation for homeless people. She had taken heroin and 'other drugs' but it was inhaling her own vomit that caused her death. The coroner returned a verdict of misadventure.

The only mention of OST in the review is in the recommendations, in a point about the safe storage of methadone in supported accommodation (see below). So whilst it can be inferred that methadone

is of some relevance to this case, details of who it was prescribed for, and according to what dispensing regime, are not given.

Ceredigion Social Services had at times throughout her adolescence considered taking Child Z into the care of the Local Authority and at one point spent a short time in foster care before removing herself and returning to her father's care. Upon release from a short time spent at a Young Offenders Institute, an application for an Emergency Protection Order was made and care proceedings commenced. After several months, care proceedings were withdrawn and the following year, her case was closed because she was uncooperative.

The review panel decided that it would be impossible to assert with certainty that different approaches would have had such an impact on the arrangements of care for Child Z, and her inability to avoid risk-taking activities, that the events that led to her death (or something similar) would not have happened.

Review process

The executive summary does not include a list of panel representatives. A report by PRISM (The Mid and West Wales alcohol and drug advisory service) was obtained.

Recommendations

- A multi-agency group should consider storage of medication and risks of prescription methadone in supported housing and make recommendations to Ceredigion Local Safeguarding Children Board

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- The Health Board should make a report to the LSCB on expectations in the West Wales Substance Misuse Service for sharing information.

The report is not available online.

Case: Cumbria, Child E
Year: 2010

Overview

A 17 year-old died of buprenorphine toxicity. No information is given as to how she accessed the drug or whether it was prescribed, however the report notes that '[buprenorphine] has become a street drug of abuse in recent years'.

Child E was well known to a number of local agencies and had experienced many difficulties throughout her life, including substance use. There is no mention of criminal proceedings having been brought as a result of the case.

The author of the review concluded that the likelihood of very serious harm was predictable. In respect of whether her death was preventable, it was noted that if the appropriate care, accommodation, counselling and support services had been provided, together with a multi-agency approach, the risk factors would have been apparent and thus her death could have been preventable.

Review process

There was no drug service or pharmaceutical representation on the SCR panel.

Key messages and recommendations

Given that the ingestion of buprenorphine is not discussed other than being mentioned as the cause of death, there are no relevant key messages or recommendations which relate to OST.

The report is not available online. However a very short summary (significantly shorter than the executive summary sourced for this research) is available [here](#).

Case: Derbyshire, Child BDS12
Year: 2013

Overview

Child BDS was 2 years old when he died in March 2012 after swallowing methadone which had been left in a child's beaker. Toxicology results found traces of cannabis, crack cocaine, heroin, diamorphine and alcohol, suggesting these drugs had been ingested directly rather than being absorbed passively. Both the mother and father denied ever having given Child BDS drugs. The methadone was prescribed to the child's mother. After requesting an increased in her methadone dose (which was refused by the GP) she was advised to split her dose, with some being supervised and some unsupervised. The rationale for this decision was not documents, and there was no record of safe storage being discussed.

Child BDS was not subject to a child protection plan at any time during his life.

Both parents were found guilty of manslaughter for which they received custodial sentences, and the mother was found guilty of cruelty to a child under 16.

The review panel surmised that the question of whether the death was predictable or preventable was a difficult one. It was noted that the parents appeared to be caring well for their child and they considered it was unlikely that unannounced home visits, on their own, would have identified the mother's devious behaviour. The panel was, however, of the opinion that had professionals referred the case to children's social care, a robust assessment would have taken place which would have in all probability ended in Child BDS becoming the subject of a child protection plan. It was ultimately considered that had BDS been referred to CSC (as it was decided he should have been) this would probably, but not certainly, have prevented his untimely death.

Review process

Represented on the SCR panel was a representative from substance misuse services and a senior public health commissioning manager.

An IMR was obtained in combination with Derbyshire Healthcare Foundation Trust. Further summary reports were provided by a pharmacy and another drug treatment provider.

Key messages

- There was a failure of drug treatment professionals to robustly risk assess the mother's suitability for having methadone in the home where she had the care of the child, a to review this as circumstances changed and incidents occurred, sharing information with other professionals as necessary
- Both mother and father felt strongly that there was a lack of information to warn parents about the dangers of drugs and 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.
- Neither the family GPs nor the Community Midwives discussed the safe storage of drugs with the mother and no one from the Drug Treatment Clinic carried out a home visit. An audit around the use of safe storage 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.
- GPs interviewed were unaware the mother had been allowed to take home her methadone and assumed the methadone was dispensed on a daily basis and taken in full on pharmacy premises. This suggests that no GP had discussed the mother's methadone and illicit drug use with her.



- A review of the research and previous SCRs around (a) the 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 this 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 hospital or attending A&E with reported accidental overdoses of any illicit drugs.

Recommendations

- 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
- 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:

- » Distribution of safe storage box facilities for all service users who have children under 5 years of age.
- 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 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.

The overview report is available [online](#).

Case: Gloucestershire, 0109

Year: 2010

Overview

'Jamie' died aged 14 months. Her death was originally considered to be a result of haemolytic chickenpox, but a later toxicology report indicated that Jamie had toxic levels of methadone in her body, sufficient to cause death within 6 hours of ingestion – meaning that it must have been ingested whilst the child was in the care of her mother and her mothers' partner. Further tests confirmed that both 'Jamie' and her older sibling 'Sam', aged three, had ingested methadone on an infrequent basis over a period of time. The mother was in receipt of a methadone prescription; her partner was also accessing services for addiction, but it is not stated that this involved a prescribing intervention.

The review reports that whilst there is some evidence that confirms information was shared with the mother about the safe storage of methadone, when interviewed for the review, the mother said this was not the case. She also indicated that she believed the practice of administering methadone to small children was not uncommon amongst some substance-misusing parents.

Whilst the family was known to services and referrals had previously been made to children's social care, none of these referrals proceeded to a home visit or an assessment.

The mother and her partner were arrested and imprisoned for child cruelty offences against both children.

The report's author determined that no professional had the opportunity to observe whether these children showed signs of methadone ingestion and that there was no occasion when a professional had cause to consider that methadone may have been given to either child, presumably to soothe or pacify them. Therefore, despite the gaps in professionals' interventions and responses, it was unlikely that Jamie's death could have been avoided.

Review process

There did not appear to be any drugs service or pharmacy representation on the review panel. An IMR was obtained from a drug service provided by the PCT, DASH.

Key messages

- More robust procedures in relation to the safe storage of methadone need to be developed by drug services and disseminated to other agencies. This needs to include information about toxicity.
- There is a need to ensure that all professionals working with substance misusing parents are aware of the potential dangers to children where their parents and carers are substance misusers, and in particular of the storage and toxicity issues in relation to methadone and other drugs where children are also involved.
- Compliance with safe storage arrangements needs to be a part of methadone reduction care plans and where children are known to be present, it is reasonable for a professional to monitor compliance by asking to see storage arrangements.

Recommendations

- The two relevant Local Safeguarding Children’s Boards (Herefordshire and Gloucestershire) should implement and monitor locally written ‘Hidden Harm’ protocols now in place to set out how all agencies will share information and work together when there are families where the adults are misusing substances; and that the protocol is explicit about ensuring that adults are made aware of the risks to children who might have access to drugs, associated paraphernalia, alcohol and other medicines. Specific recorded reference should be made on all case notes about toxicity and possible fatal consequences of administering methadone to children, in particular to confirm it has been discussed with the client
- The provision of free, lockable boxes for methadone should be available to all methadone users in treatment.

The executive summary is available [online](#).

Case: Gwynedd and Anglesey, Child 2 Year: 2010

Overview

In January 2010 Child 2, then six months old, was hospitalised due to chest and respiratory problems; she survived the incident. Toxicology tests found that she had methadone in her system, and the mother admitted she had been putting it in the child’s milk and administering it through her feeding bottle since her birth. Both parents had

been engaged in treatment with substance misuse services, although it is noted that the mother’s case was closed in the year prior to the incident. It is not clear that the methadone was prescribed to either parent.

The family was known to local services and concerns had been particularly noted over Child 2’s father, who lived in another area. However, the report notes confusion between social services and substance misuse services as to whether the case was open or closed from a child protection standpoint, and a Core Assessment or Child in Need Plan was not undertaken. After the incident, Child 2 and her siblings were placed on an interim care order and the review described care proceedings as ongoing at the time of writing.

Child 2’s mother pleaded guilty to the charges of supplying methadone and ill-treating her child, for which she is serving a prison sentence. Child 2’s father was charged with a number of offences including supplying methadone and the assault/ill-treatment/neglect of a child.

The review panel ultimately concluded that no one could have foreseen this particular outcome.

Review process

The review panel had representation from NHS services (Betsi Cadwaladr University Health Board, or BCUHB), which may have included substance misuse services. Contact with substance misuse services was also covered by the IMR submitted by BCUHB.

Key messages

- The case provides an opportunity to consider the use and validity of drug testing in cases of concern for the welfare of children whose parents are or have a history of misusing drugs. Both the process for urine testing and its contribution to the sphere of monitoring concerns about the welfare of children in this case is unclear.
- The child’s grandmother felt that there should be stringent testing and more information available for pregnant mothers about the adverse effects of drug use on their babies, particularly if drug misuse is or has been a feature.

Recommendations

- BCUHB should alert doctors to the need to consider a toxicology urine check as part of the routine investigations included for that child’s admission when a child of parents who are known to be or have been drug users, is admitted to hospital with an acute illness. The number of tests taken and the number of positive results should be collated and reported to the Board after 12 months.
- BCUHB in conjunction with the substance misuse service and primary care staff should consider developing a survey to determine whether the activity of administering small amounts of methadone to babies is commonplace in the community following the identification of this individual case.
- The BCUHB in conjunction with the LSCB, SMS and Community Safety Partnership develop

a policy with regard to the substance misuse worker allocation of service users who are in a relationship with one another, if either or both of them have children.

The executive summary is available [online](#).

Case: North Yorkshire, SNM

Year: 2005

Overview

SNM died aged 17 months in March 2004. Toxicology results showed both a potentially lethal dose of methadone and found evidence of sustained ingestion over a period of time.

The report does not state clearly whether the methadone was prescribed or to whom, although it seems clear that the mother had involvement with services, given the learning points and recommendations (see below). Further, there is no mention of whether SNM was the subject of a child protection order nor whether any criminal proceedings were initiated following her death. The panel concluded that no one agency could have predicted or prevented the death. However, it was found that her safety and wellbeing could have been addressed more thoroughly, particularly in relation to the mother’s drug use.

Review process

The executive summary does not contain any information on who was on the review panel or which agencies were asked to submit IMRs.

Key messages

- Provision of specialist posts of Drug Addiction Midwives/midwives with specialist knowledge of substance use is invaluable in terms of providing specialist ante-natal support for pregnant women who use drugs.
- It is important that anyone who may work with parents who are substance misusers recognise the impact to children and the risks that this may pose on a child. This can be achieved by ensuring that agencies have clear internal guidelines for working with substance misusing parents. The guide must include instructions to workers to give advice about the safe storage of drugs and, in particular, the dangers of children ingesting methadone or opiate substitutes.
- Additional multi-agency training in relation to substance misusing parents and the impact on children to enable workers to understand the issues and their roles and responsibilities is required.
- PCTs ensure that there are clear guidelines for Midwives and Health Visitors when working with substance misusing parents and that these guidelines address issues of safe storage of drugs at appropriate developmental stages throughout child's life.
- Hospital Trusts within North Yorkshire should explore and record a parent's substance misuse when it has been brought to their attention, in Accident and Emergency, outpatients and when a child is admitted to a children's ward. The extent of the substance misuse should be established and consideration given to the impact on the child.
- Drug agencies review their 'guidelines for Professionals for assessing risk when working with drug using parents' to ensure that safe storage of medication is addressed regularly during contact to meet the safety needs of the child in line with the child's development.
- The ACPC (Area Child Protection Committee) review procedures relating to substance misusing parents and the impact on children, and review training available on the issue.

Recommendations

- All PCTs must have clear protocols in place for working with pregnant women and parents who abuse drugs and alcohol and must ensure that they have sufficient expertise in working with pregnant women and parents who abuse drugs and alcohol, and appoint a Nominated Drug Liaison Midwife and health visitor(s) with this specific expertise.

The executive summary is available [online](#).

Case: Nottingham City, 'Thomas'

Year: 2008

Overview

Thomas, a 14 month-old child, became seriously ill after ingesting methadone which had been stored in his bottle. At the time of the incident, Thomas had been left in the care of a friend of the mother's, who was probably unaware that the bottle contained methadone. At the time of the incident, the mother was not receiving a regular prescription, which resulted in her sharing her partner's methadone. No mention is made of criminal proceedings.

Thomas had previously been subject to a child protection plan but was taken off the register 4 months before his death. The family had been well known to services for a number of years. Both of Thomas' older siblings were being cared for by relatives, but the review finds that they may have been living back with their mother at the times of the incident.

The conclusion reached was that the baby's ingestion could have been avoided and the risk of harm recognised by all agencies.

Review process

- The executive summary does not give details of panel membership or the IMRs requested.

Key messages

- That the mother would share her partner's methadone, in the absence of her own prescription, could have been predicted
- There were clear indicators of risk and vulnerability observed by agencies and not share at the time the child's case was closed by social services, or in the months afterwards
- Key agencies were regularly absent from core group meetings and child protection conferences
- The repeated non-compliance of the parent with a drug treatment programme could have been set as a measure to re-refer the child to social services.

Recommendations

- Health: promote the significance of home visiting in families where there are safeguarding issues to be assessed by drug workers.
- Health: review or develop the guidance for pharmacists and specialist workers who are prescribing drugs for adults who care for children or live in the same household as children. This should include the need for safe storage and ensuring that there is a valid script in place before prescribing drugs to those who misuse substances.
- Children's social care: all staff must ensure when undertaking assessments of drug users where children are in the household that the assessment includes issues relating to safe use and storage of drug equipment and substances.

The report is not available online.

Case: LB, Plymouth

Year: 2006

Overview

In September 2002, LB was admitted to hospital with methadone in his system. He was unconscious and suffered renal failure, liver failure, brain damage, muscular breakdown, eye abrasion and bruising. He was expected to suffer long-term neurological damage but did not die.

There is very little information provided in the executive summary of the review, which does not address the circumstances of the incident, the age of the child, who the methadone was prescribed to, whether the family was involved with social services or LB was on a child protection plan, and whether any criminal proceedings resulted from the incident. In deciding whether the incident was preventable or predictable, it is noted that the agencies involved were aware of the nature of both parents' drug use and many concerns by extended family and neighbours were voiced about both parents' ability to safeguard the child. The author concludes that 'it is difficult to comprehend why this child was not protected by the agencies charged to do so'.

Review process

Review panel membership is not stated in the executive summary. IMRs were obtained from the PCT and the NHS Trust but no mention is made of substance misuse services.

Recommendations

- For the Drug and Alcohol Team: Drug and alcohol agencies should recognise that they have a responsibility towards the children of their clients and should set up good links with other relevant agencies to improve safety of children
- To all agencies: Priority is given to training in the area of direct work with drug abusing parents to improve practice standards.

The executive summary is available [online](#).

Case: Reading, Child T

Year: 2009

Overview

Child T was 3 years old when she died in October 2006 as a result of methadone poisoning, most likely administered to her over a period of time but 'not with the intention of ending her life.' The methadone was prescribed to her mother, who was on a 5-day supervised consumption regime, taking her methadone in the presence of a pharmacist during the week but taking home weekend doses. There had also been a previous incident where Child T cut her finger on an empty ampoule of methadone at the substance misuse service.

Child T was on the child protection register, but an application for care proceedings was withdrawn five days before Child T died based on the mother's complaints that she was not being given a chance to prove herself as a mother. The mother had also had 3 previous children removed into care.

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The mother died of a drug overdose 4 months after the incident. No criminal proceedings took place in the matter of Child T's death.

It is not explicitly noted whether Child T's death could have been predicted or prevented. However, significant shortcomings in the protection offered to Child T were described, including professional failure to listen to the concerns of others, such as the foster mother with whom Child T spent a very short time.

This Serious Case Review was published after the original was deemed 'inadequate'.

Review process

Panel representation is not disclosed in the review. An IMR from Berkshire Healthcare NHS Foundation Trust (Specialist drug and alcohol, mental health and learning disability service) was examined, after being overlooked in the original review. IMRs were undertaken by Reading Drug and Alcohol Intervention Service and the Reading Drug and Alcohol Action Team.

Key messages

- Much of the review focuses on addressing the shortcomings of the original review, and as such there is limited coverage of key messages and recommendations relating to the incident itself.
- One of the reasons the original review was rated 'inadequate' was that key agencies were not requested to submit IMRs. This included several drug and alcohol services

- No thorough medical examination was undertaken when Child T was taken into foster care, which could have alerted agencies to the signs of methadone ingestion.

Recommendations

- There was an increase in social workers' uptake of training on parental substance use noted after the publication of the original review recommended this. No further details of recommendations are given.

The report is not available online.

Case: Southampton, Child F Year: 2012

Overview

In 2001 Child F, aged two, was admitted to hospital with a wheezy chest, pinpoint pupils, drowsiness and disorientation, which progressed to respiratory distress. She subsequently made a full recovery. Toxicology screening indicated the child had ingested methadone, and the report shows that she was also born withdrawing from drugs.

The methadone had been prescribed to the child's mother. Discussions about safe storage were recorded five times by the prescribing service, and the GP practice stated that the mother was aware of the need for safe storage and had a lockable box. However, the report finds no evidence that disposal of methadone was discussed, and this is said to be important as the mother's accommodation had shared rubbish disposal facilities. It is not clear how



the child accessed the methadone, although the mother stated that she must have found discarded bottles in the rubbish bin and drunk the remaining liquid from them. The father was also accessing services to address his illicit drug use and was on a methadone prescription, but at the time of the incident was not living in the family home.

Several weeks before the incident with Child F, the mother's partner died of a methadone overdose. This happened in the mother's house, and was due to use of the mother's prescribed methadone. Charges were brought against the mother for manslaughter and supplying a Class A drug, but the charges were subsequently dropped. The review notes that following this incident, there was no assessment of risk by social care in relation to the children, and the prescribing service was also not notified. Had this happened, the mother would probably have been moved to a supervised consumption regime, and Child F's ingestion could have been prevented. After the incident Child F and her older sister, Child C, were removed from their mother's care and placed with foster carers. The family had a long history of contact with social services, and two previous children had been taken into care. At the time of the incident, both children were subject to child protection plans.

The review concluded that the incident was probably not predictable in light of what agencies, individually and collectively, knew and understood about the parent's drug use and other risk factors. However, the pattern of neglect and number of incidences suggest that the event was an 'accident

waiting to happen'. It was furthermore indicated that the mother had been given safe storage advice and that professionals had failed to use the investigation into the death of mother's partner from methadone to prevent risks to the children. The mother herself felt that the incident could not have been anticipated or prevented.

Review process

No drug sector or pharmacy representation was present on the review panel. An IMR was requested from Society of St James (Drug treatment services – voluntary sector organisation). In addition, a health overview report was commissioned and additional information sought about the commissioning of substance misuse services for the Southampton Drug Action Team.

Key messages

- The risks to children from drugs in the household were unexplored and unknown throughout the child's life
- Substance misuse services were not effectively engaged in multi agency work despite their awareness of the involvement of social care and the police at certain points. Poor communication with them from statutory agencies but the organizations also lacked confidence and expertise in working with risk to children for parental substance misuse.
- The risk posed by prescribed methadone use by a parent of young children was not identified. The presence of the drug in the home, together with illicit drugs at times, posed an ever present possibility that children might have access to them.



- Lack of clarity by workers visiting the home about what methadone looked like and the arrangements for safe storage and disposal
- Lack of interagency consideration of risk following the death of Mr. G from methadone overdose only a few weeks earlier is a key issue in assessing whether the ingestion of methadone by Child F was preventable.
- Southampton SSCB should require agencies to provide assurance that when there is a critical incident such as death, accident or serious crime involving people who are actively using the drug treatment services, that information is shared with substance misuse services to ensure that they can take action to protect children and vulnerable people with e.g. supervised dosing.

SCR recommendations

- The safe storage and the safe disposal of methadone must be discussed at each new referral to drug services with the service user
- Southampton SSCB should advise the Southampton Drug Action Team of the findings of this SCR in relation to safe storage and disposal of methadone and request a revision of the guidance and a clear protocol outlining which agency is primarily responsible for agencies visiting the family home to check on arrangements
- The LSCB should ensure commissioners agree a protocol on the commissioning of a timely response for drug testing where a child is subject to child protection processes or care proceedings and that arrangements are detailed in local procedures
- Southampton SSCB should ensure all agencies working with children and families where substance misuse is a known risk factor provide practitioners with information and training in understanding the effects, prescribing options, and safe/lethal doses of commonly used drugs and being able to identify prescribed methadone.

IMR recommendations

- GP's: Practice undertaking methadone prescribing should ensure all practitioners have basic knowledge and understanding of client group and potential side effects of the medication including those of overdose
- Solent Healthcare: Complex substance misuse training should be provided to health visitors and other key groups of practitioners
- Southern Health: SHFT (HPFT) KW's and prescribing Dr's will provide information to clients regarding the safe storage, consumption and disposal of prescribed methadone and other drugs and substances for the following groups: clients who are under the care of Substitute Prescribing Services where children may come into contact with the drugs; clients who are under the care of Substitute Prescribing Service when requesting 'holiday prescriptions'; other clients whose lifestyles, health problems or disability means that there may be a heightened risk to children from unsafe storage, taking or disposal of drugs
- Health Overview: NHS Southampton as a partner in the Drug Action team should review commissioning arrangements of substance



misuse services to ensure use of consistent assessment processes which routinely and reliably consider all children and clients who may be at risk; NHS Southampton should review commissioning arrangements to substance misuse services to ensure that an appropriate and child friendly facility is available for children when they attend appointments with parents; NHS Southampton should require all substance misuse services to review their arrangements for advising clients in safe storage and disposal of prescribed and as far as possible, other medication or 'street' drugs

- Children's Social Care: A comprehensive training package for social workers around parental substance misuse alongside treatment workers and its impact should be commissioned and be supported by the joint protocol and by ongoing group supervision/ action learning groups
- Drug Action Team: Ensure safeguarding is built into commissioning agreement and that all service specifications include the key policy that drug treatment providers will focus on families where parents misuse drugs, intervening early, prioritizing parents' access to treatment where children are at risk and sharing information appropriately with other treatment providers and statutory agencies; the DAT will agree a joint protocol outlining processes and responsibilities to be undertaken by each service when dealing with service users who are parents, carers or who live in a household where there are children or vulnerable adults

The executive summary is available [online](#).

Case: Staffordshire, C1 and C2

Year: 2010

Overview

In March 2010, a 14 year-old girl was found dead by her mother in unexplained circumstances. A crime scene investigation found text messages to one of the girl's schoolmates – also 14 years old – and it became clear that they had both intended to attempt suicide. Paramedics were immediately despatched to the other address, where the second girl was found alive but critically ill. She went on to make a full physical recovery.

It was established that both girls had taken a significant quantity of methadone belonging to the father and that the deceased had taken the medication from within her home. Both parents were substance misusers and the father was known to have 'hoarded' methadone in the past.

Both families were well known to local services, but in the case of the deceased young person, there had been no referrals of concern for some years. The surviving child was placed on an Interim Care Order. A criminal investigation was conducted but no proceedings were undertaken.

It is the author's conclusion that the death and attempted suicide was both predictable and preventable. This is mainly due to the fact that one of the young people told a teacher of their intentions – although by saying 'before our 16th birthdays' this was not acted upon, with the girls being only 14.

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The author does concede, however, that intervention may only have delayed the action or changed its method.

Review process

There was no drug agency or pharmaceutical representation on the panel and information about IMRs is not given.

Key messages

- The need (or duty) to undertake assessments of children living with drug-using parents even where the significant harm threshold does not appear to be met
- During the course of the review [the author] became increasingly concerned at the ease with which the father of the deceased young person was able to stockpile significant amounts of methadone without attention being paid to safe storage, particularly given the presence of young children in the household. It is also a matter of some concern that the prescribing GP was unaware that the father had previously been caught hoarding methadone, a fact known to the police and the Substance Misuse Team. Such knowledge would have influenced the assessment of risk and may have led the GP to insist on daily collection of methadone at a local pharmacy.

- Arrangements for the dispensing and safe storage of methadone to drug using parents must be subject to careful assessment by the prescribing doctor and protocols should exist to ensure that they have access to all relevant information when making that assessment

Recommendations

- The PCT and relevant agencies review their protocols in respect of prescribing and safe storage of methadone in the light of events described in this review to address in particular: risk assessments taken by GPs; information sharing between statutory agencies to inform such assessments; robust and consistent advice by prescribing GPs on the risk posed by methadone to children; specific discussions between the prescribing GP and the patient in which the GP gains a clear understanding of storage arrangements in the family home; regular and systematic review of patients' intake of methadone assessed against their prescribed dosage; and clear record keeping that confirms that all elements of the revised protocol have been addressed with the patient.

The executive summary is available [online](#).

Case: Staffordshire, Child aged 3

Year: 2008

Overview

In May 2008, a child aged 3 years and 9 months was admitted to hospital with a life threatening condition. The paramedic initially reported that the child had ingested a mixture of bubble bath and Germolene, but a doctor recognised the symptoms of methadone ingestion and intervention by hospital staff saved the child's life. The methadone had been prescribed to the child's mother.

The family was known to local services and a Child Protection Conference had previously been convened. However, this did not result in a Child Protection Plan, no Core Assessment was completed and further multi agency meetings did not take place.

At the time of the SCR, the mother was subject to an ongoing police investigation.

There is no explicit recognition that the incident could have been predicted or prevented. However, several areas of concern were apparent, such as inefficiencies in information sharing, lack of professional understanding of the impact of substance misuse on the children and a number of missed opportunities.

Review process

It is unclear whether drug services or pharmacies were represented on the review panel. A list of agencies submitting IMRs is not provided.

Key messages

- Need for improvements in agencies' understanding of the impact of substance use and domestic abuse on children.
- Services' focus was on the mother and adults, not the children.

Recommendations

- North Staffordshire Combined Health Care NHS Trust should devise a safety plan where parents are administering prescribed methadone at home which should be reviewed every three months. A written copy of this should be retained by the service user and a copy given to other agencies involved with them.

The executive summary is available [online](#).

Appendix II: Interview questions and prompts for focus groups

- Could you give a quick rundown of your daily roles and responsibilities?
- What is your engagement with this issue? Do you or your organisation work with children and families who are prescribed with OST?
- Would you say this was an issue on your agenda? Or your colleagues agenda? Training need?
- If it isn't in your agenda where do you think it sits?
- How do you work with parents or those who care for children when they are prescribed?
- Do you think parents understand the dangers of methadone to children, including using it as a soother?
- Do you have any concerns about this issue? Have you taken any action internally about this?
- Any protocols, guidance, research that you are aware of that you follow? Internal or external?
- Are you aware of any measures which have been taken locally to reduce the risk of a child accessing OST?
- Are children allowed into the drug service, and what is workers' engagement with them? (Are they picked up etc; and are there any ways your service could identify their exposure to OST?
- Have you been involved in any incidents either that were escalated to serious case reviews or near misses? Question marks over practice?
- If involved in any serious case reviews what were the recommendations and what was done with them? How were they communicated?
- The Nice guidance states that prescribing regime decisions should be made taking into account an individual's family situation – do you have any protocols or experience of this?
- Any examples of best practice?
- Local data management systems that you are aware of?
- What do you think could be improved at both a clinical and policy level?
- What would be your key recommendation to support parents to keep children safe?
- Much engagement with prescribers, pharmacists, drug workers etc?
- What would be useful is raising this as an issue?